



Developing a New Medical Identity Through Institutional Work: A Hospitalist in a Finnish University Hospital

Noora Jansson¹, Nina Lunkka², Marjo Suhonen³, Merja Meriläinen⁴ and Heikki Wiik⁵

Scandinavian Journal of
Public Administration
Vol. 27 No. 3 (2023),
p. 73–86

DOI:
[10.58235/sjpa.v27i3.14158](https://doi.org/10.58235/sjpa.v27i3.14158)

Keywords:

medical identity;
hospitalist;
institutional work;
organisational change;
reflexivity

Abstract

This paper examines how staff at a Finnish hospital develop a new medical identity amidst other already-established professions. This study was conducted during the merger of two surgical departments at a public Finnish university hospital, and concerned the identity development process of a hospitalist which was, at the time, an entirely new medical role at the hospital. Drawing on extensive videos of authentic team meetings and entries in various actors' reflective diaries, we find that the actors collectively developed the new medical identity during the change process by using the following reflexive strategies: (1) identity inquiry; (2) identity reflection; and (3) identity legitimacy. These strategies foster temporary identity claims while the new medical identity is developed through experimentation and discourse, culminating in an identity that acquires stability within the ward environment. We found that an environment allowing transparent and open dialogue, in this case through periodic change facilitation meetings, was conducive to the development of a new identity.

¹*Corresponding author: Noora Jansson*, Ph.D, works as a director of research and innovation at the Oulu University of Applied Sciences. Her research interests are primarily organizational change and organizational discourse.

E-mail: noora.jansson@gmail.com

²**Nina Lunkka**, Ph.D, works as a senior lecturer in the Department of Health and Social Management, in the University of Eastern Finland. Her research mainly focuses on organizational and institutional level change processes in the health care setting that she examines primarily from discursive and narrative perspectives.

³**Marjo Suhonen**, Ph.D, docent, is working as a professor (acting) in administrative sciences at the University of Lapland, Finland. Her research interests are in public administration and management, digitalization and change processes.

⁴**Merja Meriläinen**, Ph.D, docent, is chief executive nursing officer in Wellbeing services county of North Ostrobothnia. Among other things, she heads healthcare research and organizational development work coordination. Her research interests are in organizational change, knowledge management and productivity in public sector.

⁵**Heikki Wiik**, MD, Ph.D, docent and eMBA, is specialized in general and gastroenterological surgery. Among other things, he is the head of Oulu University Hospital Abdominal Center, and in charge of the leadership training in medical faculty. His research interests are in organizational change in public sector.

Introduction

Medical identity is the professional identity of a healthcare professional who has medical training (Pratt et al., 2006). Professional identity is a cognitive element that reveals how people perceive themselves and the work they are doing (Clark et al., 2010; Nag et al., 2007). Traditionally, medical identity is tied to a doctor's medical specialism. For example, a cardiologist focuses on conditions of the cardiovascular system, or a gastroenterologist focuses on gastrointestinal conditions. Burkhardt et al (2010) have described hospitalists as 'generalist specialists'.

This research set out to analyse how hospital staff in a Finnish university hospital work together purposefully to establish a new medical identity. We show how the development of a new medical identity amounts to a collective learning process that can be made sense of through reflexivity. Institutional actors are able to mix different elements of already-existing professional identities to create a new identity (Clark et al., 2010). The actors involved in this

research split and reshaped traditional medical identities through institutional work and, as a result, generated a new medical identity, the *hospitalist*.

We chose to analyse the way staff work together through the lens of institutional work because institutional work theory allows us to understand how actors change institutions. Institutional work theory considers that: the actions of the actors involved are reflexive; individuals' actions drive institutional development; and agency is central to this (Battilana et al., 2009; Lawrence et al., 2013). In daily work people discuss, try something, discuss again, and try again. There is surprisingly little empirical research on reflexivity in institutional work (Berghout et al., 2018; Lawrence et al., 2013; Raviola & Norbäck, 2013). One plausible explanation for this is that daily routines and reflections are difficult to capture reliably once they have already occurred (Lawrence et al., 2013).

In the medical field, institutional work is usually discussed in terms of *protecting* existing professional identities rather than proactively *changing* the status quo (Berghout et al. 2018; Learmonth, 2017). The primary aim of the present study was to understand how institutional actors create a new identity amidst other already-existing identities, and thus contribute novel insight into institutional work. We have drawn on Nilsson's (2015) proposition to focus on 'how positive institutional actors express or challenge the logics associated with their roles' (p. 390) in the context of reconfiguring traditional hospital roles. Our study also responds to Lawrence, Leca and Zilber's (2013) suggestion that research into institutional work should employ methods that analyse 'social action *in vivo* and *in situ*' with a distinct focus on reflexivity (Locke, 2011; Lawrence et al., 2013, p. 1029). Hence, we have taken up earlier recommendations for further research in our analysis of the creation of a new medical identity during an organisational change. The findings presented in this study are based on data gathered during the process of that new identity being developed.

The research setting was a Finnish university hospital in which actors were collectively involved in developing a new medical identity amidst already-existing professions, during the merging of two surgical wards. This new identity centred around the role of a *hospitalist*. In healthcare, hospitalists are regarded as 'generalist specialists', or doctors 'whose primary professional focus is the general and medical care of hospitalised patients' (National Association of Inpatient Physicians, 2000, p. 3; Burkhardt et al., 2010). While hospitalists are common in, for example, American hospitals (Bracey et al., 2016), our understanding is that this role has not previously been seen in Scandinavian hospitals. We used empirical data to explore how hospital employees collectively developed a new medical identity during the merging of two wards. The data collection method captured the activities and reflections of all the actors involved in the merger: specifically, leaders, doctors, nurses, administrative staff, and the first hospitalist in the hospital that we studied. Video recordings of real situations and personal reflection diaries provided us with further insight into individual and collective reflexivity throughout the merger process.

We focused on the following research question: *How do institutional actors develop a new medical identity amidst other already-established professions?* The study shows that organisational actors collectively develop a new identity through various reflexive strategies, namely inquiry, reflection and legitimation. These concepts are presented by Nilsson (2015) as the key characteristics of positive organisational scholarship, which focuses on actions that combine social good (*in this case: adding a valuable new medical role to the ward*) and personal aspirations (*in this case: the physician gets a new job as a hospitalist*).

The process of identity development takes time, persuasion, airing of different views and permission to experiment. It is crucial that the new medical identity is legitimated. We found that the main reason for the new medical identity gaining legitimacy was the added value it offers to other organisational actors.

We have structured the paper as follows: we begin by introducing the theoretical background to this research, including a comprehensive overview of institutional work. Next, we explain the research methodologies employed to gather empirical observations. We then present the findings of our analysis, after which we discuss these results in light of previous research on institutional work. The paper concludes by suggesting several avenues for future research.

Institutional Work

Scholars have recognised the importance of institutions in organisational development for over three decades (Lawrence et al., 2013). When considered from the interactional point of view, institutions can be seen as established constellations of social action which include historical perspectives and the prospect of a future (Barley & Tolbert, 1997).

To date, institutions have been considered to wield significant influence over people's behaviour, as they support some ways of thinking and acting while deeming others impossible or costly (Phillips et al., 2004). By extension, this can be taken to mean that the behaviour of organisational actors is determined by their need to be regarded as legitimate in their institutional environment (Battilana & D'Aunno, 2009). Hence, the institutional environment in which individual actors are embedded influences their preferences, decisions, and behaviours.

The concept of reflexivity states that, while actors are shaped by existing institutional contexts, they may also shape these contexts (Lawrence et al., 2013). This has led several researchers to argue that institutions are also products, intentional or otherwise, of purposeful action (Lawrence & Suddaby, 2006; Jepperson, 1991). In this study, medical identity is the focus of actors' purposeful action. Medical identity describes the specific professional identity that medically qualified practitioners seek in their everyday work (O'Flynn & Britten, 2006).

Earlier research on identity in medical settings mainly focuses on already-established identities such as managerial identities (e.g. medical directors) or the identity of hybrid managers, but rarely on the construction of new identities in the organisation (Currie et al., 2012; Joffe & MacKenzie-Davey, 2012; Pratt et al., 2006). Thus, it is valuable to scrutinise how institutional actors develop a new identity while they do institutional work. Institutional work is one aspect of institutional studies that is still not fully understood. More specifically, a number of researchers have called for more complete descriptions of actors' roles in reshaping organisations (Berghout et al. 2018; Giddens, 1984; Lawrence & Suddaby, 2006; Maguire et al., 2004; Singh & Javanti, 2013; Suddaby & Viale, 2011). This area of research is concerned with the different forms of work that 'involve actors engaged in a purposeful effort' within their own organisational contexts (Phillips & Lawrence, 2012, p. 224).

Research on institutional work first started when scholars began to focus on the relationship between organisations and institutions (Greenwood & Hinings, 1996; Meyer & Rowan, 1977; Stinchcombe, 1968). Since then, numerous researchers have studied different types of work, and how this work affects institutions (Barley, 1996; Barley & Kunda, 2001; Phillips & Lawrence, 2012). Within organisational research, the number of publications on institutional work continues to grow steadily (Granqvist & Gustafsson, 2016; Moisander et al., 2016; Nilsson, 2015; Wright et al., 2017).

Battilana and D'Aunno (2009) have highlighted the concern that individuals often engage in institutional work within the same institutions that influence their preferences, decisions and behaviour. This is problematic because, as Phillips et al., (2004) suggested, institutions support certain ways of thinking and acting, but hinder, or completely block, others. Thus, the field of organisational research, particularly studies into institutional work, holds an embedded agency paradox (Battilana & D'Aunno, 2009). To minimise the effect of this paradox on results, research must adopt a relational approach to agency and, as such, consider actors as embedded in a social context which will significantly influence how they respond to the situations they encounter (Battilana & D'Aunno, 2009; Moisander et al., 2016). In our view, institutional work describes intentional actions which aim to achieve something meaningful within the institution.

Research Methods

Empirical case study

To understand the creation of a new medical identity through institutional work, we analysed an empirical case in which a medical doctor, specialised in general medicine, and her co-workers in the field of gastrointestinal surgery, together developed a new medical identity (*hospitalist*). More specifically, it was the generalist doctor who became the hospitalist, while

her gastrointestinal colleagues were involved in creating the new identity. Hospitalists are responsible for the general medical care of hospital patients (National Association of Inpatient Physicians, 2000, p. 3; Burkhardt et al., 2010). In 2016 there were over 50,000 hospitalists in American hospitals (Bracey et al., 2016; Wachter, 2016), but, to the best of our knowledge, the hospitalist in the case we studied represented the first hospitalist in a Scandinavian hospital. Our empirical research focused on analysing experiences through discourse. In our case study we have focused on reflection, inquiry and legitimation (Nilsson, 2015).

The development of a new medical identity was part of an organisational change process in which two gastroenterology wards were merged. Management played a two-fold role in this process: firstly as decision makers (superior role) and then as participants in the process (collegial role). Managers acted as superiors when they made the decision to merge the two wards, and when they decided to purchase consultative support from a facilitator to organise the relevant meetings. In this role, management enabled the change to take place. Then managers acted as colleagues when they participated in the meetings led by the facilitator alongside with the rest of the staff. In this role, management were active participants in the change.

The overall set up of facilitated meetings was planned jointly by the facilitator, the head of the unit and the hospitalist. They agreed that there would be several meetings along the way; that these would be video-recorded; and that the meetings would be led by the facilitator. The facilitator had previous experience of working in the same hospital and thus had a certain level of trust with the staff. An important aspect of the meetings was that it was compulsory for staff members to attend them. The facilitated meetings offered staff members opportunities to talk about the change in a safe environment and without being disturbed. In sum, the meetings formed “pit-stops” during an open-ended change process, which also involved discourse outside of the meetings during everyday hospital work.

The overall process was led by a key institutional actor (the hospitalist) and supported by colleagues and the facilitator. The aim was to specify what the hospitalist's identity should be in relation to other identities within the organisation (hospital). We focus in particular on the reflective, purposeful institutional work of staff members, which took place in conjunction with their adaptation to a changing environment and the co-creation of a totally new medical identity. In this case study, both the university hospital and the gastroenterology ward are regarded as institutions. They have long, overlapping traditions in terms of organisational cultures, work practices and professions, all of which are intertwined in acting purposefully to ensure patient safety.

Empirical data

The empirical data behind this study (see Table 1) can be divided into primary and secondary data. The primary data consists of video material collected during the facilitated meetings that occurred during the merger and hospitalist pilot study. These enabled us to analyse organisational discourse in its authentic form. Video recording was possible because staff members were used to having their workshops recorded for learning purposes. Moreover, two of the authors work in the organisation studied, and this enabled us to access the videos with the appropriate permissions for their use as research materials. The video material covered eight workshops and meetings, amounting to 16 hours and 36 minutes of video and voice recording. The videos were also transcribed in Microsoft Word, resulting in 357 pages of text in 12-point Times New Roman font.

All employees of the two wards, including the hospitalist, were aware from the beginning of the project that all change project materials would be used for research purposes. All participants gave their written informed consent to the publication of the study. As there was only one hospitalist, her anonymity could not be assured. However, this was unavoidable given hospitalist's centrality to the change project, and was agreed to and understood by all participants.

Table 1. List of empirical materials

Material type	Items	Length	Timing
Videos capturing change facilitation meetings (voice and video)	8	16 h 36 min	Jan – Sep 2017
Transcriptions of video discussions	8	357 pages	Jan – Sep 2017
Reflective diaries	5	11 pages	Jan – Sep 2017
Electronic questionnaires sent to employees via email	2	28 pages	Dec 2016 – Jan 2017
Hospitalist presentations during the process	3	35 pages	Feb, Mar, Jun 2017
Change facilitator emails to personnel, with related attachments	83	45 emails	Jan 2017 – Oct 2017
Meeting memo concerning the planned merger of wards 8 and 9	1	3 pages	Mar 2016
Internal report on the development of nursing management work	2	30 pages	Dec 2014
Internal presentation on the organisation of nursing management	1	19 pages	Dec 2015
TOTAL	123	518 pages	

The secondary data used in this study consisted of an electronic questionnaire sent to staff members in two phases; emails and workshop presentation materials from the change facilitator; presentation materials from the hospitalist; and internal memos and reports regarding preparations for the merger. The hospitalist's presentation materials illustrated how her perception of her new identity developed during the process, while the change facilitator's emails provided a detailed timeline of the change process, including steps taken at each meeting, and current topics of discussion at each stage. In addition, key personnel kept personal reflective diaries throughout the change process. These diaries provided insight into employees' thoughts and concerns, and captured their individual sense-making processes through personal narratives.

The empirical materials used in this research have certain strengths that distinguish this study from previously published studies. Firstly, video recordings of authentic organisational discourse are rarely analysed in organisational research. The material was collected during the change process and includes many accounts of staff members collectively reflecting on previous experiences. Videos are useful for capturing how a group thinks, communicates, and reflects *in vivo* (Brown et al., 2015; Karreman & Alvesson, 2001). Secondly, the reflective diary entries analysed in this study provided valuable insight for understanding reflexivity in institutional work. Thirdly, the three presentations that the hospitalist gave to colleagues during the identity construction process captured the development of this identity, her personal learning curve, and collective reflection by employees (Gubrium & Holstein, 2009). Fourthly, the questionnaire which was sent to staff at the beginning and end of the process provided information about their attitudes towards the change and reflections on the new medical identity construction, before and after the change. Fifthly, the rich email material from the change facilitator enabled us to clearly chart the development pathway, including the temporal organisation of the change process through meetings and small team-work presentations (Granqvist & Gustafsson, 2016). Despite these strengths, a weakness of the research data is that it relates to only one organisational change and the actors involved in that specific change. Overall, we designed the study approach to understand how individual team members apply reflexivity, within the organisational discourse that occurred during change facilitation meetings, to develop a new medical identity amidst other already-established professions.

Analysis

We have applied narrative analysis to draw meaning from organisational discourse. Narratives are central to human communication. The term *narrative* is often used as a synonym for *story*,

and narrative analysis is a systematic way to study narrative data (Riessmann, 2008). Organisational narratives are ‘temporal, discursive constructions that provide a means for individual, social and organisational sensemaking and sensegiving’ (Vaara et al., 2016, p. 3). Gubrium and Holstein (2008, p. 244) have explained how narrative analysis has shifted to focusing on stories as ‘windows on distinctive social worlds’ which can thus reveal ‘the relational selves of storytellers’. They emphasise that researchers must closely consider the circumstances in which stories have been produced and received when trying to draw meaning from them. Thus, narrative analysis is not only a way to describe what has been said (explanatory purpose) or analyse a story (focus on formality rather than content), but is also a methodology that can enhance the understanding of an individual or group experience (Gubrium & Holstein, 2008; Lieblich et al., 1998).

There are many ways to study narratives. In our research, we treat narratives as a source of examples of how a new identity is constructed. This approach was motivated by previous research which has shown that, even if employees seem to be discussing basic work topics, they are simultaneously making sense of various levels of identity through such discourse (Brown et al., 2015; Karreman & Alvesson, 2001). Bamberg and Georgakopoulou (2008) have introduced *small stories* as a useful perspective in narrative and identity analysis because meaning is constructed based on experiences and accounts of everyday life. They propose that new information on identity development can be revealed when interactions are analysed like a small story. By extension, focusing on small stories instead of large narratives may have advantages for capturing institutional work, sense of self, and related experiences in the process of sense-making (Bamberg & Georgakopoulou, 2008, p. 392). In the narrative analysis for the present study, we considered the interactions during change facilitation meetings as small stories which formed the overall organisational discourse.

There were three main phases to our data analysis. Firstly, we began the analytical process by critically evaluating the primary data, i.e. watching videos of the change facilitation meetings about the merger. At this stage the main purpose of our analysis was to see the big picture of the meetings. The videos revealed that organisational discourse during the meetings generated four main narratives, through which ward employees were making sense of the changes ahead: hospitalist identity creation; a new practice for checking patients; practices concerning food delivery; and ostomy care. To ensure that the study had a clear focus we chose to concentrate only on narratives concerning hospitalist identity creation. We made this decision for two main reasons: firstly, the development of a new identity through actors’ reflexivity matched the research gap identified in institutional work theory (Lawrence et al., 2013; Nilsson, 2015); and secondly, the hospitalist role was interesting because of its novelty, this being the first use of such a role in a Scandinavian hospital. Hence, our research question was influenced by both theory and the data collected.

The next phase of the analytical process included a detailed assessment of narratives relating to development of the hospitalist identity. This phase was guided by the concept of institutional work, and focused on discourse relating to hospitalist identity. We also attempted to detect hospital staff members’ personal experiences by identifying small stories with the dialogue that took place in the change facilitation meetings. This largely consisted of watching and listening to the video recordings of the change facilitation meetings. As stated before, videos are rarely analysed in organisational research, so this study offers a novel perspective on studying institutional work (Meyer et al., 2013, Vaara et al., 2016). The video-recorded discussions were also transcribed, and these transcripts were also analysed, to form a complete picture of the hospitalist identity development process. Further, we drew on secondary data to identify details which verified the evolution of the relevant narratives over time (Riessman, 2008, p. 11). Although the reflective diaries offered unique and interesting data, their role in the analysis process was largely limited to corroborate the stories concerning hospitalist identity identified through the other methods.

The final phase of data analysis focused on the performative and interactional nature of the change facilitation meetings as small stories (Bamberg & Georgakopoulou, 2008). Bamberg (2004) has proposed that positioning is a useful method for analysing interactions. Hence, in the third stage of the analytical process, we attempted to identify patterns that would expose

the positioning of the new medical identity as the merger process rolled out. The small stories identified from the change facilitation meetings revealed that the dynamics of identity claims and actor positioning evolved over time (Bamberg, 2004).

Ravasi and Phillips (2011) claim that identity claims are central to the search for an appropriate organisational vision, and suggest that organisational identity can shift during times of uncertainty. We found that the identities of actors within the organisation, in this case the hospitalist, can also shift. Our analysis suggests that reflexivity in institutional work involves identity drift during the organisational discourse process. During the process we identified several examples of temporary identities relating to the hospitalist role, and provide evidence that these identities were clearly related to how other identities in the organisation were positioned in relation to the hospitalist. We present the overall findings of this research in the following section.

Findings: Strategies in Developing a New Medical Identity

Institutional work can be described as a set of intentional actions that are performed to achieve something meaningful within an institution, such as creating a new professional identity. We have studied how a new medical identity can be developed amidst other already-established professions. Drawing on the data about the hospitalist identity development process, we identified that institutional actors use different reflexive strategies while developing a new medical identity: (1) identity inquiry; (2) identity reflection; and (3) identity legitimisation. The next sections will present each of these strategies in more detail.

Identity inquiry

We labelled the first strategy through which actors used reflexivity in their institutional work *identity inquiry*. This describes the stage during which the new identity is open for testing and proposals, or “enquiries”, by the institutional actors. Nilsson (2015, p. 376) notes that ‘a key dimension of positive institutional work must involve surfacing and sharing the inner experiences of field members’.

We found that the change facilitation meetings became the key discursive arena for identity inquiry about the new role of hospitalist. During these meetings staff members discussed and experimented with the hospitalist identity, creating different, temporary versions of it at different stages of the process. Between meetings, the identity underwent continuous development through discourse and identity claims through daily practice on the ward. The facilitated meetings included specific reflections relating to emerging identity claims; for example, we identified a discourse concerning staff members’ feeling that the hospitalist should not be a ‘walkover’ who completes the work of others, but should rather be an ‘ultimate professional’ in her unique role.

The construction of a new medical identity through inquiry started by employing a hospitalist and giving her permission to start creating the new medical identity with her colleagues. The starting point with regards to the hospitalist identity was largely supportive: the merger opened up opportunities for the development of new practices; the facilitated workshops fostered collective discussion; and the hospitalist had a legitimate position once the new ward was completed, even though the precise nature of the identity was unclear. In table 2, we present examples of the three different strategies through which personnel applied reflexivity to their institutional work.

Table 2. Examples of identity inquiry used by institutional actors

Identity inquiry
<p>The hospitalist presented her co-workers with the idea of the hospitalist for the first time: <i>“So, I am a general doctor and will very soon be specialised in general medicine. I have a job at the health centre, but have now been on leave. The results of this pilot project will determine whether or not the hospitalist role will be continued, and also affect my professional trajectory.”</i></p> <p>Right from the beginning, the hospitalist engaged the team as a part of the pilot project, and openly stated that it is yet to be determined whether the role will persist on the ward. The hospitalist role became open to inquiry, offering work teams the opportunity to discuss and develop identity claims.</p>
<p>In the change facilitation meetings, inquiry was a central strategy:</p> <p>Nurse 1: <i>“Sounds great but at this moment, at least, I have been asked many times, by both nurses and surgeons, what the hospitalist has been doing, and when we can use her and we can call her and so on. I do not know how much doctors have discussed the hospitalist’s role, or what she has done lately, and this also remains unclear to me. So it is a bit like that.”</i></p> <p>Hospitalist: <i>“No there has not been, ... I have come here from the outside, and that way there is no foundation and it is only now that we have thought about this, because first we have to know what I should do so that we can think about whether it will be the mornings or afternoons, or one week on and the other week off. I myself don’t really...”</i></p> <p>Facilitator: <i>“We have actually purposefully agreed that it is this working group’s task to further develop the hospitalist’s role and search for the role description, and it is an official plan of inquiry...”</i></p>
<p>Here is an example of how inquiry was pursued in practice:</p> <p>Nurse manager: <i>“But for example today there was that challenging patient on room Z, but I do not know if you (hospitalist and surgeon) checked him together?”</i></p> <p>Hospitalist: <i>“We did.”</i></p> <p>Nurse manager: <i>“Yeah, I recommended that you go there together, as if the hospitalist goes alone and the stomach situation is challenging then she will probably need the specialised doctor.”</i></p> <p>Hospitalist: <i>“We both thought it was good that we went there together, and good that you came there too. In a way [this shows] that both rely on each other...”</i></p> <p>Nurse manager: <i>“So, exactly the idea!”</i></p> <p>Hospitalist: <i>“We both explained our thoughts to the other, ... and then we (formed the view) together.”</i></p> <p>Nurse: <i>“In my opinion it makes it easier to agree the patient treatment line, what is the surgeon’s view, what is your (hospitalist) view and what is the common tone as today with the patient in (room) B.”</i></p>

The collective development of the new hospitalist role through inquiry was an experiment that involved many people but was led by an institutional agent (hospitalist). Ward staff made sense of the new role in their daily work, and shared their feelings, particularly when they were empowered to raise questions and discuss the new hospitalist role during the facilitated meetings. The video material demonstrates that open and honest dialogue during the change facilitation meetings became an important structural mechanism in the creation of a new medical identity. It was evident that these meetings were characterised by a relaxed and friendly atmosphere, with few barriers to talking and discussing.

As the hospitalist was constructing a new medical role for herself, with the help of the rest of the staff, she had a central role in the identity inquiry. The fact that she already knew the staff helped them to reflect and share their personal experiences. Experiences relating to identity development were shared collectively from the very start, through the change facilitation meetings and practical daily work on the ward, and the hospitalist was clearly involved in both of these processes. As the merger proceeded, all of those involved gained more understanding of the hospitalist identity from different situations and experiences. The identity creation process, initially based on collective understanding, later progressed to re-evaluation through identity reflection, which is explained in the next section.

Identity reflection

We labelled the second strategy through which actors used reflexivity in their institutional work *identity reflection*, through which new identity is collectively constructed by the actors through continuous iteration. This is important because actors must be able to access their colleagues’ experiences if they are to reflect upon, learn, notice, and feel certain aspects of their work from a collective perspective (Kanov et al., 2004). Reflection was found to be an important element throughout the hospitalist identity creation process.

The change facilitation meetings served as suitable reflection points for the hospitalist and other staff members during the identity development process. Reflection primarily entailed staff members sharing their experiences of how the new medical identity fit into everyday situations. This type of institutional work ‘involves actors engaged in a purposeful effort’ within their own organisational contexts (Phillips & Lawrence, 2012, p. 224). The change facilitation meetings were organised to enable hospital staff to share ideas and collectively work through topics relevant to the new hospitalist identity. During the meetings, reflection was central to the discourse: how did staff members experience interactions with and without the hospitalist? Why did they feel the way they feel? How could the identity construction process be improved? What best describes the identity of the hospitalist? Discussions across eight change facilitation meetings revealed that none of the staff were sure of the hospitalist’s exact role, even though she had already begun to work in the ward. In other words, the hospitalist identity constantly shifted due to identity reflection.

Table 3. Examples of identity reflection used by institutional actors

Identity reflection
<p>Reflective learning welcomes ambiguity as a natural part of the process. The next small story shows how the hospitalist advanced in her thinking about the new medical identity, yet still left room for further development:</p> <p>Surgeon: <i>“We must remember that hospitalism is a new specialty field in Finland, and that the operations will constantly develop as we find efficient ways to influence patient treatment. Even though it is practiced in other countries, every country has their own situation and system, so the development of Finnish hospitalism will take time.”</i></p> <p>Nurse (to hospitalist): <i>“Have you had a feeling that there have been incidents when someone has asked you (for help) for no reason, and that it was unnecessary? Or that it was a waste of time?”</i></p> <p>Hospitalist: <i>“Not really for no reason. But some of the things have been how to say... No. Nothing has been for no reason because with my background I can comment on all things up to a certain point. And the more complex or challenging the matter, the more I feel that the hospitalist is needed. And then of course there are the easy things like some single questions, those are nice too, like snacks there. That they are not one hour cases, well not many cases have been that long. But there has been kind of complex stuff where I have had to plan for multiple days, or there has been many specialty fields involved so I have had to think about those. Something like that. So no, there has not been any questions for no reason, instead all the time better and better. Just in recent times probably I felt that (we) are somehow finding “the pearl”. They start to be selected, the sediment, the dust at the bottom, that will be the hospitalist material then.”</i></p>
<p>The following comments are examples of identity reflection:</p> <p>Nurse manager: <i>“Well the cancer nurse delivered a message that the hospitalist has been well-placed on many occasions. Mrs. B is hunting for the doctor as the calls come in and there are those problem situations, so the hospitalist has been helpful..”</i></p> <p>Surgeon: <i>“And it is somehow identifiable when you do sensible work. We have a lot of staff that do not have to be involved, as some consultations, such as those about incontinence, require a detailed view from an expert. However, they sometimes don’t have the guts to make a decision (exaggerating a bit) and we need to have straightforward, efficient, and sensible decision-making that takes into account the patient’s situation; for example, helping patients feel that they will get home from the ward.”</i></p> <p>Surgeon (to the hospitalist): <i>“Yeah think that in ten years when there are 50-100 hospitalists, you will be their chairman and the 100-year history will include your picture.” (group laughter)</i></p> <p>Hospitalist: <i>“That is exactly what I am aiming for.” (laughter)</i></p> <p>Surgeon: <i>“But take the picture before the 100 years has gone by.” (group laughter)</i></p> <p>Facilitator: <i>“Yes I agree with that. (In fact) I sent the hospitalist a photograph yesterday (taken when I was observing her the other day), and told her that this image will be next to the following text: ‘the first hospitalist at hospital X started her work in 2017’. You don’t always notice these historical moments when they are happening...”</i></p> <p>Joking about an imaginary picture in a 100-year history demonstrates that the employees collectively reflected on the topic of identity development.</p>

As the hospitalist pilot proceeded and time passed the new medical identity was no longer new but was still shaped through collective reflection (Table 3). For example, while people joked about more hospitalists being hired and the pioneer role of the case hospitalist, they were in fact reflecting upon their experiences so far, and thus strengthening the legitimacy of the hospitalist identity. The need for a hospitalist was no longer under debate, with the leadership discussion being more about how the identity may develop in the future.

During the change facilitation meetings, ward staff watched and analysed videos together, taken from their own ward on a normal day. The purpose of this exercise was to see how the hospitalist fit in with daily ward activities and how the new medical identity should be involved in patient treatment. In other words, the team collectively analysed their own actions so that they could reflect on them through leadership discourse. After watching the video, they divided into pairs to discuss specific questions prepared by the facilitator, and then shared their views with all participants. Identity reflection of this type is a crucial part of identity formulation, as well as a prerequisite for identity legitimation, which is described in more detail in the next section.

Identity legitimacy

We labelled the final strategy through which actors applied reflexivity to their institutional work *identity legitimacy*. This denotes the point at which identity development stops and the identity created holds a stable position amidst the other identities. Once the ward staff had tested several initial ideas about the hospitalist identity, and collaboratively reflected upon how these options worked in their daily work environment, the new hospitalist identity started to become a natural part of the team's work. Thus, the newly developed identity gained more and more legitimacy which, in this context, can be defined as 'a generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions' (Suchman, 1995, p. 574).

The collective development of a new medical identity involves work on legitimacy, i.e. 'changing, reinforcing, or disrupting the criteria by which people evaluate practice' (Nilsson, 2015, p. 373). During the facilitated meetings, staff commented that the hospitalist role clearly helped both colleagues and patients on a day-to-day basis (Table 4). By offering added value the hospitalist achieved legitimacy.

Table 4. Examples of identity legitimation used by institutional actors

Identity legitimation
<p>In a change facilitation meeting:</p> <p>Hospitalist: <i>"But still, then, the thing about going to see the patients with the surgeon, the collaboration, you never see when they have visited patients and they have gone somewhere and then I am there (all alone)."</i></p> <p>Nurse1: <i>"Now you have also learned that."</i> (group laughter)</p> <p>Hospitalist: <i>"What I thought about was for example related to a patient with a psychological problem that not always all the surgeons wanted to visit there but we agreed that I will visit there every second day."</i></p> <p>Nurse 1: <i>"I hope that we could also choose..."</i></p> <p>Hospitalist: <i>"And it (the treatment) went really well as we both knew the direction in which we were going and (we) both spoke about the same thing and there were no misunderstandings."</i></p> <p>Hospitalist: <i>"But what kind of thoughts come from this?"</i></p> <p>Nurse 1: <i>"First of all the afternoon patient check, there is no way that it is negative from the nurse's perspective."</i></p> <p>Nurse 2: <i>"Surely I believe that everyone welcomes it with open arms. We have, at least what I have heard that everyone thinks that you are the right person just at the right place so I don't think anyone will show an unhappy face that they would not have time to do (the second) round. Everyone is just thrilled that things are working."</i></p> <p>Nurse 3: <i>"Absolutely wonderful."</i></p>
<p>The following quote is from a meeting at which the hospitalist presented three patient cases. It demonstrates how she uses identity legitimation in leadership discourse:</p> <p>Hospitalist: <i>"So, just as we discussed, the patients who should be on the hospitalist list are no longer a focus of this new operation model development. It has been solved in a way by now and the patients are the right kind, very good patients (for the hospitalist), so that also has been solved. This is also relevant to our discussion about streamlining the hospitalist's work, so when we have many patients in bad condition, the hospitalist can bring support and efficiency, especially to those borderline patients. This would be co-management, meaning that certain patients would be treated by the surgeon in collaboration with the hospitalist... There is no ready working model we can directly apply and test, but we should instead create the model what we think is good."</i></p> <p>The videos also demonstrated that the hospitalist had more confidence.</p>

At one of the facilitated meetings a staff member suggested that the team should closely follow a few patient cases and analyse them, to facilitate further learning and development. Three weeks later, the hospitalist presented three patient cases which had been followed up. The presentation, along with the subsequent discussion, demonstrated that many earlier uncertainties had been resolved and, thus, the hospitalist role gained further legitimacy. The video recordings also demonstrated that the hospitalist had become more confident (signalled through non-verbal clues such as presence) as her identity became better defined. Analysis of the three patient cases presented revealed that the team realised how important the hospitalist was to the routine functioning of the ward. Hence, approval from the team strengthened the hospitalist's identity. The careful comparison of the hospitalist's first presentation and later presentations revealed another difference: in the first presentation, she relied entirely on facts from publications but, after four months of real experience and collective sense-making, her later presentation included patient cases from the ward and reflected her personal learning curve. Hence, shared experiences enhanced the legitimacy of the new medical identity during the merger process.

We can conclude that, in cases of identity creation, institutional actors use three distinct strategies when exercising reflexivity: inquiry; reflection; and legitimacy. We found that the inquiry strategy was more widespread during the beginning of the merger process, while new identity legitimation was more prevalent in later phases. Reflection was a salient topic throughout the process, which suggests that it is a constant mechanism for identity development. While our analysis distinguished inquiry, reflection and legitimacy perspectives within the reflexivity practice by hospital staff, the observed collective sense-making was also supported by identity claims (Ravasi & Phillips, 2011). Hospitalist identity claims helped institutional actors articulate and define the hospitalist identity in an exploratory manner.

Discussion and Conclusion

Institutional actors may combine parts of numerous professional identities while constructing a new role. In the case of a hospitalist, studied here, the new identity captured parts of various healthcare professions, including the doctor (through status and know-how), nurse (through working practice) and general manager (through responsibility for the organisation). This ensured that all the relevant parts of different professions would be integrated into the new medical identity (Wright et al., 2017). Overall, new identity development is a collective learning process that can be made sense of through reflexivity. The learning process was driven by purposefulness, and coordinated by one employee in a central role (Nilsson, 2015; Zilber, 2013; Raviola & Norbäck, 2013).

This research paper primarily contributes to institutional work theory in the field of social sciences. It represents significant progress on responding to previous calls to study the interplay between reflexivity and purposeful action, and determine how personnel perceive, as well as shape, their identities (Berghout et al., 2018; Locke, 2011; Lawrence et al., 2013; Nilsson, 2015). As a key finding of this study, we identified three reflexivity strategies that institutional actors use while developing a new medical identity: (1) identity inquiry; (2) identity reflection; and (3) identity legitimacy. These strategies foster temporary identity claims while the new medical identity develops, until a point at which it stabilises in the environment within which it is embedded. For practitioners, the strategies identified offer tools which can be applied to collective learning processes that are led by an influential actor seeking legitimacy and purposeful action.

The academic field of institutional work has long accepted that, in addition to being influenced by existing institutions, actors may also intentionally influence the institutions with which they interact (Lawrence & Suddaby, 2006; Battilana & D'Aunno, 2009). Inquiry, which occurs alongside the intertwined processes of discourse and sense-making, is an effective way to develop practices based on experience and discussion. Moreover, our analysis has shown that this can be the first step on the path towards legitimation. We show that, while purposefulness is central to institutional work (Raviola & Norbäck, 2013), collaborating on something beneficial to both the actors and the organisation underlies successful identity

creation, rather than trying to predefine a final identity at the beginning of a process. Hence, creativity and freedom foster institutional work and support new identity development. In line with the view that developmental inquiry involves a mix of individual growth and continuous learning through experimentation (Nilsson, 2015), we found that the actors involved in this case used drifting identity claims to articulate their thinking. Identity claims about the new hospitalist identity became a central element in making sense through discourse: they were helpful for the eventual concretisation of the new medical identity, yet left enough room for further development.

Our study also contributes to healthcare management research and is particularly relevant for development and change processes. The results of our analysis offer a clear path for the development of a new identity or role in a specialised hospital setting. As such, the experiences described in this paper might be useful for hospital practitioners who are considering introducing hospitalists or other novel medical identities to their operations. This case also serves as an example of successful organisational change in a university hospital. While the initial call to merge the two wards came from hospital management, the actual implementation was executed by other hospital staff. We found that systematic change facilitation workshops can noticeably benefit how a new medical identity develops throughout a change process. Although some staff were initially troubled by the workshops (mainly because they had to take time away from patient work), they later embraced the process as the workshop environment allowed them to freely discuss daily practical challenges and how the new role would affect multi-professional collaboration. Identity development also contributed to successful change implementation, as it afforded personnel a rare chance to rethink their daily practices, not only in terms of work, but also in terms of the related identities.

In conclusion, organisational actors collectively develop a new identity through various reflexive strategies which we have termed inquiry, reflection and legitimation. These three strategies are interdependent: without inquiry, actors cannot reflect on the transient identity claims, and without reflection, the identity will not achieve sufficient legitimation. We used a case study, in which a new medical identity was developed amidst other existing professions, to identify what is conducive to successful identity development. We found that the process requires ample time, so that different ideas and concepts can be experimented with. We also found that developing an identity that is beneficial for both the relevant actors and the organisation as a whole must be developed with transparent input from diverse actors - in this case, relevant hospital staff. In this example, periodic change facilitation meetings served as an environment for free discussion. It could be argued that, through this approach, identity development became a game that was played with the permission of senior management and for which the rules were developed along the way.

Acknowledgements

We would like to thank professor Tuija Mainela from Oulu Business School at the University of Oulu for her valuable comments in developing the article. We would also like to thank the North Finland Healthcare Support Foundation Terttu-säätiö for providing the project financial support.

References

- Bamberg, M. (2004) Talk, small stories, and adolescent identities. *Human Development*, 47 (6): 366-369. <https://doi.org/10.1159/000081039>
- Bamberg, M. & Georgakopoulou, A. (2008) Small stories as a new perspective in narrative and identity analysis. *Text and Talk*, 28 (3): 377-396. <https://doi.org/10.1515/TEXT.2008.018>
- Battilana, J. & D'Aunno, T.A. (2009) Institutional work and the paradox of embedded strategy. In T.B. Lawrence, R. Suddaby & B. Leca (Eds.), *Institutional Work: Actors and Agency in Institutional Studies of Organizations* (pp. 31-58). Cambridge, UK: Cambridge University Press.

- Battilana, J., Leca B. & Boxenbaum, E. (2009) How actors change institutions: Towards a theory of institutional entrepreneurship. *Academy of Management Annals*, 3 (1): 65-107. <https://doi.org/10.5465/19416520903053598>
- Barley, S. R. (1996) Technicians in the workplace: Ethnographic evidence for bringing work into organization studies. *Administrative Science Quarterly*, 41 (3): 404-441. <https://doi.org/10.2307/2393937>
- Barley, S. R. & Kunda, G. (2001) Bringing work back in. *Organization Science*, 12 (1): 76-95. <https://doi.org/10.1287/orsc.12.1.76.10122>
- Barley, S. R. & Tolbert, P. S. (1997) *Institutionalization and Structuration: Studying the Links Between Action and Institution*. Ithaca, NY: Cornell University, ILR School. <https://doi.org/10.1177/017084069701800106>
- Berghout, M. A., Oldenhof, L., Fabbriotti, I. N. & Hilders, C. G. J. M. (2018) Discursively framing physicians as leaders: Institutional work to reconfigure medical professionalism. *Social Science & Medicine*, 212: 68-75. <https://doi.org/10.1016/j.socscimed.2018.07.013>
- Bracey, D. N., Kiyamaz, T. C., Holst, D. C., Hamid, K. S., Plate, J. F., Summers, E. C., Emory, C. L. & Jinnah, R. H. (2016) An orthopedic-hospitalist comanaged hip fracture service reduces inpatient length of stay. *Geriatric Orthopaedic Surgery & Rehabilitation*, 7 (4): 171-177. <https://doi.org/10.1177/2151458516661383>
- Brown, A. D., Colville, I. & Pye A. (2015) Making sense of sensemaking in organization studies. *Organization Studies*, 36 (2): 265-277. <https://doi.org/10.1177/0170840614559259>
- Burkhardt, U., Erbsen, A. & Rüdiger-Stürchler, M. (2010) The hospitalist as coordinator: An observational case study. *Journal of Health Organization and Management*, 24 (1): 22-44. <https://doi.org/10.1108/14777261011029552>
- Clark S. M., Gioia, D. A., Ketchen, D. J. & Thomas, J. B. (2010) Transitional identity as a facilitator of organizational identity change during a merger. *Administrative Science Quarterly*, 55 (3): 397-438. <https://doi.org/10.2189/asqu.2010.55.3.397>
- Currie, G., Lockett, A., Finn, R., Martin, G. & Waring, J. (2012) Institutional work to maintain professional power: Recreating the model of medical professionalism. *Organization Studies*, 33 (7): 937-962. <https://doi.org/10.1177/0170840612445116>
- Giddens, A. (1984) *The Constitution of Society: Outline of a Theory of Structuration*. Cambridge, UK: Polity Press.
- Granqvist, N. & Gustafsson, R. (2016) Temporal institutional work. *Academy of Management Journal*, 59 (3): 1009-1035. <https://doi.org/10.5465/amj.2013.0416>
- Greenwood, R. & Hinings, C. R. (1996) Understanding radical organizational change: Bringing together the old and the new institutionalism. *Academy of Management Review*, 21 (4): 1022-1054. <https://doi.org/10.2307/259163>
- Gubrium, J. F. & Holstein, J. A. (2009) *Analyzing Narrative Reality*. Thousand Oaks, CA: Sage.
- Jepperson, R. L. (1991) Institutions, institutional effects, and institutionalism. In W.W. Powell and P. J. DiMaggio (Eds.), *The New Institutionalism in Organizational Analysis* (pp. 143-163). Chicago, IL: University of Chicago Press.
- Joffe, M. & MacKenzie-Davey, K. (2012) The problem of identity in hybrid managers: who are medical directors? *International Journal of Leadership in Public Services*, 8 (3): 161-174. <https://doi.org/10.1108/17479881211282649>
- Kanov, J. M., Maitlis, S., Worline, M. C. & Dutton, J. E. (2004) Compassion in organizational life. *American Behavioral Scientist*, 47 (6): 808-827. <https://doi.org/10.1177/0002764203260211>
- Karreman, D. & Alvesson, M. (2001) Making newsmakers: Conversational identity at work. *Organization Studies*, 22 (1): 59-89. <https://doi.org/10.1177/017084060102200103>
- Lawrence, T. B., Leca, B. & Zilber, T. (2013) Institutional work: Current research, new directions and overlooked issues. *Organization Studies*, 34 (8): 1023-1033. <https://doi.org/10.1177/0170840613495305>

- Lawrence, T. B. & Suddaby, R. (2006) Institutions and institutional work. In S. R. Clegg, C. Hardy T.B. Lawrence & W. R. Nord (Eds.), *Handbook of Organization Studies* (2nd edition) (pp. 215-254). Thousand Oaks, CA: SAGE.
- Learmonth, M. (2017) Making history critical: recasting a history of the “management” of the british national health service. *Journal of Health Organization Management*, 31 (5): 542-555. <https://doi.org/10.1108/jhom-11-2016-0213>
- Lieblich, A., Tuval-Mashiach, R. & Zilber, T. (1998) *Narrative Analysis: Reading, Analysis, and Interpretation*. Thousand Oaks, CA: Sage.
- Locke, K. (2011) Field research practice in management and organization studies: Reclaiming its tradition of discovery. *Academy of Management Annals*, 5 (1): 613-652. <https://doi.org/10.5465/19416520.2011.593319>
- Maguire, S., Hardy, C. & Lawrence, T.B. (2004) Institutional entrepreneurship in emerging fields: HIV/AIDS treatment advocacy in Canada. *Academy of Management Journal*, 47 (5): 657-79. <https://www.jstor.org/stable/20159610>
- Meyer, J. W. & Rowan, B. (1977) Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 83 (2): 340–363. <http://dx.doi.org/10.1086/226550>
- Meyer, R., Höllerer, M., Jancsary, D. & van Leeuwen, T. (2013) The visual dimension in organizing, organization, and organization research: Core ideas, current developments, and promising avenues. *Academy of Management Annals*, 7 (1): 489-555. <https://doi.org/10.5465/19416520.2013.781867>
- Moisander, J. K., Hristo, H. & Fahy, K. M. (2016) Emotions in institutional work: A discursive perspective. *Organization Studies*, 37 (7): 963-990. <https://doi.org/10.1177/0170840615613377>
- Nag, R., Corley, K. G. & Gioia, D. A. (2007) The intersection of organizational identity, knowledge, and practice: Attempting strategic change via knowledge grafting. *Academy of Management Journal*, 50 (4): 821-847. <https://doi.org/10.5465/AMJ.2007.26279173>
- Nilsson, W. (2015) Positive institutional work: Exploring institutional work through the lens of positive organizational scholarship. *Academy of Management Review*, 40 (3): 370-398. <https://psycnet.apa.org/doi/10.5465/amr.2013.0188>
- O’Flynn, N. & Britten, N. (2006) Does the achievement of medical identity limit the ability of primary care practitioners to be patient-centred?: A qualitative study. *Patient Education and Counseling*, 60 (1): 49-56. <https://doi.org/10.1016/j.pec.2004.12.002>
- Phillips, N., Lawrence, T. B. & Hardy, C. (2004) Discourses and institutions. *Academy of Management Review*, 29 (4): 635-652. <https://psycnet.apa.org/doi/10.2307/20159075>
- Phillips, N. & Lawrence, T. B. (2012) The turn to work in organization and management theory: Some implications for strategic organization. *Strategic Organization*, 10 (3): 223-230. <https://doi.org/10.1177/1476127012453109>
- Pratt, M. G., Rockmann, K. W. & Kaufmann, J. B. (2006) Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal*, 49 (2). <https://doi.org/10.5465/amj.2006.20786060>
- Ravasi, D. & Phillips, N. (2011) Strategies of alignment: Organizational identity management and strategic change at Bang & Olufsen. *Strategic Organization*, 9 (2): 103-135. <https://doi.org/10.1177/1476127011403453>
- Raviola, E. & Norbäck, M. (2013) Bringing technology and meaning into institutional work: Making news at an Italian business newspaper. *Organization Studies*, 34 (8): 1171-1194. <https://doi.org/10.1177/0170840613492077>
- Riessman, C. K. (2008) *Narrative Methods for the Human Sciences*. Thousand Oaks, CA: Sage.
- Singh, J. & Javanti, R. K. (2013) When institutional work backfires: Organizational control of professional work in pharmaceutical industry. *Journal of Management Studies*, 50 (5): 900-929. <http://dx.doi.org/10.2139/ssrn.2080864>

- Stinchcombe, A. L. (1968) *Constructing Social Theories*. Chicago, IL: University of Chicago Press.
- Suchman, M. C. (1995) Managing legitimacy: Strategic and institutional approaches. *Academy of Management Review*, 20 (3): 571-610. <https://doi.org/10.5465/amr.1995.9508080331>
- Suddaby, R. & Viale, T. (2011) Professionals and field-level change: Institutional work and the professional project. *Current Sociology*, 59 (4): 423-442. <https://doi.org/10.1177/0011392111402586>
- Vaara, E., Sonenshein, S. & Boje, D. (2016) Narratives as sources of stability and change in organizations: Approaches and directions for future research. *The Academy of Management Annals*, 10 (1): 495-560. <https://doi.org/10.5465/19416520.2016.1120963>
- Wachter, R. M. & Goldman, L. (2016) Zero to 50,000: The 20th anniversary of the hospitalist. *New England Journal of Medicine*, 375 (11): 1009-1011. [10.1056/NEJMp1607958](https://doi.org/10.1056/NEJMp1607958)
- Wright, A. L., Zammuto, R. F. & Liesch, P. W. (2017) Maintaining the values of a profession: Institutional work and moral emotions in the emergency department. *Academy of Management Journal*, 60 (1): 200-237. <https://psycnet.apa.org/doi/10.5465/amj.2013.0870>
- Zilber, T. B. (2013) Institutional logics and institutional work: Should they be agreed? In M. Lounsbury & E. Boxenbaum (Eds.), *Institutional Logics in Action*, vol. 39 (p. 77 – 96). Bingley, UK: Emerald Group.