Chapter 3

Responses to professional identity threat: Identity management strategies in incident narratives of health care professionals

The aim of our chapter is to explore sensemaking of incidents by health care professionals through an analysis of the role of professional identity in narratives of incidents. Using insights from Social Identity Theory (SIT), we argue that incidents may create a threat of professional identity, and that professionals make use of identity management strategies in response to this identity threat.

The chapter draws on a qualitative analysis of incident narratives in 14 semi-structured interviews with physicians, nurses and residents at a Dutch specialist hospital. We used an existing framework of identity management strategies to categorize the narratives.

Our analysis yielded two main results. First, nurses and residents employed multiple types of identity management strategies simultaneously, which points to the possible benefit of combining different strategies. Second, physicians used the strategy of patronization of other professional groups, a specific form of downward comparison.

We discuss the implications of our findings in terms of the impact of identity management strategies on the perpetuation of hierarchical differences in health care and argue that efforts to manage incident handling may profit from considering social identity processes in sensemaking of incidents.

This is the first study that systematically explores how health care professionals use identity management strategies to maintain a positive professional identity in the face of incidents. This study contributes to research on interdisciplinary cooperation in health care.

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6 This chapter is based on Van Os, A., De Gilder, D., Van Dyck, C., & Groenewegen, P. “Responses to professional identity threat: Identity management strategies in incident narratives of health care professionals.” Accepted for publication by Journal of Health Communication and Management. Prospective DOI: 10.1108/JHOM-12-2013-0273
In the context of incidents, professional identity has vital implications. For instance, cooperation across professional boundaries in health care is often difficult to achieve because of the professional identity of members of different professional groups, e.g., physicians and nurses (2012). Suboptimal cooperation between professional groups has been associated with an increased risk of incidents (Sutcliffe et al., 2004). Moreover, professional identity is reflected in the content of incident reports (Iedema, Flabouris, Grant, & Jorm, 2006; Waring, 2009), and finally, incidents can result in an experience of threat to the professional identity (Dixon-Woods et al., 2009). Social Identity Theory (SIT; e.g., Tajfel & Turner, 1979) posits that when a group’s identity is threatened, people who identify with that group (in this case, a profession) will be motivated to maintain a positive image of their group vis-à-vis other groups, which is expressed through identity management strategies (Blanz et al., 1998). Given the important connection between identity and incidents, we study how health care professionals use identity management strategies in response to incidents.

In line with the World Health Organization, we define an incident as “an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient” (Runciman et al., 2009, p. 19). We are specifically interested in human error (unintended deviations from a planned action) and the types of incidents that errors may result in: near misses (an incident that did not reach the patient), no harm incidents (an incident that did reach a patient but did not result in noticeable harm), or adverse events (an incident that resulted in harm to a patient; cf. Runciman et al., 2009). To illustrate these concepts, imagine the simple case of a health care professional who unintentionally gave the wrong dose of medicine to a patient. Whereas this action itself is an error, it would result in a near-miss if the error was detected and corrected in time and in an adverse event if the
wrong dose was administered and the patient suffered from this.

Incidents are often not as straightforward and easy to classify as in our example, which introduces the need for sensemaking after incident occurrence. Sensemaking is defined as the way people give meaning to experiences and is inherently a social activity (Weick, Sutcliffe, & Obstfeld, 2005). Sensemaking can be observed through the narratives people tell about previous experiences (A. D. Brown, Stacey, & Nandhakumar, 2008). Narratives, or the accounts that people give of an event or series of events (Czarniawska, 2004), are a means to express identity (Humphreys & Brown, 2002) and therefore offer a suitable type of empirical material to investigate how professional identity influences sensemaking of incidents.

Previous research on sensemaking after incident occurrence in health care has touched upon issues of professional identity and intergroup relations by showing that narratives of incidents can reinforce group identities (Waring, 2009). Furthermore, group hierarchy and identity are important factors contributing to differences in sensemaking between members of multi-professional teams (Rovio-Johansson & Liff, 2012). Our contribution is that we use insights from SIT explicitly in our effort to better understand how professional identity influences sensemaking of past incidents through narratives. We agree with Brown et al. (2008), who stated that a further exploration of the factors that inhibit a shared understanding of previous events is needed. In health care, it is of crucial importance that professionals learn from incidents, which may be inhibited by a lack of shared understanding of these incidents. We argue that the use of identity management strategies in incident narratives may account for the absence of this shared understanding after incidents. In order to support this claim, we investigate how the professional identity of health care professionals (in this case, physicians, nurses, and residents—physicians in training of becoming a
specialist) is expressed through identity management strategies in their narratives of incidents.

**Background**

The professional group is one of a number of possible sources of social identity (Lammers & Garcia, 2009). Social identity is “that part of an individual’s self-concept which derives from his knowledge of his [or her] membership of a social group (or groups) together with the value and emotional significance attached to that membership” (Tajfel, 1981, p. 255). Central to SIT are the notions that people categorize themselves and others in terms of group membership, that they tend to feel affectively connected to these groups, and that they are motivated to maintain a positive social identity, because membership of the group is important for the self-concept. Such maintenance of a positive social identity can be achieved through social comparison with other groups (Tajfel & Turner, 1979). A final important characteristic of SIT is that identification affects behavior, because people have a tendency to behave in accordance with the norms and values present within their group (Van Dick, 2001).

In health care settings such as hospitals, the professional identity of health care professionals is likely to be stronger than their team, departmental or organizational identity (Callan et al., 2007). If this is the case, it can lead to divisions between health care groups (Kreindler et al., 2012), intergroup polarization, rivalry, and competition (Ashforth & Mael, 1989), a perception of inadequate intergroup communication (Grice, Gallois, Jones, Paulsen, & Callan, 2006) and difficulties in implementing new ways to improve patient care (Powell & Davies, 2012). These consequences of professional identity are relevant because professionals from different
disciplines have to work together to provide care for patients and this cooperation becomes more problematic because of the factors just discussed. As argued by Dixon-Woods et al. (2009), health care professionals perceive errors as a threat to their identity because errors are incongruent with their professional ideals. When this professional identity is threatened, and when status differences between groups are difficult to change, individuals or groups can use different cognitive strategies (Blanz et al., 1998) for maintaining or restoring a positive image of their group and themselves (see Table 3.1 for an overview of the strategies, including examples). Three general types of cognitive identity management strategies can be differentiated, which all revolve around a comparison or categorization. The first type of strategy is about emphasizing certain comparative dimensions: on which characteristic are groups being assessed, or how are these characteristics valued? In the second type of strategy, the object of comparison is central: who or what is the ingroup compared with? This comparison object can be a different group, a standard, or a different point in time. The third type of strategy involves self-categorization: what level of identity is dominant? For instance, one can highlight one’s individual identity or a superordinate (e.g., organizational) identity. Since its conception in 1998, Blanz et al.’s framework has inspired both experimental (e.g., Becker, 2012; Hornsey & Hogg, 2002) and applied (e.g., Ashforth et al., 2007) research on identity management strategies, confirming the notion that people, and in particular members of low status groups, tend to use these strategies when their identity is threatened.

Whereas no research to date has explicitly applied the framework of Blanz et al. (1998) to health care, several aspects of the relations between
Table 3.1. Overview of cognitive identity management strategies (Blanz et al., 1998)

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Name of strategy</th>
<th>Description of strategy and examples related to health care context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on comparison dimension</td>
<td>Compare groups on favorable dimension</td>
<td>Comparison of groups on a dimension that is favorable for the ingroup, instead of a dimension that is unfavorable for the ingroup. <em>Example</em>: Compare professional groups on the characteristic of ingroup supportiveness instead of level of education.</td>
</tr>
<tr>
<td></td>
<td>Re-evaluation of comparison dimension</td>
<td>Reversion of the evaluation of the two poles of a status-defining comparison dimension by a devaluation of the positive pole and inflation of the negative pole. <em>Example</em>: Level of education: higher level (positive pole) = too much focus on technical knowledge, lower level (negative pole) = better social relation with patient.</td>
</tr>
<tr>
<td>Downward comparison</td>
<td>Comparison with standard</td>
<td>Comparison with a lower status outgroup on relevant comparison dimensions. <em>Example</em>: Compare with administrative personnel.</td>
</tr>
<tr>
<td>Temporal comparison</td>
<td>Individualization</td>
<td>Comparison of ingroup between another point in time and now instead of with other, higher status groups. <em>Example</em>: Emphasize the improvement of procedures compared to ten years ago.</td>
</tr>
<tr>
<td></td>
<td>Subordinate categorization</td>
<td>Defining and/or presenting oneself as an individual, instead of a group member. <em>Example</em>: When the performance of the professional group as a whole is low, focus on individual achievements instead.</td>
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<td></td>
<td>Superordinate categorization</td>
<td>Distinguishing within the ingroup between two or more subgroups and comparing the new ingroup with a lower level outgroup (part of former ingroup). <em>Example</em>: Differentiate high performers (= new ingroup) from low performers (= new outgroup) within professional group.</td>
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<td></td>
<td>Merging the former ingroup and outgroup into a new, common ingroup. <em>Example</em>: Focus on organization, department or team instead of professional group.</td>
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Responses to professional identity threat

professional groups in health care make it an important setting to study identity management strategies. For instance, the relation between nurses and physicians is characterized by a strong power asymmetry, associated with differences in social class, education, and tasks (Fagin, 1992). This hierarchical relation between physicians and nurses remains difficult, if not impossible, to change (Finn, Learmonth, & Reedy, 2010). Nurses therefore occupy a relatively low hierarchical position, which can be an identity threat. Furthermore, nurses frequently deal with patients who do not comply with their requests, which also represents a possible source of identity threat for nurses (McDonald, Rogers, & Macdonald, 2008). Considering the relatively low status of nurses in comparison to physicians, and the threat posed by nurses’ interaction with patients, incidents may be especially threatening for this professional group, because incidents may endanger the already vulnerable position of nurses. The use of social identity management strategies could be a way for nurses to protect their group status in the face of incidents.

As earlier authors have already mentioned, it is more difficult to assess the presence of identity threat in higher status groups (in this case, physicians), because they have more opportunities to ‘express their confidence in the ability or worth of the group, even when anticipating a possible status-loss’ (Scheepers & Ellemers, 2005, p. 193). Whereas identity threat in itself is indeed difficult to observe, we can infer from previous studies (e.g., Dixon-Woods et al., 2009) that it consists of the danger that involvement in an incident diminishes the image of infallibility of physicians. Other research shows that the primary response to identity threat of a member of a higher status group is emphasizing social dominance (Morrison, Fast, & Ybarra, 2009). We therefore expect that for physicians, incident occurrence will spark efforts to legitimize and maintain their
dominant high status professional identity, for instance by means of downward comparison (Wills, 1981) with other professional groups.

Residents, the third professional group we study in this chapter, occupy a special position in the hospital hierarchy (Ibrahim, Jeffcott, Davis, & Chadwick, 2013). Studies focusing on medical socialization of residents show that residents gradually develop their professional identity as physicians during the years of specialist training (e.g., Pratt et al., 2006). In this period, their identities as physicians are not yet fully established and they are therefore less certain about what is expected of them and what they can do to fulfill that expectation (Brooks & Bosk, 2012). Physicians function as role models who transfer the norms and values of the profession onto the residents by giving feedback on both desirable and undesirable behavior (Apker & Eggly, 2004). Whereas residents may already have internalized aspects of the physician identity, they are still in a vulnerable position given their error proneness and the implicit norms related to errors (Bosk, 2003). These two factors can result in a discrepancy between desired and expected behavior on the one hand (i.e., not making any errors) and actual behavior (i.e., making errors) on the other hand, leading to a lack of coherence of their professional identity (Pratt et al., 2006). Because residents’ identity is so sensitive to the impact of incidents, this group is likely to use identity management strategies to protect and enhance this fragile identity.

To study how identity management strategies come to the fore in sensemaking after incidents, we use storytelling in a narrative approach (Boje, 2001). Research on well-known crises shows that shared identity is crucial for collective sensemaking (e.g., Weick, 1993), as it provides a ‘vital anchor around which collectives construct meaning and understand their experiences’ (Maitlis & Sonenshein, 2010, p. 563). In reality, however, this shared identity does not always exist, and within organizations a great
variety of identity narratives coexist that may not always be reconcilable with each other (Humphreys & Brown, 2002), which can have negative consequences for intergroup cooperation. Brown and Jones (1998) conclude from their research on narratives in a failed information systems project that stakeholders explained this failure through self-serving narratives that functioned to “bolster the self-esteem of those whose social identities are tied to the work they perform” (A. D. Brown & Jones, 1998, p. 85). Similarly, a study of the interaction in a multi-professional health care team shows that professionals interpreted situations to the benefit of their own professional group, which contributed to a persistence of role hierarchy within the team (Rovio-Johansson & Liff, 2012). These examples show that social identities are relevant to take into account when studying narrative sensemaking, because of the role narratives can have in shaping intergroup relations. Through analyzing how identity management strategies are employed in the narrative expression of professional identity in relation to incidents, we wish to shed light on the different ways in which professional groups in health care respond to incidents.

Methods

We performed a qualitative interview study with fourteen health care professionals. Our respondents were five physicians, three residents and six nurses, all working in a centre that is part of a hospital in the Netherlands specialized in ophthalmology (eye care). The hospital promoted a positive safety culture consisting of openness and transparency. As part of this endeavor, all professionals were trained in non-technical skills, focusing on communicative behavior such as speaking up and performing a time-out (i.e., an extra safety check before commencing a surgical procedure). Given
the profitability of the medical procedure performed in the centre, the hospital encouraged its execution by setting a yearly target number. As a consequence, these short procedures were performed under great time pressure. Furthermore, the patient receives local anesthetics during this particular procedure. This presents both patients and care providers with particular challenges (Karlsson, Ekebergh, Mauleon, & Osterberg, 2012). For instance, patients’ trust in their care providers during local anesthesia is important for their feeling of safety during the procedure (Mauleon, Palo-Bengtsson, & Ekman, 2007). Specifically, it can be stressful for a patient when the surgical staff uses technical jargon (Caddick, Jawad, Southern, & Majumder, 2012). Directly discussing errors or complications among practitioners might also cause stress for a patient, which would increase the risk of an adverse event. In practice, the circumstance of local anesthetics forces all professionals involved to act diplomatically and formally towards each other. The characteristics mentioned above—training in non-technical skills, time pressure, and the presence of wakeful patients—are important context information because they give an indication of how interaction between professional groups would generally occur in this setting.

The semi-structured interviews, held by an interviewer trained by the first author, took place in meeting rooms at the hospital. To structure the interviews, we composed a topic list that consisted of themes such as professional identity, specific incidents and how these incidents were handled, and intergroup communication during and after incidents. The critical incident technique (Flanagan, 1954; Van Dyck et al., 2005) was employed, the goal of which is to gather information about specific activities or events that an interviewee has encountered. In this case, we asked participants to elaborate on specific health care incidents. Participants were free to choose the incidents they talked about, so involvement of themselves...
or other members of their professional group in these incidents was not required. The interview duration varied from thirty minutes to one hour. After confidentiality was guaranteed, interviews were tape-recorded and transcribed.

After initial readings of the transcripts to familiarize ourselves with the data, we focused on analyzing the interviewees’ incidents narratives. Narratives were coded as such when respondents spoke of instances in which patients were potentially or actually harmed as a result of a health care professional’s behavior. The primary goal of our analysis was exploring the use of identity management strategies in incident narratives. We used the identity management strategies of Blanz et al. (1998), presented in Table 3.1, as a framework for analyzing the narratives. In order to differentiate between strategies, we asked the following questions when analyzing the narratives: what individual or group characteristic is emphasized in the context of an incident? Is it possible to identify a comparison object, e.g., another person/group, a standard, or a point in time? What level of identity is apparent in the narrative (e.g., personal, professional, or team identity)? The first author performed the primary coding, whereby the relevant parts of the narratives were categorized into identity management strategies. Subsequently, the authors deliberated amongst each other about coding decisions until an agreement was reached regarding what identity management strategies certain parts of narratives should be assigned to.

Results

In total, we identified 51 narratives in the fourteen interviews. The length of the narratives varied from four sentences to three pages of written text. There was hardly any overlap in the incidents respondents discussed.
Respondents often discussed incidents in general terms, referring to incidents that occurred more often, which was marked by the use of words such as “sometimes,” “often” and “mostly.” This could be an indication of a possible response to the identity threat incidents pose: by acknowledging that incidents indeed occur but that they also happen to others, the association between the behavior of specific individuals and the occurrence of incidents is diminished. From the total number of narratives, we coded 23 as non-specific incidents and 28 as specific incidents. 16 of these specific incidents were near misses, compared to seven adverse events and one no harm event. We did not find any indication that these different types of incidents were related to differences in the use of identity management strategies. Therefore, we do not make a distinction between them in the remainder of this chapter.

**Identity management by nurses and residents**

We noticed that nurses and residents regularly used multiple identity management strategies together in the same narrative. Specifically, the nurses’ narratives were characterized by an emphasis on both individual and collective extra-role behavior: positive and voluntary behavior that goes beyond existing role expectations (Van Dyne, Cummings, & McLean Parks, 1995). Whereas individual extra-role behavior corresponds with the identity management strategy of *individualization*, collective extra-role behavior corresponds with the identity management strategy of *comparison with a standard*, because emphasizing extra-role behavior implies that the individual or group does more than is officially expected of them. Presenting extra-role behavior as a shared mode of conduct can contribute to the positive ingroup image of being constructive actors. In other narratives of nurses and residents, individual extra-role behavior was accompanied by a
reference to a *superordinate identity* or an emphasis on *positive characteristics of their professional group*. In the following sections, after showing how individual extra-role behavior was accentuated, we explore how different combinations of identity management strategies were employed by nurses and residents.

**Individualization and comparison with standard.** Individualization in the form of individual extra-role behavior was the type of identity management most often present in the narratives of nurses. The expression of individual extra-role behavior was accompanied by a need for acknowledgment of this type of behavior, for instance in the narrative of a nurse who noticed an error in the chart of a patient:

>This [patient] said [something] to me, and I thought “hey,” and then I looked at the chart, and that’s not something I have to do [...] So I took this chart to physician X [...] and then I got a compliment from the physician that I noticed it correctly [...] This may sound odd, but a pat on the shoulder from the physician, like “you did a good job,” that’s something I want to share [with the other nurses]. Nurse 1

This nurse does not refer to the professional group, but merely to her own, individual extra-role behavior, which is characterized by going beyond her limited responsibilities in providing care for patients. Furthermore, the importance of acknowledgment is visible in the nurse’s response to the compliment of the physician. She seems to be proud of this acknowledgement of her capacities and therefore wants to share it with other nurses, as a way of showing off the positive aspect of her behavior in this
situation.

The absence of acknowledgement could result in a sense of disappointment, as we noticed in a different narrative by a nurse who handled the documentation in a case where a patient was mistakenly declared dead because of an administrative error:

*I handled these data correctly myself, but I never heard back from it, like “good that you solved it.”* Nurse 3

Receiving feedback after an incident report, in this narrative, can be seen as an acknowledgement of the effort the nurse took in solving the problem. Criticism on the limited feedback after an incident report was common among respondents, but there was a difference in the nature of this criticism. While physicians’ criticism mostly targeted the futility of reporting incidents because they observed that the hospital consistently failed to learn from them, nurse 3 primarily seemed to be aggrieved that her attentiveness and decisive actions were not recognized. This sentiment was shared by other nurses. The difference here is that physicians did not appear to need feedback about their incident reports as a confirmation of their efforts and their response even signaled a sense of superiority in reference to the organization, whereas this nurse shows a more dependent attitude, indicative of a need for recognition of extra-role behavior.

As said, individual extra-role behavior was often accompanied by a reference to collective extra-role behavior. For example, a nurse said about the attempt to change a procedure related to marking the method of anesthesia in patient files:

*At first we weren’t allowed to implement that right away. So*
we were like “why do we have to wait for anything? We can do it right away.” So I edited the posters right away. Nurse 2

In this narrative, the difficulty of implementing an improved procedure was presented as the standard. The nurses exceeded this standard by taking the initiative to change the procedure anyway. Also, the co-occurrence with individual extra-role behavior is shown here by mentioning the individual pro-active role of immediately changing certain posters with information on the procedure to note the method of anesthesia. This narrative thus shows how a focus on personal and group identity can go together in a fluent way.

**Individualization and comparing groups on a favorable dimension.**

Another mixture of identity management strategies we found was the combination of *individualization* (i.e., individual extra-role behavior) and comparison of groups on a *favorable dimension* (i.e., emphasis on positive characteristics of the professional group). Specifically, positive individual behavior in relation to an incident was sometimes compared with the more negative behavior of a higher-status outgroup member. In the following extract, a nurse compares her own behavior to the behavior of an anesthesiologist, a representative of a higher-status outgroup. The focus in this narrative is thus both on the individual and on the professional group. In this incident, the wrong patient was anesthetized, and both the nurse and the anesthesiologist were responsible: the anesthesiologist had incorrectly performed a procedure and the nurse had been inattentive.

*When the patients were all gone, the anesthesiologist left right away. Physician X did immediately follow him [to address the*
Knowing this anesthesiologist, he doesn’t respond to this a lot. Like “oh yeah,” and then next day it’s the same again. [...] With the people involved – the anesthesiologist was on holiday so he wasn’t there – we did sit down to have a chat about what had happened. [...] It was a pity that this didn’t happen that same afternoon, getting back to it right away. A weekend was in between, and well, you feel pretty bad during that weekend. So for myself, I had already put some things on paper, like how could this happen.

Nurse 4

The nurse presents the anesthesiologist as being uninvolved with patients (in this case, leaving directly after a procedure was finished) and uninterested in learning from incidents (in this case, not responding to the physician’s remarks after the incident). In sharp contrast, the nurse was aware of the gravity of the incident (indicated by the comment that she had felt bad about it during the weekend) and spent time preparing for the evaluation of the incident. This comparison on a characteristic (responding to an incident) that is in favor of the nurse results in an impression of the nurse as being reflexive of her own behavior and successful in constructively responding to an incident, in comparison to the indifferent attitude of the anesthesiologist. By means of this favorable comparison, the nurse is able to boost her identity in the face of an incident in which she was partly responsible: a clear example of a successful identity management strategy.

*Individualization and superordinate categorization.* Yet another type of identity management was a focus on a *superordinate identity*. In the nurses’ narratives, this categorization translated into a focus on the
multiprofessional team as a whole. In one narrative, the incident consisted of a failure to check whether the calculation made for a certain procedure had been correctly copied to the patient chart. It was apparently unclear who was responsible:

*Physician X is the one it happened to, and well anyway, I personally think he is also responsible for it, but he was really like, “you…” No, “we…” [both nurses and physician]! And we [nurses] also made a report of it and he made a report of it. And then we said, or he said, let’s make sure this form [with the calculation] is always in front of the pink paper [with the patient information].* Nurse 1

The level of categorization is adapted flexibly to facilitate or avoid association with certain types of behavior, as the meaning of “we” shifts within the narrative. In the second sentence, “we” refers to the team as a whole, thereby emphasizing that not only nurses were responsible. In the subsequent sentence, however, “we” refers to nurses, who filed a report of the incident separately from the physician; presumably to indicate the different perspectives they had on the incident. Finally, “we” refers again to the team as a whole, a categorization that is nevertheless quickly corrected because it was the physician who took the initiative to change the routine and not the team. This narrative shows how the level of categorization can shift, even within one narrative, based on the positive or negative associations with a certain level of identification.

The flexibility of the type of categorization also shows in the narrative of a resident who resorts to yet a different type of superordinate identity, one which is not available to nurses: the physician’s identity.
If you don’t do the time-out, you can get in trouble; as a physician, you are responsible. Since that time [when a patient switch almost occurred as a result of not doing the time-out procedure] I always consciously ask for the name, even if everyone thinks it’s nonsense. Resident 3

Association with a higher-status group is accomplished by the simple statement “as a physician, you are responsible.” Additionally, the expression of individual extra-role behavior (in this case, doing a double-check, although it is not obligatory) can serve to emphasize that one is a legitimate and worthy representative of this superordinate group. Thus, in this case individualization and superordinate categorization are combined in a way that strengthens this resident’s association with the professional identity of physicians.

Summarizing, our exploration of identity management strategies shows that nurses and residents incorporated different identity management strategies within one narrative. Nurses expressed individual and collective extra-role behavior, and emphasized positive characteristics of their professional group. Both nurses and residents used the strategy of categorization into a superordinate identity group. Nevertheless, the level of superordinate identity that is accentuated appeared to differ across situations (even within a narrative) and across individuals or professions, the implications of which we will discuss after focusing in on the main identity management strategy used by physicians.

Identity management by physicians: Downward comparison

We found that physicians engaged in downward comparison, in the sense that they explicitly expressed the differences between professional
groups by naming the obvious characteristics that differentiate physicians from nurses:

You’re a specialist in a certain area, so you have years of training in that one subject. So only because of that, because of your experience and because of what you see, you already have a much better overview of what you’re doing at that moment than the nurse […] The chance that the nurse doesn’t see it correctly, is much greater than that the physician gets it wrong. Physician 3

This physician here emphasizes the level of experience and knowledge that distinguish physicians from nurses and links this to the small likelihood that a physician makes a mistake. Whereas this comment may come across as a bit haughty, it also reflects a factual, obvious difference in years of training that can hardly be disputed. Contrary to this narrative, the main identity management strategy among physicians was not direct downward comparison but a more subtle strategy: patronization of other professional groups, particularly nurses. Patronization includes the term “patron,” whose linguistic roots are related to “protector” and “master.” Being a patron comes with a supportive and didactic attitude, but is also associated with treating others condescendingly. These two elements of patronization were manifested by a physician when cooperation with nurses was described:

It’s like with raising children. If they do something that isn’t right, then you confront them with that immediately. You identify what isn’t right and that that’s not the way it should
The twofold connotation of patronization comes to the fore in the comparison used by this physician. The educational element of patronization is reflected in the desire to teach nurses; however, equating nurses with children comes across as somewhat degrading, as it implies that nurses need to be reprimanded in the same way as children. An even more concrete and controversial manner of expressing the hierarchical differences between the professional groups by ways of patronization comes from the following physician:

*Sometimes I do things wrong on purpose. Just to test them. I mean, then I just do something, like I want to start cutting, while the time-out hasn’t happened yet, and then I hope they’ll say “wait, stop,” and I always think it’s disappointing that the nurses don’t say anything.* 

Physician 1

This physician explains his purposeful deviation from a rule as an attempt to steer nurses towards what is desirable behavior in his view. In this case, the rule is conducting a time-out before starting a procedure, and the desirable behavior of nurses is speaking up in case a time-out is not performed. The condescending aspect of patronization becomes visible in multiple ways: the fact that the physician feels the need to test the nurses is an indication that he does not trust them to respond in the way he wants them to, and the apparent ease with which the physician misleads nurses implies that nurses are easily fooled.

Apparently, this physician’s educational method usually does not lead to the preferred response. When asking a nurse why she did not speak
up, she replied (according to him) as follows: “Yeah, yeah, I did that twice now, I got such a big mouth [from other physicians], I’m not doing that anymore.” Another nurse similarly indicated that whereas in trainings physicians were taught that nurses are not their “little helpers,” the actual behavior of some physicians reflected a condescending attitude. There is an important interplay between two aspects of the expression of patronization by physicians. Specifically, the desire to educate others on the one hand, as is reflected in the aspiration of physicians that other professional groups express speaking up behavior, seems to go together with the desire to maintain a dominant hierarchical position and, thus, status, on the other hand. This interplay may result in a failure to elicit the desirable behavior among other professional groups, the implications of which we elaborate on in the following section.

Besides the strategies already mentioned, all other strategies from the framework (except re-evaluation of comparison dimension) were also used, albeit less frequently and sometimes inconsistently. Therefore we did not pay elaborate attention to these strategies. First, nurses and residents also used the strategy of subordinate categorization to differentiate between different subgroups within their professional group, e.g., high performing vs. low performing nurses, and starting residents vs. more experienced residents. Second, residents engaged in downward comparison with nurses, whereby they emphasized the task division between nurses and residents and the necessity that nurses keep to their own tasks and not get in the way of the residents’ more advanced tasks. Third, physicians used the strategy of temporal comparison. This last finding was not consistent, however, because these temporal comparisons were not always favorably for the present
Table 3.2. *Overview of identity management strategies in incident narratives by health care professionals*

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Identity management strategy</th>
<th>Primary group(s) using this strategy</th>
<th>Example from narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on comparison dimension</td>
<td>Compare groups on favorable dimension</td>
<td>Nurses</td>
<td>The physician went to school and earns a lot of money and is very important of course, but he has nowhere to go when we’re not there. Then he can do nothing at all. Nurse 2</td>
</tr>
<tr>
<td>Focus on comparison object</td>
<td>Downward comparison</td>
<td>Residents, physicians</td>
<td>That is not what the nurse should be concerned with. The supervisor is supposed to do that. [...] But the nurse knows it through experience, so she starts to sort of think along in the process, which is not wrong in itself, but yeah, there is a sort of task division. Resident 3</td>
</tr>
<tr>
<td></td>
<td>Comparison with standard</td>
<td>Nurses</td>
<td>Physicians don’t ask for it themselves, it’s more that we as nurses, we come with the initiative to also look at the previous procedure. Nurse 5</td>
</tr>
<tr>
<td></td>
<td>Temporal comparison</td>
<td>Physicians</td>
<td>I already notice in the team that a lot of work has been done on it, so I have to say my stories are more based on the past. What I noticed very much in the past was the turmoil in the OR. So people started chatting, distracting the patient and shouted things that made the patient unnecessarily agitated. Physician 3</td>
</tr>
<tr>
<td></td>
<td>Individualization</td>
<td>Nurses</td>
<td>I want to be able to do anything that’s in my power and more, you know. I am really stretching it out completely. I go that far to make sure that things are taken care of. I constantly keep contact with the patient. Nurse 2</td>
</tr>
<tr>
<td>Focus on level of categorization</td>
<td>Subordinate categorization</td>
<td>Nurses, residents</td>
<td>You usually do [name of specific procedure] with the youngest resident [...] and then sometimes it’s like hey, you’re not anesthetizing in the right layer, so then you say “I would go a bit higher or lower” [...] It doesn’t have to be a problem for the entire procedure if they take up the instruction, because usually if they follow your instruction you get a good result. Resident 3</td>
</tr>
<tr>
<td></td>
<td>Superordinate categorization</td>
<td>Nurses (team identity), residents (physician identity)</td>
<td>We actually do the same as the physicians, just at a lower speed. And we need to deliberate more often and we need supervision more often, but essentially we do exactly the same. Resident 1</td>
</tr>
</tbody>
</table>
moment; we also found instances in which the present situation was compared to a more prosperous past. Because of this inconsistency, we did not report in depth on these findings among physicians. From our analysis it was clear that patronization was the dominant identity management strategy used by physicians.

In Table 3.2, we provide an overview of the types of identity management strategies we found in our narratives, including an example quote for each strategy. Two results stand out: first, nurses and residents often employed multiple types of cognitive identity management strategies simultaneously. Second, physicians often used the strategy of patronization of other professional groups, a specific and extreme, yet subtle form of downward comparison. In the following section, we argue that both these findings have implications for the process of maintaining or even increasing status differences between professional groups, which may have important consequences for sensemaking of incidents and for interprofessional cooperation in health care.

Discussion

Increased use of multidisciplinary teams to carry out health care tasks, combined with more attention to the prevention of incidents, has brought the manner in which health care professionals collaborate to the forefront of management and research interests. Our results support the claim from SIT that individuals employ identity management strategies in situations of possible identity threat. Our finding that these strategies can be expressed in different ways, sometimes even simultaneously, contributes to our knowledge of the way health care professionals deal with the complexity of interprofessional cooperation and incident occurrence. Our
findings also yield some unsettling thoughts that contribute to recent debates on the undesirable side-effects of emphasizing interprofessional teamwork; see, for instance, Finn et al. (2010), who found that this actually led to a reinforcement of hierarchical barriers in cooperation and communication. With our two main findings, we add knowledge on the crucial and problematic role professional identity plays in the dynamics of the relationships between professional groups.

The use of multiple identity management strategies by nurses and residents shows how lower status groups in health care may respond to the identity threat caused by incidents, which has both positive and negative implications. On the one hand, the motive behind identity management is to increase individual and group-based self-esteem (Blanz et al., 1998), and resisting identity threat has been shown to positively influence long-term motivation as well as performance (Sherman et al., 2013). In this light, identity management in response to incidents can be seen as a coping strategy that is beneficial for individual health care professionals and for the cohesion and cooperation within professional groups.

On the other hand, these strategies can have unwanted effects for relations between professional groups. We discuss this last aspect by focusing on the expression of a superordinate identity. Even though this was a frequently occurring strategy in the narratives of both residents and nurses, we did observe notable differences in the level of superordinate identity that was emphasized. Residents presented themselves as a physician rather than a resident, which may contribute to a feeling of responsibility and status attached to this profession. Nurses, conversely, emphasized the multiprofessional team identity instead of their professional identity. This last finding might be considered good news, since health care literature on social identity recommends an emphasis on shared identity as a facilitator of
Responses to professional identity threat

intergroup cooperation (Bartunek, 2011; Kreindler et al., 2012). However, the choice of level of categorization (professional group vs. multiprofessional team) seems to be highly dependent on the situation and on the group a narrator feels identified with. Consider, for instance, the difference between residents emphasizing their physician identity and nurses emphasizing a team identity. If these differences in level of categorization of nurses and residents would happen simultaneously (e.g., during the same incident), then shared superordinate identity and its positive effects for cooperation cannot be achieved, which can represent a problem for health care quality.

Moreover, even though superordinate categorization is a cognitive and not a behavioral strategy, there may be consequences for behavior. A recent experimental study indicates that if using cognitive strategies leads to a perception of increased equality between groups, for instance by emphasizing a superordinate identity, the motivation to actually challenge the hierarchical structure may decrease (Becker, 2012). In this way, even though cognitive identity management strategies are most often used in situations of stable intergroup differences, and thus do not have the goal of decreasing these differences in reality, cognitive strategies may indirectly contribute to the perpetuation of social inequality. This may become a problem in situations in which unequal power relations hinder the quality of interdisciplinary teamwork or even lead to adverse outcomes, such as when members of professional groups with a lower status do not dare to speak up (Kerr, 2009).

Our second main finding is that in physicians’ narratives, we found identity management in the form of patronization of other professional groups, which is a specification of the strategy of downward comparison in the framework of Blanz et al. (1998). This response of physicians to identity
threat can have important implications for the relationships between professional groups in health care as well as for incident reporting. Specifically, even though physicians indicate that they want to stimulate speaking up behavior by other professional groups, their patronizing behavior may in reality keep in place a fear to speak up. We thus believe that physicians’ patronization contributes to the problematic pervasiveness of a traditional hierarchical structure, especially in situations such as the time-out procedure where patient safety is at stake (Tanner & Timmons, 2000). Moreover, the consequences of patronization suggest that it may be difficult to come to a truly interprofessional approach to incident handling, which is deemed necessary to achieve organizational learning (Iedema et al., 2006; Waring, 2009). Patronization thus may hinder the successful implementation of tools such as incident reporting.

In general, we believe that this chapter has important practical implications for health care organizations, e.g., in the context of interdisciplinary team training. One upcoming type of team training, which was also followed by the respondents in our study, is based on the principles of crew resource management (CRM). Developed in aviation and adapted to the health care context (Helmreich, 2000), this form of team training zooms in on non-technical skills and aims at enhancing patient safety, through leadership and speaking up behavior (Kemper, De Bruijne, Van Dyck, & Wagner, 2011). The insights we have obtained in this study can be incorporated in these trainings, so that more awareness is created for the effects of professional identity, incidents, and identity threat. More specifically, trainings should not only pay attention to non-technical behavior during health care procedures, but also to the way incidents are discussed afterwards. Nevertheless, further analysis of identity management strategies is needed to provide further insights into their effects on safety.
behavior. For instance, some identity management strategies (e.g., downward comparison) may be more detrimental for intergroup relations in health care than others (e.g., comparison with a standard).

Two limitations of this study need to be pointed out. While our use of the narratives allowed for a contextualized and thorough analysis of the expression of professional identity, this type of analysis is not suitable for making generalized inferences. In order to come to a more structured analysis of the use of identity management strategies in narratives of incidents, future studies could concentrate on analyzing narratives from members of different professional groups regarding the same incident. In the current study we did not influence the selection of incidents by the respondents, which resulted in a broad range of incidents. It is imaginable that the type of incident has consequences for the type of identity management strategies professionals use. For instance, individualization may be an appropriate strategy when an adequate intervention after an error led to a near miss, whereas in the case of an adverse event, a focus on superordinate identity distracts the attention from a professional’s own share in the incident. The fact that we did not find such patterns in the current study may be due to the limited sample or the freedom we gave the respondents. We expect that comparing narratives concerning the same incident and comparing different types of incidents will give more insight into how sensemaking of incidents is influenced by professional identity.

Furthermore, we want to underscore the importance of the specific research context, in particular the role of the patient. The fact that patients only receive local anesthesia and, therefore, are awake during the surgical procedure is likely a prominent factor in the intergroup behavior of the health care professionals. Respondents from all three professional groups indicated that the presence of a conscious patient during procedures made
them more hesitant to raise questions about the behavior of other health care professionals during surgery, for instance in the case of possible errors. Hence, it would be too simplistic to state that only the physicians’ patronization is the cause of a possible reserved attitude of nurses related to speaking up during surgery. Because of these specific circumstances, our findings are not directly transferable to other situations, such as procedures in which a patient receives full anesthetics.

This is the first study that explores how health care professionals use identity management strategies in the expression of their professional identity in narratives of incidents. Our results indicate that identity management strategies offer a suitable and valuable theoretical frame for analyzing sensemaking after incident occurrence by health care professionals. Furthermore, our findings suggest that narratives are powerful forms for fluently and flexibly employing these strategies, thereby building on the work of Iedema et al. (2006) and Waring et al. (2009), among others, who already hinted at how narrative aspects of incident reporting relate to identities at work. Whereas cognitive identity management strategies may not have direct consequences for incident occurrence, they do have the potential to influence long term relations between groups through the perpetuation of hierarchical inequality between professional groups, which may manifest itself in a fear of speaking up, as we demonstrated in our chapter. Our results suggest that when efforts are made in order to improve the quality of incident handling, the professional identity influence on sensemaking of incidents should be accounted for.