Asia-Pacific Journal of Health Management ACHSM

RESEARCH ARTICLE

WHAT IS THE PROFESSIONAL IDENTITY OF ALLIED HEALTH MANAGERS?

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ABSTRACT

OBJECTIVE:

This paper explores the professional identity (PI) of Allied Health Managers (AHMs) and how their identity is typically constructed.

METHODS:

A qualitative research methodology utilising semi-structured interviews was employed for this research. Thematic analysis was used to extract relevant data from the transcripts.

SETTINGS:

The study was undertaken in five acute hospitals within one of the largest metropolitan Local Health Districts in New South Wales, Australia. A total of sixteen AHMs and deputy AHMs were interviewed.

RESULTS:

Three key themes identified were: PI of AHM, motivation of becoming a manager, and construction of their identity. Factors motivating AHMs to follow a management pathway were identified as being a natural progression and having interest in high-level decision-making. Despite AHMs sharing similar role conflict as the medical managers, they adapted to hybrid manager roles with minimal resentment. They also adopted to the hybrid manager role with a positive, realistic and flexible perspective.

CONCLUSION:

Despite facing role conflict as a hybrid-professional-manager, AHMs manage the transition from clinicians to managers with a positive approach. This indicates that AHMs may require certain skills or characteristics to successfully construct their PI.

KEYWORDS

professional identity, managers, allied health, health professionals

INTRODUCTION

Allied Health (AH) is a collective term for health professionals who are university-trained but are not part of medical, dental or nursing professions. In Australia, AH make up a quarter of the total health care workforce [1] and is described as the third pillar of the patient care workforce, in addition to doctors and nurses [2]. Each AH discipline has their unique and specialised expertise in preventing, diagnosing and treating a range of conditions and illness [3]. AH professional (AHP)'s roles and interventions focus on protecting, maintaining and restoring the basic functions and needs of an individual, such as mobility (physiotherapist), eating/nutrition (dietitian), activities of daily living (occupational therapist), communication and swallowing (speech pathologist), psychological and social wellbeing (social worker). AHPs contribute to safe and speedy patient discharge in hospitals [4,5]. However, the literature suggests that AHPs remain under acknowledged, including having a lower value within the clinical team, which results in a perception of less clinical contributions, lack of autonomy in decision-making, and lack of authority [6-8].

In health, clinicians in the medical and nursing domains are often employed to carry both clinical and managerial roles. They are referred as hybrid-professional-managers (HPMs) [9-11]. The role and position of AH managers (AHMs)

within healthcare organisations also make them suited to the description of 'hybrid-manager'.

Professional identity (PI) is a stream of social identity [12]. It arises from how a group of professionals classify and differentiate themselves. PI can be viewed at a macro or micro level. At the macro level it relates to the status, privileges, duties and self-image of the profession, while at the micro level it refers to the unspoken behavioural norms of the professions [8].

The PI of HPMs is well researched in health, particularly in doctors and nurses [13-17]. The majority of the research found HPMs experience an internal tension of being both a manager and a clinician [13,18]. These complex and challenging identities often arise from the difference in orientations between professionals and managers [14,19,20].

HPMs often experience role conflict when balancing time allocated for managerial tasks, clinical work, teaching, and research responsibilities [21-23]. Role conflict is also evident when organisational decision making is required for resource priorities, such as staffing levels, that impact on patient care [21,23,24]. Employees often have the perception of 'them' (management) and 'us' (clinicians), and managers are at risk of being seen as a traitor to their professional group and thus lose support from their subordinates [11,23].

At present, there is limited research on the PI of AHMs. The tradition of medical dominance remains prevalent in health, such as medical intimidation during ward rounds and unfair workspace allocation [25-27]. AHPs continue experiencing difficulty in establishing their roles within the healthcare system [7,28,29]. This lack of authority is likely extended to decision-making at the management level.
The importance of AH disciplines in patient care is increasingly being recognised, however AHPs still experience significant challenges through medical dominance and lack of professional recognition. The AHMs are role models for staff (AH clinicians) in establishing their disciplinary role within the hospital, while accepting the reality of being less influential in the health care hierarchy. A strong and concrete PI is essential for the success of mastering a role [30]. Therefore, a more in-depth understanding of the construction of AHMs PI is critical in the professional development of an AHM. The aim of this paper is to explore the nature and construction of the PI of AHMs.

METHODS

This paper reports on the qualitative component of a wider mixed-method study investigating the competencies of AHMs. Qualitative research methodology was used as some competencies, especially those skills which are ambiguous and difficult to articulate, such as emotional intelligent. A qualitative research approach is best suited to investigate such complex concepts [31].

The study sites consisted of all five acute hospitals within one of the largest metropolitan Local Health District (LHD) in New South Wales, Australia. Approximately 620 AHPs are employed in the five hospitals, accounting for 6-7% of the health workforce in this LHD. The percentage is much lower than the national average (25%) as not all AH disciplines are employed in the hospital settings, such as music therapists. The AH disciplines included in this study were: dietetics, speech pathology, physiotherapy, occupational therapy and social work. In the LHD, a total of 35 managers and deputy managers are employed across these five hospitals within the five disciplines. Invitation emails with a research information sheet were sent to all hospital facility AH Directors or Discipline Directors to forward on to the potential research participants.

A total of sixteen AH managers and deputy managers volunteered to participate in the interview component of the research, with recruitment ceasing when no additional new themes were identified. To ensure the sample was representative, demographic data were collected in the introductory questions of the interview. These data are shown in Table 1.

Face-to-face semi-structured interviews were conducted by the principal investigator (MM) using an interview guide. Audio recordings of the interviews were transcribed verbatim. Their accuracy was confirmed by cross-checking the written transcription and the audio recording (by MM). Data coding and analysis were performed by MM. Thematic analysis was used to analyse the data from the semi-structured interviews using NVivo version 11.4 (QSR International, Melbourne, Vic., Australia). Braun and Clarke's six step approach was followed to syntheses themes: familiarising data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing up [32]. The following diagram illustrated the creation of the theme "centre of knowledge".

TABLE 1 DEMOGRAPHICS OF THE PARTICIPANTS

	SEX		YEARS IN MANAGEMENT*			ROLE	
Disciplines	MALE	FEMALE	< 2 YEARS	3-5 YEARS	>10 YEARS	MANAGER	DEPUTY
Dietetics		4	2	1	1	3	1
Occupational Therapy	2	1	2		1	3	
Physiotherapy	3	1	2	2		4	
Speech Pathology		3	2		1	3	
Social Work	1	1	1		1	1	1

* None of the respondents had management experience between 6-10 years

FIGURE 1: EXAMPLE OF THEME GENERATION – CENTRE OF KNOWLEDGE

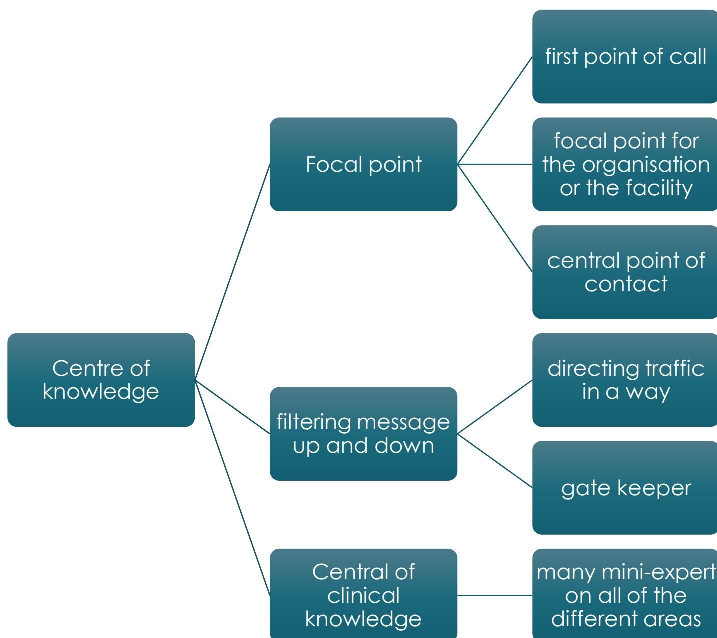

TABLE 2. SCORE OF INDIVIDUAL DOMAINS FOR COREQ CHECKLIST

DOMAINS (NUMBER OF CRITERIA PER DOMAIN)	NUMBER OF CRITERIA REPORTED	NUMBER OF CRITERIA NOT REPORTED BUT HAS BEEN TAKEN INTO CONSIDERATION DURING THE STUDY
Personal characteristics (n=5)	3	2
Relationship with participants (n=3)	2	1
Theoretical framework (n=1)	1	
Participant selection (n=4)	4	
Setting (n=3)	3	
Data collection (n=7)	3	2
Data analysis (n=5)	4	
Reporting (n=4)	4	

Consolidated criteria for reporting qualitative research (COREQ) checklist was used to rate and ensure the quality of the interview [33]. Table 2 shows the score of individual domains.

Overall, this study met 27out of the 32 criteria. Some of the criteria, such as gender and training, have been taken into consideration during the research process but have not been reported. The main bias of this study was originated from the personal characteristics of the researcher and the relationship with the participants. The researcher was a AHM and has worked with some of the participants. In order to mitigate the selection and respondent bias, the recruitment process was through an independent person (Directors). There was also no selection of participants as all volunteered participants were included in the study. The use of a standardised interview guide also assisted to ensure the consistency of the interview irrespective of the relationship between the researcher and the interviewees. Since the researcher is an AHM, subjectivity and own opinion may create bias to the results. To ensure the rigor of the study, a subset of transcripts was reviewed by other researchers to confirm the accuracy of the coding.

Ethics approval for the research was obtained from the Human Research and Ethics Committees of the South Western Sydney LHD (LNR/16/LPOOL/203) and Western Sydney University (RH11762).

RESULTS

The PI of AHM was identified from discussions exploring how respondents viewed their roles, hierarchical level and influential power within the acute hospital setting. The construction of their PI was identified from their management career progress and the way they responded to challenges in relation to conflicts between their AHM role and PI. Various concepts related to AHM PI were identified, such as: centre of knowledge, lower hierarchical status, and construction of these identities. These were further condensed into three key themes: 1) identity as AHM, 2) motivation for becoming a manager and 3) construction of the identity. Table 3 presents the themes related to PI identified by the participants.

TABLE 3: THEMES AND SUB-THEMES OF THE MANAGERIAL CHALLENGES OF AHMS

THEMES	SUB-THEMES
Identity as allied health manager	Less influential and lower status Expectation of being the centre of knowledge Being hybrid professional manager
Motivation of becoming a manager	Opportunity Ability to make changes and be involved in decision making More enjoyment from a management than clinical role
Construction of professional identity	Positive motivation of being a manager Identity work

IDENTITY AS ALLIED HEALTH MANAGER

Similar to other medical and nursing HPMs, respondents in this study experienced role conflict. In addition, there were various factors acknowledged as being central and unique to the identity of AHMs, including the profession being less influential and holding a lower status, and the expectation of others to be the centre of knowledge.

The issue of occupational prestige remains prevalent and there is a status difference between AHPs and their medical and nursing counterparts [8]. This power difference may extend to their managerial role. All participants commented on a self-image of lower status and hierarchical position (when compared to other health managers). One respondent described AH as being:

"at the bottom of the pile' (respondent four).

Since PI also relates to unspoken behaviour and rule [8], another respondent provided an example of how doctors and nurses often take priority over AHPs when it comes to resource allocation.

"If you have money at the end of the financial year, they will take it from you and give it to medical and nursing. That's those behaviours show you that they are the important one and they are the one to take priority over AH. (respondent six)

In addition to comparing themselves with other health service managers, respondents also described how they were viewed by other professions and stakeholders. Respondents reported that AHMs are expected to have high levels of clinical knowledge in all clinical areas:

"It can be difficult in terms of the perception that the manager needs to be a clinical expert of having clinical knowledge about all clinical areas." (respondent eleven)

This expectation creates additional stress to the AHMs, especially those with less managerial experience.

"If you try to lead something that you're not 100% knowledgeable in, you can make a huge mistake and you can lose a lot of respect. Once you lose the respect, you can't get it back." (respondent six)

Similar to other HPMs in health, various respondents also described PI role conflict. This conflict originated from the AHM holding various responsibilities with limited time and resources.

"Take into account the responsibilities for supervising staff and undertaking clinical duties. All those restrict the time for strategic work [which I am passionate about]." (respondent five)

Asia Pacific Journal of Health Management 2019;14(1):i219. doi: 10.24083/apjhm.v14i1.219

In addition to time constraints and multiple responsibilities, respondents described an internal conflict that exists between balancing organisational priorities and responsibilities, and their passion as a clinician. One respondent also expressed experiencing ethical struggles of being a HPM.

"I take that patient-clinician hat with me wherever I go….. if you do not have a clinical role, then you probably can make those decisions [cutting services] much easier. But for me that's always my struggle." (respondent four)

Within this hybrid identity, there was a difference in how the respondents viewed their main role. Managers with greater experience as a clinician have a stronger clinician PI.

"I would see myself as a [professional S] with managerial duties." (respondent twelve)

Whereas, managers with less clinical experiences have a stronger managerial identity.

"I came into management after probably three years as a clinician. I don't have that ingrained professional identity to [professional O] compare to somebody that was [professional W] for 25 years and became a manager. " (respondent eleven)

In summary, AHMs identified being at a lower hierarchical level and being the centre of knowledge as their unique identity. They experienced role conflict and time constraints of being a HPM. AHMs with less clinical experience have a stronger managerial identity and are less attached to their clinician identity, when compared with those working up their career path over many years. These differences may be related to the motivational factors drawing them to management, which will be discussed in the next section.

MOTIVATION FACTORS

A person's identity in an organisation may change as he/she progress in their career or change roles [34]. Therefore, the AHM's motivation to become a manager will have an impact on this identity transition. Various respondents commented that progressing into management roles is a natural pathway for their career progression.

"I came into this role, kind of worked my way up in this District." (respondent two)

Some respondents deliberately chose the management path as they have an interest in being involved in high-level strategic activity and decision-making.

"At the early phase, the interesting part was a new hospital is being built ……. We were actually developing the service and working out the process; and working with people and the organisation to develop those good services." (respondent sixteen)

Other respondents, with less clinical experience, had a clear interest in management work rather than the clinical work.

"I love being with patients but also to be honest I don't want to do that all the time. I really like that non-clinical side, so I applied for the deputy position." (respondent fifteen)

In summary, there were different factors motivating respondents to follow a management pathway, including natural progression and interest in being involved high-level decision-making. Male respondents and those with less clinical experience were drawn to managerial roles because of a strong interest in management tasks. In addition to motivational factors, the way that an AHM constructs his/her managerial identity has a strong influence on how this identity is consolidated. This construction will be discussed in the next section.

CONSTRUCTION OF IDENTITY (IDENTITY WORK)

When a clinician first moves into a management role, he/she constantly compares the actual work with their initial expectation. This leads to a deeper understanding of the PI of this new role. This is referred as integrity violation [12]. Being at a low hierarchical level and status has been identified as a unique PI of AHMs. One respondent suggested this PI is a result of AHMs experiencing integrity violation in relation to power.

"I don't think AH has as much power within that organisational structure. I think we have inherited this construct of powerlessness and sometimes there's a little bit of this victim mentality." (respondent seven)

Adaptation to this integrity violation may be easier for those AHMs without a strong clinician PI.

"For me, I don't feel that I need to justify why [professional O] is so great …… I have a more practical approach to it. I look at it from the use of resources and time factor." (respondent eleven)

When facing this lack of status in the managerial role, the respondents reported they adapt and change their 'manager' identity to suit the situation.

"Whatever influence we have to build, it's not something necessarily comes with 'I am an AH manager title'.….. So I think our management position doesn't' carry an assumed level of power the way a similar medical manager would." (respondent two)

Many respondents described the method they used to consolidate their managerial identity. This included building confidence with both objective and subjective measures, such as seeking feedback and number of complaints. Others described this as a "trial and error" process. Role modeling is a common strategy described by the respondents as part of their identity learning.

"I definitely think a mentor or a support person is important.... Somebody that you aspire to be like or you really trust and value their opinion that can help support you through some challenging times." (respondent three)

In summary, the respondents accepted the AHM identity may not necessarily come with power and authority. They accepted this 'reality' and adapted their behaviour to suit the situation. The respondents also suggested the ways or strategies they use to build this identity, such as implementing subjective and objective measurement, role modeling and mentoring.

DISCUSSION

The findings of this research, including lower hierarchical level, centre of knowledge and hybrid manager, were developed through the lens of PI theory. Medical dominance over AH has been widely studied [25-27]. This hierarchical difference also exists at the managerial level. The widespread nature of AHPs practice, including varying age groups, clinical areas and settings, plays a significant part in the "centre of knowledge" identity expected of AHMs.

This research confirms the role conflict experienced by other HPMs. The majority of PI research finds HPMs experience role conflict in being both a manager and a clinician [14,19,20]. They expressed internal conflict when management work intruded on their clinical role [13,35]. However, contrasting with previous reports, respondents did not express resentment regarding managerial tasks as do medical managers, and they appear to adapt well with their new identity.

This positive adaptation to this role conflict and lower hierarchical status may indicate some respondents had a less strong AH clinician PI, especially those who transitioned to a managerial role early in their career. As Pratt et al. suggest, a new identity is constructed through violation of identity, and when violation occurs, a person will either choose identity patching (i.e. adapting to the new identity through adding to existing identity) or identity splinting (i.e. reverting back to a previous familiar identity) [12]. So, instead of reverting to their previous clinician identity, the respondents were more willing to change their expectations and adjust for the role conflict or lower hierarchical status.

In addition to the less strong AH clinician PI, the motivational factors drawn to management would also explain the positive adaption of the hybrid role. The majority of the respondents described the transition from clinician to managerial role as a mostly opportunistic and a natural progression. This is similar to findings in other studies in AH [36]. In addition, respondents also reported other positive motivating factors, such as wanting to be involved in high-level decision-making and a genuine interest in management. Two respondents (both male) were drawn to management much earlier in their career. They had established these goals and desires even two or three years after graduation. This finding is different from that for medical HPMs described in other studies. Doctors were motivated by feeling pressure from colleagues, being obligated to address a problem, preventing someone else taking on the role, or by being the oldest in the department [13,16].

Another interesting finding is related to the construction of the AHM identity through organisaitonal socialisation [37]. Some of the less experienced AHMs expressed a feeling of being unsure about their roles and apprehensive about their status. In order to fit-in within the organisation they need to understand the politics and work process, the role expectation and behavioural norm, and the power and

status structure through observation of others and mentoring. In addition to the external factors, the new managers are also required to build their self-definition or identity through socialisation. The present findings confirm the importance of social validation through feedback and role modeling [36].

This research identifies that having a clear goal and positive motivation in management progression is essential in establishing the AHM's PI. In addition, AHMs are required to accept the reality of having a lower hierarchical identity despite having a manager title. The ability to adapt and establish this identity is necessary in surviving this less-than-ideal situation while continuing to advocate for their department and patient care. This research provides key insight into what qualities a person may require to master a managerial role under the medical dominance environment. This will assist in establishing a list of characteristics which will be useful in succession planning for AHM positions.

Historically, the most senior and experienced clinician was viewed as the most suitable candidate for a management position. This research highlights that this may be different for the AH discipline. A motivated clinician with a career goal as a manager and less developed clinician PI (i.e. less clinical experience) may also be an ideal candidate. However, since AHMs are often viewed as the 'centre of knowledge' for the discipline, this may create challenges for those less experienced clinicians in gaining respect from their peers, doctors and nurses as they may not have worked in all clinical areas. Additional guidance should be provided to this group of AHMs, such as utilising support from other senior clinicians or other discipline managers.

A limitation of this research is the small number of participants (n=16). However, concept saturation was reached. Although this research was conducted in one LHD, the analysis indicates the identity described was AH specific, such as lower hierarchical status and centre of knowledge, rather than context specific. Therefore, the results are likely be transferable to other organisations. However, more research on AHM's PI are required, including the comparison with other professions.

CONCLUSION

Despite AH making up of a quarter of the healthcare workforce, there is limited research in understanding the PI of AHMs. It is evident that AHMs adopt an identity of being less influential and having lower status than other HMs. Instead of showing resentment, they develop mechanisms to cope with this less than ideal situation. AHMs also carry the identity of being the centre of knowledge for their discipline, which is particularly challenging for new managers. With less experienced clinicians increasingly being willing and interested in stepping into managerial role, an organisation's ability and mechanisms to identify talent and provide support to build managerial capacity is essential, and strongly dependent on employing the right person at the right time. Therefore, it is important to properly investigate the unique attributes required for an AH professional to better adapt to a managerial role.

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