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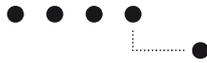
Identity work, the other, and potential conflicts: The case of Swiss physicians

Nada Endrissat

André Spicer

Dan Kärreman

Nada Endrissat, André Spicer, Dan Kärreman
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nada.endrissat@bfh.ch
andre.spicer@wbs.ac.uk
dan.karreman@fek.lu.se

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Abstract: The question of identity work has become a prominent theme in the social sciences By identity work we mean the activities that individuals undertake in order to express, negotiate, construct, or sustain their identities. One of the primary transitions which motivate intense identity work is large scale organizational change. For instance, the adoption of New Public Management in the public sector often upsets entrenched and valued workplace identities, which sparks off identity work. While much research attention has been focused on the intra-individual identity work such as development of self-narratives (Thomas & Davies, 2005) or the creation of an identity hierarchy (Kreiner et al., 2006), researchers have largely ignored the *inter-individual* aspect of identity construction. The present paper tries to fill this paucity by considering in greater detail the processes of interactional identity work and the practices by which this identity work takes place. To illustrate our argument we draw on interviews with chief physicians and hospital managers from fifteen hospitals in the German-speaking part of Switzerland.

Introduction

In modern organizations, people find that they are increasingly required to spend time engaged in identity work (Kreiner, Hollensbe & Sheep, 2006; Pratt, Rockmann & Kaufmann, 2006; Sveningsson & Alvesson, 2003). This involves the activities that individuals undertake in order to express, negotiate, construct, or sustain their identities (Kreiner et al., 2006; Snow & Anderson, 1987; Sveningsson & Alvesson, 2003). Identity work is vital in a range of workplaces such as those which rely on 'soft' forms of control which target the employees' sense of self (Alvesson & Willmott, 2003), work settings such as service work where displays of the self are a vital part of what is offered to the customer (Sturdy, 1998), and during times of transition when employees need to rework identities which have become inappropriate or outdated (Ashforth, 2001; Ibarra, 1999). One of the primary transitions which motivate intense identity work is large scale organizational change (Dutton & Durkrich, 1991). For instance, the adoption of new public management (NPM) in the public sector often upsets entrenched and valued workplace identities, which sparks off identity work (Thomas & Davies, 2005). The result is that during shifts from a public service ethos to a more
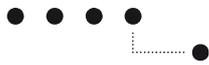
market oriented ethos, employees often are required to not just change what they do, but also the sense of who they are.

Existing studies have identified different forms of identity work that employees engage in. This involves the development and re-crafting of self-narratives (Thomas & Davies, 2005), which helps them to link the new sense of self which is demanded of them with past experiences and values. Employees also seek the creation of an identity hierarchy (Kreiner et al., 2006), whereby some order is given to the different sense of self expected of an employee through a process of ranking. Finally, employees will often experiment with new or provisional selves by trying them on for fit and seeking to adjust them to their personal circumstance (Ibarra, 1999). While we have a well developed picture of intra-individual identity work required during change processes, we know far less about the *inter-individual* dynamic of identity construction during change processes. Recent work on identity suggests that we need to attend more closely to how we build and maintain our sense of identity through relational identity work (Sluss and Ashoforth, 2007). This would involve taking seriously how we collectively and interactively work on identities with others in an organization. The present paper tries to heed this call by considering in greater detail the processes of interactive identity work and the practices by which this identity work takes place. By doing so, we pay particular attention to the role of 'the other' and the potential 'conflicts' or struggle that might arise in the process of this kind of identity work.

To address these issues we look at identity-relevant practices of chief physicians and hospital managers in the context of current changes in Swiss hospitals. Like many other hospitals around the world (see e.g. Clarke & Newman, 1997; Denis, Langley & Cazale, 1996; Doolin, 2002; Exworthy & Halford, 1999; Rainey & Chun, 2005), Swiss hospitals are facing calls for greater financial accountability and efficiency. To answer these calls, measures of efficiency and new organizational structures were introduced that grant greater importance to management and the managerial logic. This change is particularly relevant for chief physicians who have long enjoyed great autonomy in managing their clinics or departments including financial authority and decision power for human resource- and organizational issues. The former arrangement was in line with their professional identity which is deeply rooted in the idea of autonomy and superiority (e.g. Abbott, 1988; Benveniste, 1987; Hall, 1968; Quinn, Anderson &

Finkelstein, 1996). In the course of the NPM reforms, however, the work of many chief physicians has become more constrained (e.g. Ferlie et al., 1996). They are facing changes that challenge their professional identity as well as their prestige and social standing (e.g. Fiol & O'Conner, 2006). It is thus often argued that the focus on managerialism has led to an increase in power and legitimacy for the hospital management at the expense of chief physicians or professionals in general (e.g. Clarke & Newmann, 1997; Fiol & O'Conner, 2006).

However, our empirical material that was collected by means of narrative interviews illustrates that the chief physicians do not simply succumb to the imperatives of the current changes. Instead of accepting the new managerial attitudes, values, and priorities they engage in identity work and find ways to resist and thus sustain their professional values and identities that are challenged by the hospital managers. In order to explicate this argument, we proceed as follows: We begin by drawing on existing work on identity work and outline the role of 'the other' in this process and the process' reciprocal nature. Next we turn to the empirical study that was conducted in Swiss hospitals. We will illustrate how chief physicians and hospital managers understand themselves, what practices hospital managers employ that are perceived by the physicians as threatening and outline how chief physicians react in order to sustain their valued identities and how this eventually leads to a conflict. In the final section of the paper, we will discuss the results as well as the different dynamics and their consequences.

Conceptualizing interactive identity work

Building on early work by symbolic interactionists such as Mead (1934), we argue that people's identities are constructed in interactions with others. In order to know who I am, it is important to know how others see me. Identities thus develop in a dialectic process between 'me' and 'I', that is, between the social expectations and reactions that others have towards a person (the 'me') and the individual responses of that person (the 'I') that mark the individual's unique point of view (Mead, 1934). A person's identity is therefore neither socially determined nor representing an inner core but socially constructed in interactions with others (e.g. Ashforth, 2001; Berger & Luckmann, 1966; Czarniawska, 1997; Markus & Nurius, 1986; McCall & Simmons, 1966; Shibutani, 1961; Stets & Burke, 2003).

The importance of the other is reflected in concepts such as 'social appraisal' (e.g. Giddens, 1991), 'social confirmation' (e.g., Milton, 2003; Milton & Westphal, 2005), 'social validation' (e.g., Ashforth, 2001; Pratt, Rockmann, & Kaufmann, 2006), 'social verification' (Riley & Burke, 1995; Swann, 1987), or 'social support' (Ashforth, 2001; Schlenker, 1984). All of these terms account for the interaction aspect of identity work. They suggest that the way a person sees him- or herself needs to be validated by his or her interaction partner. Only if the other sees, accepts, and treats the person according to how he or she views and presents him- or herself, can the person be who he or she wants to be (Ashforth, 2001; Schlenker, 1984). The importance of social confirmation has been demonstrated by scholars both theoretically (e.g., Ashforth, 2001; Giddens, 1991; McCall & Simmons, 1966; Mead, 1934) and empirically (e.g., Burke & Stets, 1999; Milton, 2003; Milton & Westphal, 2005; Pratt et al., 2006; Riley & Burke, 1995; Swann, 1987; Swann, Stein-Seroussi, & Giesler, 1992). However, social confirmation does not happen automatically in interactions. The interaction partners will only support and validate those identities that they can agree with. It is this collective process of seeking an interaction partner to recognise our identity (and we recognise theirs) that we call interactive identity work – a process that is also known as identity bargaining or identity negotiation (e.g., McCall & Simmons, 1966; Swann, 1987).

The 'self' and the 'other': Self- and person-concept, self-presentation and altercasting. In principle, interactive identity work is thought to take place on two levels: the cognitive and the expressive level.

The *cognitive level* involves our active attempts to generate mental categories which we use to understand ourselves and others. Typically we generate two broad types of mental categories: Person-concepts and self-concepts (Turner, 1968). Person-concepts are the mental categories which we generate in order to understand others who we interact with. Our person-concept of others provides mental cues for how we should understand and indeed interact with these other people. For instance, if we hold a person-concept of another group as being dirty, unclean and perhaps morally dubious, it is likely we will try to keep some distance from them (Ashforth and Kreiner, 2006). We should note that person-concepts evolve and change as our ongoing interaction with an individual changes and proceeds over time. Self-concepts are the

mental categories which we generate in order to understand our self. They are typically generated out of our own expectations and assumptions of how others see us. These self concepts often incorporate our anticipated responses of others (the 'Me') as well as our own individual assessment and experience of these anticipated responses (the 'I) (Mead, 1934). For instance, the self concept of a 'dirty worker' is made up of their own internalised expectations that other members of the community will keep some distance from them as well as their assessment of this distance they are kept at (Ashforth & Kreiner, 2006). Our self concept often embodies 'identity cues', such as defining and describing oneself as a member of a social category, wearing specific clothes, etc. (Goffman, 1959; Schlenker, 1984; Shibutani, 1961; Swann, 1987). Our self-concept does not only inform us about who we are but also how we should act, feel, and how we would like to be treated by others (e.g., Keller, 2003; Leary & Tangney, 2003; McCall & Simmons, 1966; van Knippenberg, van Knippenberg, de Cremer & Hogg, 2004). The more visible and socially salient aspects of interactive identity work take place at an expressive level. This involves the active attempt to convey and express ones own identity in public. Self-presentation implies the creation of an identity-image that shows others who the person would like to be (McCall & Simmons, 1966; Schlenker, 1984; Swann, 1987). For instance, studies of service work find that employees typically put on a particular engage in a 'front-stage' presentation of oneself so they might be perceived by others as friendly, approachable and perhaps professional (Goffmann, 1959; Hoschild, 1983; Sturdy, 1998). These outward activities are sometimes referred to as image creation or impression management insofar as they involve an active attempt on the part of employees to manipulate the sense of self which others take from us (e.g., Dutton & Dukerich, 1991; Gardner & Avolio, 1998; Roberts, 2005).

Alongside self-presentation comes *altercasting*. This is "casting Alter into a particular identity or role type" (Weinstein & Deutschberger, 1963: 456). By making explicit who ego (the 'self') would like to be, he or she also defines whom he/she would alter (the 'other') like to be (McCall & Simmons, 1966; Schlenker, 1984). For instance, studies of workplace resistance have frequently shown how shop-floor employees attempt to build up a vibrant occupational subculture which often involves alter-casting managerial employees as being effeminate, not in touch with reality of work, and scared of getting their hands dirty (Ackroyd & Crowdy, 1990; Collinson, 1994; Rodrigues & Col-

linson, 1995). Similarly, studies of dis-identification have shown how actors in organizations seek to build up individually and collectively identities by clearly identifying who they are not (Elsbach, 1999; Pratt, 2000; Elsbach and Battacharya, 2002). Therefore, it is through this process of altercasting that we seek to assign an identity to our interaction partner. Self-presentation and altercasting go 'hand in hand'. Our actions do not only "express an image of who *we* are, but it also simultaneously expresses an image of whom we take *alter* to be" (McCall & Simmons, 1966: 139; see also Stets & Burke, 2003). Altercasting thus expresses a counter-identity for the interaction partner. Through self-presentation and altercasting, ego and alter engaging in the process of identity bargaining whereby they indicate to each other who they would like to be and whom they would like the other to be. Figure 1 summarizes the interconnectedness between self-expression and altercasting in interactive identity work.
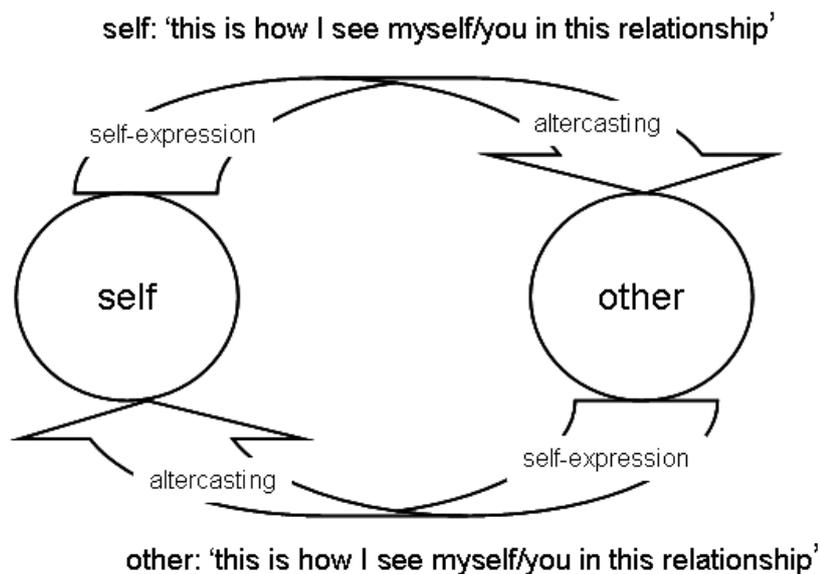

Figure 1. Self-expression and altercasting in interactive identity work.

The identity negotiation process is generally thought to lead to some sort of compromise or working agreement with respect to who the interaction partners are going to

be in this specific relationship (McCall & Simmons, 1966).[1] A working agreement involves a more or less stable cognitive alignment between our self-concept and the person-concept that other hold of us (and visa-versa). For instance a young male graduate in a law firm may perceive himself as 'potential partner material' (his self concept) which would be confirmed if the partners also saw him in such a light and would treat him accordingly (their person concept). A working agreement also implies that the alignment is expressed in our actions and reactions whereby our self-presentation and the way we are alter-cast by our interaction partner (and visa-versa) are not in conflict but complementary. For instance a young male graduate in a law firm might find his self-presentation as ambitious young professional (which is reflected for example in working very long hours and winning all the cases he is responsible for), is confirmed by senior members of the firm by treating him with a degree of professional respect, giving him appropriate tasks, and acknowledging his work. While a working agreement might be a desirable outcome of identity negotiation (at least for some), it is not the only possible outcome.

Conflicts in interactive identity work. Processes of identity work often result in significant *identity disagreement* between the interaction partners. This disagreement may happen due to cognitive disagreements when ones self-concept does not match the person concept which others hold of him or her (and visa-versa). For instance, a young female graduate may see herself as potential partner material (her self concept) while the existing partners may think in a few years time she will be more likely to choose the 'mommy track' than struggle to get a partnership (their person concept). Disagreements might also be expressive in nature, and happen when our self-presentation is in conflict with how our interaction partner alter-casts us (or visa-versa). This happens when our self-presentation mismatches the identity which is projected onto us by someone else. For instance, a young female graduate in a law firm may also present herself as an ambitious young professional, but she may be alter-cast by senior colleagues as a quasi-secretary who should engage in menial activity such as fetching coffee and photocopying papers. This would set up a signifi-

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[1] In general, the process leads to some sort of compromise with both giving in on some of their claims (McCall & Simmons, 1966). The rational for it is rather straightforward: the interaction partners are inextricably linked to each other and need each other for the acknowledgement and confirmation of their identities. Because ego depends on alter's appraisal, he will be wise not to deny all of alter's identity claims and vice versa.

cant tension between the identity she displays and the identity she is alter-cast into by senior members of the firm.

The reciprocal nature of interactive identity work. Self-concept and person-concept as well as self-presentation and alter-casting are not independent. Rather they are mutually intertwined and take on the form of 'interlocked behaviors' whereby double interacts form the basic unit of identity work (Weick, 1979; Weick, 1995). In such cases "the behaviors of one person are contingent on the behaviors of another person(s), and these contingencies are called interacts. The unit of analysis in organizing is contingent response patterns, patterns in which an action by actor A evokes a specific response in actor B (so far this is an interact) which is then responded to actor A (this complete sequence is a double interact)" (Weick, 1979: 89).

We can observe these chains of behaviour in interactive identity work. Accordingly, one's self-presentation will influence the way in which the interaction partner will respond. Depending on whether the other receives confirmation or disconfirmation for their identity, they will react in a way which expresses either agreement or resistance and evokes a new response by the initiator. Neither ego nor alter can construct their identities on their own. Their identity work is directly linked to their interaction partner, and their identity is the product of the dynamic that develops in the course of self-expression and altercasting.

In summary, interactive identity work is thought to involve the creation of self-concepts and person-concepts as well as self-expression and alter-casting. Our identities are negotiated through everyday actions which are interlocked. This means that the re-action by actor B (alter or the 'other') is contingent on the action of actor A (ego or the 'self').

The empirical study

Research site. In order to explore the dynamics of interactive identity work, we decided to focus on Swiss hospitals. We picked this as a broad arena because it has recently undergone large scale transformation. Until recently, Swiss hospitals had a 'double' or 'triple' leadership structure whereby the hospitals were effectively controlled by a medical director, a hospital managers and possibly a nursing director. In other words, they were organised as professional bureaucracies. This meant that the
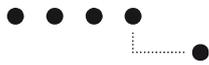
administrative body was largely 'facilitative rather than directive' (Ferlie & Geraghty, 2005: 425), and the real power lay with clinicians who had significant autonomy to regulate themselves. Clinicians were typically organised into 'silos' (Mintzberg, 1997: 10), with little interaction and cooperation among them. However this arrangement has increasingly been threatened by the adoption of the techniques of new public management (NPM). This has broadly involved calls for a more business like approach to running hospitals (Denis et al., 1996; Doolin, 2002; Rainey & Chun, 2005). The introduction of NPM typically included a package of new managerial practices such as including privatization, sub-contracting, marketization of service provision, the institution of efficiency measures and accountability (Hood, 1991; Osborne and Gaebler, 1992; Pollitt, 1993). Perhaps one of the most important factors typically involved in the adoption of NPM is the increased power and influence of management (Parker, 2002). Most strikingly, they have abandoned the dual or triple leadership structure in favour of a 'one-person-at-the-top' or 'CEO-structure' with CEOs who usually have a background in law or management (and not medicine). This means that the different medical clinics are now overseen and 'led' by a manager and no longer a medical director. This shift in the power relation between management and clinicians opens up a situation where what were fairly routine forms of interactive identity work become destablised and called into question. This provides us with an ideal situation to explore processes of identity upsetting, identity conservation and the overall dynamics of identity work.

Research method. To examine the changing dynamics of collective identity work in this setting we set out to collect qualitative data in the form of semi-structured narrative interviews (Czarniawska, 2004; Hopf, 2004). This involved structuring the interviews around eliciting information in the form of stories and then exploring the mean and local terms used by the respondent. We were not searching for facts but for interviewees' own perceptions and understandings of a specific situation. We decided to use this interview method because it allowed us to access the subjective understandings and perceptions that our respondents had of the ongoing changes. It also had the advantage of allowing us to elicit 'concrete action sequences' rather than 'ideologies and rationalizations' and thus provide access to meanings that inform action and behaviors (Czarniawska, 2004: 49).

All of the interviews were conducted in the interviewees' personal office. Before the interview started, the researcher explained the purpose of the study, the approach, and the feedback procedure that would provide every interview partner with the opportunity to comment on the interview analysis that the researchers would provide. The researcher also explained the way the data was used and granted confidentiality and anonymity. Also, permission to record the interview was obtained from all interview partners.

Findings

Managers' self-concept. Hospital managers see themselves as the 'winners' of the current changes. They consider themselves to be decisive for the hospital's 'well-being' because they have the competencies to manage the organization and to increase the efficiency. According to them, they are able to anticipate future requirements and to consider the overall interest. These competencies give them the legitimacy to lead chief physicians and to reduce their autonomy and take over some of their tasks such as human resource issues or the clinic's financial autonomy.

The relationship to the chief physicians is often conflict-ridden. According to the hospital managers, it is very important to be consistent and to stand one's ground in order to keep the control. One hospital manager recounts the following episode in which he describes a conflict over a contract that the physicians did not approve of.

> The day before I started my new job I got into a terrible argument with the physicians in the new hospital. We had decided to sign a new contract with the insurance companies that was not in the interest of the physicians … And on the 31st of October – I was supposed to start my job on the 1st of November – on the 31st a meeting was held and I said to the physicians, 'We have made this new contract and we will make sure to enforce it. Those of you who do not accept that will have to look for a new job.' … This led to a big outcry! But I pushed it through. …. I had decided for a direction that was rational … And I was willing to push it through. (HM 02: 400)

Because hospital managers know 'what is right' for the hospital and because they are hierarchically superior, they are able to defend their position against chief physicians. Another hospital manager explains

> We [hospital manager and chief physicians, NE] literally 'collide' with our views and expectations. But I have the great advantage that I am hierarchically the number one – all others are subordinates to me. And as a consequence, the whole situation is relatively easy for me. … In the beginning we had some very

severe conflicts ... and as a consequence, three chief physicians had to leave... They were not willing to pull in the same direction like me and this is why I had to take some consequences. (HM 05: 158)

To take actions and to be able to 'move' and change the organization is another important aspect of the managers' self-concept. It represents the experience of agency and makes the managers indispensable for the organization. They network and establish good relationships, bridge the different interests and integrate the key actors to achieve common goals. They claim that it is the common interest that motivates their behaviour and not personal objectives. This differentiates them from the chief physicians who are often perceived as people who live in their own world with no link to reality. The following hospital manager provides a vivid account of his personal experience with chief physicians:

It is about the willingness to integrate oneself into a system, which would imply some subordination. And I experience on the level of senior residents and above - and particularly on the chief physician level – that there are people who cannot imagine that there might be other viewpoints and perspectives than their own. One example is … when all of the sudden, this particular chief physician had the idea that the telephone list had to be revised. The whole internal telephone list had to be revised because he thought that he and his staff did not have the right telephone numbers. (HM 05: 223)

According to the hospital managers, the chief physicians have a very restricted view that makes them blind to economic and managerial issues such as financial accountability. This person-concept serves as a basis to legitimize the hospital managers' position. Accordingly, hospital managers are decisive for the hospital's success because chief physicians lack an understanding of what is necessary and required for the hospital's economic survival. It is therefore important to explain to make it very clear to the chief physicians how the reality looks like and what it requires. The following hospital manager recounts how he had to explain to the chief physician what was possible and not.

You have to convince them [the chief physicians] and tell them: 'This is not possible for the following reasons... Just imagine, if we go in this direction, the patients' anger will rise even more and it will also have consequences for the staff who are required to fulfill the job. You have to know that when you decide about the strategy and the direction you want to pursue, you always have to consider the consequences this strategy might have.' (HM 09: 469)

By defining what is possible and not and how the reality 'really' looks like, the hospital manager does not only express his self-concept as superior but also casts the chief

physician into an identity that is marked by inferiority.

Physicians' self-concept. The physicians' self-concept is closely linked to the values of the medical profession. They view themselves as 'elite' and disdain the values and approaches of those outside their discipline. They consider the management education to be inferior to their own medical training and have difficulties to subordinate themselves to people who have no medical background. For example, one chief physician explains:

> *I would describe myself as being fundamentally against a CEO system. If you place a CEO on top of me, I will turn out to be a horrible grouch (ger. 'Querulant'). I promise you that. Because I cannot accept that someone who has no knowledge and competence of the subject matter tells me what to do… I accept people who have knowledge of the subject matter, who are able to argue in a rational way - 'this is correct; this is not correct.' But if I have the impression that they have no clue, … that they only do it because it is a new management fashion that they picked up in some training course and that dictates how something should be done in order to be successful - and they do it only because it is the fashionable thing to do and the best and the cheapest - you cannot do that with me! (CP 03: 984)*

They stress the importance of taking responsibility and of being autonomous – especially when it concerns their own clinic or department. One chief physician describes his point of view as follows:

> *I always had a big problem with hierarchical structures. Not because I have a problem if someone tells me what to do, but I did not like the supervision and the control. What I appreciated was when I had a chief who said: 'This is your garden. I expect you to do this and that.' But who then let me do it my way. And it didn't matter to him whether I planted the roses in the right corner and the sunflowers in the left corner. He simply wanted me to make a nice flower garden. And the other chiefs, who would say 'Oh, but I would have liked to have the flowers in the centre and why did you plant them over there, and you should give them more water, etc.' Then I always thought, well, HE should do it himself if he knows everything better. (CP 02: 15)*

According to the chief physicians' narratives, they are dedicated 'front-line fighters' who will try everything to take care of the patients and to deliver the hospitals' 'core services' and 'core products'. They assume the responsibility for the patients as well as for the training and development of the junior staff and are thus decisive for the hospital's functioning. They are also the 'experts' who claim decision power because they know it best.

Because the chief physicians present themselves as the superior ones who deliver the hospitals' core services, they cast the management into a role that represents a support rather than a central leading function. The following chief physician outlines the management role that would match the important functions the chief physicians fulfil:

> We carry out our task, i.e., we take care of the patients. In order to fulfill this task, we need a relatively big infrastructure that supports our work. If you compare our structure to the military context, then the administration is like the headquarters in the back. It is their job to make sure that we, at the front, have everything we need to do our job. They make sure that we have enough to eat, that there are enough supplies, clothes, etc. (CP 11: 448)

Another identity relevant aspect can be found in the chief physicians' emphasis on having a clear, individual standpoint which is communicated even if it is unpopular. They do not avoid conflicts and enjoy possibilities to assert themselves. By showing their 'rough edges' and their personality, the chief physicians are not only authentic and 'true' to themselves, they also demonstrate their individuality that makes them stand out from the ordinary 'gray mice' (or 'average Joes'). Taking a clear stand might imply not being 'everybody's darling'. But self-assertion seems to be more important for chief physicians than social validation from hospital managers or the Ministry of Health. According to the chief physicians, this 'taking a clear position' differentiates them from the managers who are often concerned with establishing good relationships and of making compromises instead of clearly telling others what they think. One chief physician notes:

> Political flip-flopping, that is, to say something just because the tape is running and because it seems to be opportune to tell a particular story, and then, if someone else enters the room I tell you the exact opposite even though it still concerns the same matter. One time the door is white, another time the door is beige - depending on whom you are speaking to. If you think it is a little darker, they [the people you are talking to, NE] might think the same. I find people like this really annoying and I think they are absolutely inept for a leadership position. Wanting to be everybody's darling; no clear line. These are the same people whom everyone considers to be 'so nice'. But this can't be! As a leader, you need to provoke from time to time. Or let me put it in another way: if you are never in conflict with anyone, you have a problem. Either you want to please these people, who think this way, or you want to please those others [but you have to choose which side you are on, NE]. (CP 02: 59)

Managers' altercasting is upsetting for the chief physicians

The new organizational structure and the NPM reforms have led to several changes

that challenge the physicians' self-concept as autonomous, superior and powerful expert. Yet it is not the reforms per se that upset the physicians but the way the reforms are enacted and put into practice by the managers. It is thus in the interaction with the managers that the chief physicians experience the change and are challenged in their self-concept.

Monitor and control the professionals. The first practice that upsets the physicians' self-concept is the limitation of their autonomy and decision power. For example, the managers increase the financial control and limit the physicians' autonomy by asking them to submit budgets and by monitoring and limiting the way the chief physicians can spend the money. One chief physician explains:

> *I agree that a budget is a good idea. It can even have narrow margins, but we need to be able to make autonomous decisions on how to spend the money! For example, do we want to spend it on a brochure, etc. But at the moment, we always have to ask for permission and negotiate our plans. (CP 10: 723)*

This experience is confirmed by another chief physician who comments that the control is almost so tight that he can't decide which pencil to purchase. He notes

> *They do not decide over each and every pencil – but almost, which is very disturbing for our daily routines. (CP 09: 69)*

Another chief physician expresses his lack of understanding for having to submit a detailed budget because he never receives the money he has asked for. As a result, submitting a budget seems like a waste of time. According to him, it is simply a way to keep physicians busy and to control them. The increased control of their work is also mentioned by the following chief physician who compares his current situation to the conditions of the former Soviet Union.

> *We always made fun of the Soviet Union, because they only had offices and did nothing else but monitor and supervise each other. But how is it here today? We do exactly what they used to do. (CP 09: 126)*

To the chief physicians, taking responsibility and having autonomy go hand in hand. The person who assumes the responsibility for his or her decision should also be the one who has the decision power. This has long been the case for them in their daily work. However, some hospital managers have introduced new regulations reducing the chief physicians' decision power while still expecting them to assume the responsibility.

But the CEO has dissociated the responsibility from the decision power. We still have the responsibility – which is enormous in our discipline. While we are sitting here, some catastrophe could happen for which I would be held responsible and for which I could appear in the newspaper tomorrow. … And the new management position is filled with someone who, in fact, does not have to assume any responsibility at all. At the same time however, he is supposed to be our superior. (CP 10: 760)

Some hospital managers even interfere in internal clinic matters such as the hiring of new employees or the organization and division of tasks among the staff. This is extremely upsetting to the following chief physician who had introduced the internal organization and which worked very well for them as he notes:

Everything worked very well. But all of the sudden the hospital manager decided that we can no longer divide the work load like this. And in addition, she has decided that the extra money that we earn through private consultations is no longer credited to our department but is transferred to an account of the administration. She even reclaimed the money that we made from the year before! Her argument is that she has issued the directive that none of the specialists are allowed to spend more than two half days on private consultations. And according to her, we violated her directive by the way we had organized the work load. But I think it is up to us how we want to organize the work! On average, none of my specialists spent more than two half days on private consultations. It was just that some spent more time on it than others. But this was because they were excellent at it. And I think everyone should do what he or she can do best. But now we have to follow the directive which means that even the person who is not a specialist in a particular area has to do the consultation and the person who is really excellent at it can't do it. And I think this is unbelievable! (CP 10: 933)

Exclude the experts from the decision making process. According to the chief physicians, most hospital managers do not consult the chief physicians before making decisions, even though the chief physicians possess the relevant expertise for many decisions. Leaving them out of the decision process or keeping them uninformed suggests that the hospital managers do not consider them as partners and active subjects but as passive objects to whom the final decisions simply need to be communicated. The following episode describes how the chief physicians were informed about a redistribution of tasks – a 'Sunday-home-alone' decision by the CEO as the chief physician calls it; and a wrong one - as it later turned out.

On a Sunday afternoon, the new CEO decided that the pharmacist would no longer be the one to be in charge of distributing the pharmaceuticals but that from now on, this would be the job of the logistician who is responsible for the pharmaceutical depot. The CEO simply informed us and noted, 'I hope I have

made the right decision.' And we were all totally perplexed. We had no idea what had happened and why this decision was made. (CP 06: 604)

Similarly, another physician stresses the importance of clarity and open dialogue between the manager and the chief physicians. Taking the current confusion in resource distribution as an example, he argues:

By what criteria are the resources distributed? This is a very important question. And it can work out more or less well. If there are some, let's call them 'favorites', and they are well fed and all the others look like 'Hansel and Gretel' [the main characters of a German fairy tale, NE] and are starving to death, then the hospital does not function well. This is why it is so important that the dialogue between the CEO and the chief physicians is open and clear. (CP 12: 393)

The chief physicians possess expert knowledge that is crucial for the hospital's functioning. Because they know best what is necessary in order to fulfil their jobs, they should be the ones to make the decisions. However, according to the new regularities the decision power has been taken away from the chief physicians in an attempt to increase the financial efficiency. Again, this puts the chief physician in a passive status which is not appreciated.

And now they think they can decide whether or not my department can have a new CT scanner or another instrument, even though they have no qualification to evaluate the situation. And I must say, this is not against THEM, but when experts are available, you should leave the decisions to the experts. Or give us a budget and then trust us that we will spend the money wisely. (CP 02: 526)

Play the boss / pretend they are the legitimate 'leaders'. Another practice that is extremely irritating to the chief physicians is the fact that the hospital managers act as if they were the legitimate leaders of the hospital and could thus tell chief physicians what to do. Their actions suggest that the chief physicians are followers or subordinates – a role that is contrary to the chief physicians' self-concept as superior expert. Not only are most hospital managers not members of the medical profession (which would give them some legitimacy to lead chief physicians) but they often also lack competence in their own area. This makes it even more difficult for chief physicians to accept them as leaders. But the hospital managers nevertheless act as if they know better than the chief physicians on how to organize clinics or spend money. One chief physician notes:

Last Friday, we realized that our manager had actually no idea about the new changes. He simply knew the name of the concept and maybe one or two key-

words. But he called in a meeting that all of the chief physicians were required to attend. (CP 10: 805)

Many chief physicians are upset because they have to negotiate with the hospital managers if they want to purchase new equipment even though they are already limited in their scope of behaviour by budgets. This is difficult to accept, especially if the hospital manager is seen as incompetent. The restriction then might be perceived merely as a way for the hospital manager to demonstrate his power. One chief physician argues:

> *To negotiate our proposals with someone who might just want to show that he is the boss, is extremely unpleasant. (CP 12: 727)*

Don't acknowledge and don't support the work. According to the chief physicians, many hospital managers do not appreciate the physicians' work and effort to provide excellent services. For example, some chief physicians report that even though they deliver the hospital's 'core services', they do not receive the resources they need in order to fulfil the job. One chief physician illustrates this situation very aptly. He explains that due to a budget cut, he does not have enough staff to fulfil the required tasks. Yet, the CEO refuses to acknowledge the physician's dilemma and instead delegates the responsibility back to the clinic. The chief physician describes himself as 'front-line fighter' who is deserted by his captain and left alone in the 'battlefield'.

> *I went to the CEO and said, 'We don't have the necessary resources to fulfill the task.' The answer I got was, 'It is not our responsibility but the clinic's to provide the necessary resources.' The clinic, in turn, replied, 'Sorry, but we have empty pockets, we can't do anything.' This is the prototype of our communication with the CEO. We signal that we have reached the limit; and even though I don't like to compare it to a military setting, it really resembles the situation of being at the front. We [the medical doctors] fight and when we lack munitions to continue to defend the position we communicate to our captain and say, 'Send us ammunition,' and the answer is, 'Ask your colleague to give you some.' But the colleague has nothing left himself. (CP 04: 456)*

Similarly, another chief physician recounts a situation in which he had expected a financial appreciation for his efforts when he was called in by the HR department without any prior notice. As it turned out however, he was about to get a salary-cut because of a new regulation. This is very troubling; not so much because of the money, but because of the missing appreciation and the way the HR department and the CEO treated him.

Where is the appreciation for my work? I always wonder how I would have dealt with the case if I would be forced to cut someone's salary. To be sure, I would try everything to find a way around it. I would talk to the person, explain to him or her what the situation is like, and would try to find a solution together. But none of this happened in my case. (CP 10: 961)

Other chief physicians report that the hospital manager do not back them up in negotiations with insurance companies or other departments or in the implementation of clinic information systems. These experiences are upsetting because they challenge the chief physicians' status and importance for the hospital. The way the hospital managers act transports the message that the hospital managers are not as important as they think they are. Another chief physician explains:

We have some problems with the administration because we expect them to support us more …We just had an argument yesterday in the board meeting about the purpose of the clinic information system. We have the feeling that the administration has no link to the 'base'. We are not satisfied with what they're offering us. We have the feeling that the administration is only concerned with monitoring our performance. This is the only reason why they are in favor of the clinic information system. (CP 15: 474)

Chief physicians' self-expression as form of resistance

In reaction to the disconfirmation of core aspects of their identity and in an attempt to maintain their valued identity, chief physicians respond to hospital managers with the following practices.

Joking, criticising, or disdaining. Management is generally seen as an inferior line of work to medicine. According to the chief physicians, the 'accelerated degree programs' (CP 02: 496) for people earning their MBA cannot be compared to the long training of medical doctors. Managers are therefore neither qualified nor legitimized to lead chief physicians. According to them, the hospital managers do not have an understanding of the hospital's 'core business' and in addition, often do not even have an understanding of their own domain. As a consequence, many chief physicians speak of the hospital managers in a rather disrespectful way. For example, one chief physicians concludes with respect to the necessity of management:

Physicians do not need any vendors (ger. 'Kaufleute') to lead a hospital. (CP 13: 117)

The German word 'Kaufleute' (engl. vendors) aims at people who sell and buy things but who have no academic or higher education. In a similar way, another chief physi-

cian talks about the hospital manager as someone who likes to 'play the boss' even though he has no competence and therefore knows that he is not accepted as 'boss'.

The managers' attributed inferiorities provide the physicians with the opportunity to assert themselves and to corroborate their superiority.

Arguing, fighting back, asking for justification and explanations. The second practice involves more direct disagreement with decisions made by managers through arguing, fighting back, asking for justification and explanations. This is a way for the chief physicians to assert themselves. They do not try to avoid the conflicts but actively take on the challenges and see a conflict as opportunity. For example, one chief physician notes:

> I do not try to avoid conflicts. In fact, I have some pretty good enemies [laughs]. And I value cultures in which arguments can be made. This is important. (CP 01: 380)

Another chief physician recounts two situations in which he challenged the hospital manager's decision.

> Then I told him ‚I haven't studied law but I cannot believe that this is correct. Maybe you can explain to me what is the difference between a fundamental and a basic revision?' And then I left the office. Of course, I didn't sign the new contract. But he made it clear to me that the revision would come no matter what. But I say: Let's see what happens! (CP 10: 879)

Instead of taking on a passive and accepting role as the hospital manager expects him to, the chief physician challenges the decision the hospital manager has taken and thus remains active and agentic. The other situation deals with financial issues. Instead of accepting that a great amount of money from the insurance companies goes directly to the hospital's administration, the chief physician questions this practice and looks for possibilities to avoid it. He notes:

> Then I realized that our clinic has x Million Francs income from the insurance companies. This used to be much less and has increased only over the last years since I have become chief physician. The sum is a very large amount of money. And then you look at the expenses: So and so much for the personnel and then you realize that more than x Francs are directly subtracted for the management! Incredible! I feel like I fund the administrative body all by myself! …. And I think it is important to question this circumstance (CP 10:891)

Together, these reactions represent an attempt to recover the power and the expert

status associated with the physicians' identity.

Wilful disobedience or ignorance. The third group of reactions involves wilful disobedience or ignorance of 'ill conceived orders' issued by management such as submitting budgets, negotiating how to spend the granted budget or following the regulations concerning overtime hours. The following citation is from a chief physician who has decided to no longer submit a detailed budget. Preparing one always takes a lot of time and he has experienced that it does not make any sense because he usually does not end up getting what was on the list anyway. It reminds him of when he was a young boy and prepared a Christmas 'wish list' only to find himself getting something that was not on the list. He argues:

> *I compare it to making a list of wishes for Christmas as a young boy. I used to write down twenty different things; but in the end, I got something totally different, something that was not on the list. At some point, I therefore decided that there was no use in making a list for Christmas anymore. And the same situation is taking place right now. For a long time, I have submitted these budgets. But now, I don't do it anymore. I prefer that they tell me how much money I will get and then I am very willing to tell them what I am going to do with this money. It resembles more the situation of me as young boy going to the kiosk with a Swiss Franc and asking the owner 'What can I get for a Swiss Franc?' And then I can look at what they offer me and choose the things I like best. But what we have done so far is to list every single item, to consider every item and then specify how much we will probably need. And in the end, the government says, 'Sorry, but you only get half of it.' You really wonder: why was I required to make all of the specifications? (CP 02: 464)*

The quotation shows how the chief physician actively creates a situation in which he proves his autonomy and continues to be an active subject. Similarly, another chief physician explains the dilemma that the reduction of the workload for interns and residents to a 50 hr-week has caused in his clinic. An adherence to the regulation would imply no longer being able to take care of all his patients. Yet, the latter has a higher value than following 'orders' and the chief physician therefore finds ways to get around the regulations. He explains his position as follows:

> *Here in Switzerland we are more or less used to following the rules. If you talk to Frenchmen who have theoretically a 35 hr week, they only laugh. 'Laws? Who cares about laws?' We are not that far yet, but maybe one day. They can decide what they want, but we cannot abandon our patients. They are the last ones we give up on. We would rather ignore the laws than stop taking care of patients. I think I can speak for the majority of physicians when I say that we will always try to take care of the patients, and for that, will not worry about the fine print and the insane orders. (CP 04: 481)*

The identification with their work and the subject of their work (the patients) provides enough reasons to resist the external restrictions and to act according to their self-concept as professionals.

Dissociating themselves from managerial logic. The last group of reactions which enable the chief physicians to maintain their sense of self is through emphasizing professional values. This includes putting the patients in the centre of their attention and reducing the value of managerial thought. As mentioned in the above citation, some chief physicians will ignore the official regulation concerning overtime hours in order to manage the patient care. Others stress the importance of their professional values and of following them instead of adopting a managerial logic.

> *It is very difficult if someone who adheres to different cultural values tries to get into our profession. We have a distinct professional culture and it is necessary to know this culture... And if some economist comes and acts in line with his own models and doesn't know our professional culture, his behavior can destroy everything that is important to us. (CP 08: 147)*

Dissociating themselves form managerial logic helps the chief physicians to maintain their sense of self as professional.

To summarize, there are basically four ways in which the managers upset the chief physicians' self-concept: increasing the control and monitoring the chief physicians, excluding them from decision making processes, 'playing the boss' and neither supporting nor appreciating the physicians' work and contribution to the hospital. By these actions, the physicians' self-concept as autonomous, superior and powerful expert is disconfirmed. The actions convey the message that physicians should follow the rules, that they are employees like all others, that the managers have superior knowledge and that the physicians' work is not really important. Because this offered role is not in line with how the chief physicians understand themselves, they react accordingly and resist the identity that is offered by the hospital managers in four different ways. First, they joke, criticise or disdain the professional status of hospital managers. By doing this, the physicians seek to recover the superiority of their identity. The second practice involves more direct disagreement with decisions made by managers through arguing, fighting back, asking for justification and explanations. These practices involve an attempt to recover the power and the expert status associated with the physicians' identity. The third practice involves wilful disobedience or

ignorance of 'ill conceived orders' issued by the management. Together with the practice of dissociating themselves from managerial logic through emphasizing professional values and the Hippocratic oath, these practices allow physicians to maintain their sense of autonomy. Table 1 summarizes the interlocked actions and reactions.

Even though some practices upset more than one aspect of the chief physician's self-concept, we propose that the practice of monitoring and controlling the professionals upsets the autonomous aspect of their identity, that the exclusion of the professionals from the decision making process challenges the powerful aspect and their understanding as experts, the practice of 'playing the boss' and pretending to be the legitimate leader upsets the physicians' sense of superiority and the fact that the hospital managers don't acknowledge and don't support the physicians' work challenges their centrality and importance for the hospital.

Table 1. Upsetting practices (actions) and reactions from the chief physicians' point of view

Perceived upsetting practices (action)	Example	Upset which aspect of the chief physicians' self-concept?	Practices (re-action) to maintain valued identity	Example
Monitor and control the professionals • increase their control by limiting physicians' financial autonomy • making them submit budgets but not giving them the money they ask for • interfering into their internal clinic organization.	*I agree that a budget is a good idea. It can even have narrow margins, but we need to be able to make autonomous decisions on how to spend the money! For example, do we want to spend it on a brochure, etc. But at the moment, we always have to ask for permission and negotiate our plans. (CP 10: 723)*	Autonomous aspect	Wilful disobedience or ignorance of 'ill conceived orders' issued by the management Dissociating themselves from managerial logic through emphasizing professional values and the Hippocratic oath	*I compare it to making a list of wishes for Christmas as a young boy. I used to write down twenty different things; but in the end, I got something totally different, something that was not on the list. At some point, I therefore decided that there was no use in making a list for Christmas anymore. And the same situation is taking place right now. For a long time, I have submitted these budgets. But now, I don't do it anymore. I prefer that they tell me how much money I will get and then I am very willing to tell them what I am going to do with this money. It resembles more the situation of me as young boy going to the kiosk with a Swiss Franc and asking the owner 'What can I get for a Swiss Franc?' And then I can look at what they offer me and choose the things I like best. But what we have done so far is to list every single item, to consider every item and then specify how much we will probably need. And in the end, the government says, 'Sorry, but you only get half of it.' You really wonder: why was I required to make all of the specifications? (CP 02: 464)*

| Perceived upsetting practices (action)	Example	Upset which aspect of the chief physicians' self-concept?	Practices (re-action) to maintain valued identity	Example
Exclude the experts from the decision making process • do not give physicians a chance to express their opinions on important policies and remove their influence in human resource decisions that affect the physicians' clinics • don't inform / don't consult the experts	*On a Sunday afternoon, the new CEO decided that the pharmacist would no longer be the one to be in charge of distributing the pharmaceuticals but that from now on, this would be the job of the logistician who is responsible for the pharmaceutical depot. The CEO simply informed us and noted, 'I hope I have made the right decision.' And we were all totally perplexed. We had no idea what had happened and why this decision was made. (CP 06: 604)*	Powerful aspect and their understanding as expert	Disagreement with decisions made by managers through arguing, fighting back, asking for justification and explanations.	*I do not try to avoid conflicts. In fact, I have some pretty good enemies [laughs]. And I value cultures in which arguments can be made. This is important. Once a week, during our team meeting, we argue excellently about very different topics, and some are very difficult. (CP 01: 380)*
Play the boss / pretend they are the legitimate 'leaders' • 'play the boss' by speaking about important changes they often have little knowledge of, and calling in meetings when there are no important decisions to be communicated	*Last Friday, we realized that our manager had actually no idea about the new changes. He simply knew the name of the concept and maybe one or two keywords. And for this he called in a meeting that the chief physicians were required to attend. (CP 10: 805)*	Superiority / expert status	Joking, criticism, or disdain targeted at the professional status of hospital managers.	*I would describe myself as being fundamentally against a CEO system. If you place a CEO on top of me, I will turn out to be a horrible grouch. I promise you that. Because I cannot accept that someone who has no knowledge and competence of the subject matter tells me what to do... I accept people who have knowledge of the subject matter, who are able to argue in a rational way - 'this is correct; this is not correct.' But if I have the impression that they have no clue, ... you cannot do that with me! (CP 03: 984)*

Perceived upsetting practices (action)	Example	Upset which aspect of the chief physicians' self-concept?	Practices (reaction) to maintain valued identity	Example
Don't acknowledge and don't support the work • Do not adopt the support function that the physicians are expecting them to adopt	*We have some problems with the administration because we expect them to support us more …We just had an argument yesterday in the board meeting about the purpose of the clinic information system. We have the feeling that the administration has no link to the 'base'. We are not satisfied with what they're offering us. We have the feeling that the administration is only concerned with monitoring our performance. This is the only reason why they are in favor of the clinic information system. (CP 15: 474)*	Centrality/ importance for the hospital	**Wilful disobedience** or **ignorance** of 'ill conceived orders' issued by the management Dissociating themselves from managerial logic through **emphasizing professional values** and the Hippocratic oath	*Here in Switzerland we are more or less used to following the rules. If you talk to Frenchmen who have theoretically a 35 hr week, they only laugh. 'Laws? Who cares about laws?' We are not that far yet, but maybe one day. They can decide what they want, but we cannot abandon our patients. They are the last ones we give up on. We would rather ignore the laws than stop taking care of patients. I think I can speak for the majority of physicians when I say that we will always try to take care of the patients, and for that, will not worry about the fine print and the insane orders. (CP 04: 481)*

Discussion

Our findings suggest that managers and physicians hold very similar self-concepts. The hospital managers seek to create a self concept through locating themselves as central to the organizational functioning and vital for the organization to be able to take action. This creates a positive association as them being 'guardians' of the hospital. Physicians' self-concept is associated with their elite medical training, their professional autonomy, and their technical expertise. Attempts to create a positive self-concept by both the hospital managers as well as the chief physicians involves attempts to represent themselves as being central to the functioning of the hospital. The hospital managers do this by positioning themselves as financial guardians of the hospital while the chief physicians do it by placing themselves as those who deliver the core services of the hospital. In each of these cases we see a practice of *connecting* their self concept with the collective identity. This involves both the managers' and the physicians' attempt to link their own identity with the core functioning of the organization. They do so by asserting themselves as being absolutely central to the functioning of the organization as a whole. Moreover they seek to closely integrate their own identity with the identity of the organization as whole. This would allow them to literally become the central representatives of the organization as a whole.

In addition to seeking to create a positive self-concept by connecting themselves to the central functioning of the organisation, both groups also seek to generate a fairly negative person-concept associated with their counter-parts. Managers have created a person-concept of physicians as being unable to deal with the harsh economic decisions required by the changing markets. Physicians have created a person concept of managers as less sophisticated, daring and knowledgable than themselves. In both these cases, what they seemed to be engaged in is a practice of *distancing* whereby they are trying to mark out clear space between their own identity (which they have asserted as being central to the functioning of the organization) and the identity of their counter-parts who are represented as being very different from themselves. By creating this distance, each group is not only able to negatively mark the other group. They are also able to seek to assert their own special qualities which they see as being central to the functioning of the organization.
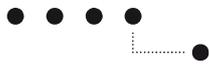
On the expressive or behavioral level, we see that the hospital managers engage in several practices that cast an identity on the physicians that is upsetting and thus unacceptable to them. As a consequence, they engage in practices that seek to bolster their sense of self against what they consider unjust intrusions. By doing so they are able to feel they can hold onto an unmodified version of their identity despite a range of identity threats and challenges posed by the other.

The dynamics of interactive identity work.

So far we have argued that identity work takes place through an interaction process which involves the presentation of self and the confirmation or disconfirmation of the claimed identity by the interaction partner's reaction or altercasting. If we do not receive social confirmation and instead, are offered an identity that is not in line with our self-concept, our identity might be upset leading to indignation and resistance (Ashforth & Mael, 1998). However, this does not imply that the identity work is not successful. As the data shows, the chief physicians are able to sustain their valued identities by showing some resistance practices, suggesting that their identity work is 'successful'. However, in the long run this kind of interaction among manager and physician will lead to ineffective and strenuous interactions. By resisting the offered identity, the physicians are able to maintain their identity. At the same time however, their reactions imply a disconfirmation for the managers' identity claims. In other words, instead of coming to a working agreement as suggested above, the two interaction partners work against each other: *none provides* and *none receives* social support from the other which leads to conflict and a difficult working relationship. The sustainment of the physicians' identity happens at the 'expense' of the managers' and their relationship is therefore thought to be unstable and rather dissatisfactory.

The crucial theoretical as well as practical implication is that each of these behaviours are interlocked. A mismatch between self concept and person-concept give rise to tension which produces attempts to create negative alter-casting of the interaction partners which in turn produces attempts at positive self expression. Such positive self expression often involves a further attempt to entrench our existing identity. Often times this can only act as a further provocation to our interaction partner whose assumptions about us contained in their person concept are also further entrenched, giving rise to a

further round of identity bargaining. What is particularly interesting about this kind of identity bargaining is that it involves a cycle of what we might call 'destructive struggle'. This involves a situation where both interaction partners seek to sure up their own identity at all costs. Often the cost is the degradation of our interaction partner's identity. The result is that identity struggle becomes a kind of zero sum process whereby one person's gain is another's loss. This is what Karl Jaspers calls 'struggle by force'. It is "coercive, limiting, oppressive, and conversely space-making: in this struggle I may succumb and lose my existence" (Jaspers, 1932/1970: 206). For Jasper's there are two possible reactions when we are locked in this kind of struggle. The first is simply disgust and absolute rejection of the struggle and all the various gains it brings us. This involves 'non-resistance' and giving up on politics. This would mean we would be swayed by the smallest and most base demands that others make upon us. The result according to Jaspers is self-destruction because we give up on the struggle which actually calls us into being in both an existential sense and a more basic material sense. The second option that Jaspers identifies in the destructive struggle is an utter 'will to power'. This involves the enthusiastic grasping the instruments of power and engaging in a ceaseless fight for the eventual victory over all. This absolute struggle, "would end with a lone destroyer or conqueror of all the rest. He (sic) would not know what to do with his limitless conquests: he has a task only while he has something to crush. The tendency to rule or ruin everything, to remove all limitations on one's own power, consistently ends in despair at having no one to fight anymore" (Jaspers, 1932/1970: 209). The result of a destructive struggle is therefore either utter victory or annihilation.

However, destructive struggle is not the only possible dynamic associated with identity bargaining. Theoretically, we could imagine a very different process of interactive identity work which is not characterised by a destructive dynamic of tension between self-concept and person-concept, identity upsetting and identity conserving. Instead this dynamic would involve more a process of identity confirmation. It would involve a process where there is mutuality between an actor's self-concept and the person-concept that the other holds of him or her. It would entail processes of alter-casting which render the other in a role which confirms their own self expression. In contrast to the zero-sum game of destructive struggle it would involve a kind of positive sum dynamics.

This kind of positive dynamic of struggle is close two what Jaspers (1932/1970) meant by the idea of 'the loving struggle'. For Jaspers (1932/1970: 206), "a loving struggle is non-violent, jeopardizing without a will to win, solely with a will to manifestation". At the centre of the loving struggle is the recognition our opponent has the right to exist. This means that we do not seek to utterly destroy or degrade their identity. Rather a loving struggle involves the attempt to affirm, extend and glorify each other's identity through the mutual and consistent process of calling our partner into question. It is through this process of questioning (and being called into question) that we come to know our own identity and our partner in struggle. This mutual calling into question 'extends' each actor and the struggle more generally. In this struggle, "there is no victory or defeat for one side; both win or lose jointly . . . the fight is possible only as one simultaneously struggle against both the other and myself" (Jaspers, 1932/1970: 213). Indeed, this process involves struggling *with* someone rather than *against* them.

Conclusions

Research on identity work has primarily focused on intra-individual processes of identity construction such as crafting a self-narrative (Thomas & Davies, 2005) or creating an identity hierarchy (Kreiner et al., 2006). Yet, recent work on identity suggests that we need to pay more attention to the relational aspect of identity work. The present paper has tried to address this issue by outlining how interactive identity work can be understood both from a theoretical and an empirical perspective. We have argued that interactive identity work is achieved by means of self-expression and altercasting which are inextricably linked to each other. Further, the empirical material has shown that the partners' actions and reactions are interlocked and mutually reinforcing. Identity construction is not done in isolation but depends on the existence and reaction of the 'other'. Finally, we have tried to show that different relationship- and identity-dynamics can develop depending on whether the interaction partners receive social confirmation for their self-concepts. Disconfirmation is likely to trigger conflict and might lead to what we have called 'destructive struggle'. We hope that our empirical data and arguments will spark off discussion and insight into the pressing question of who we are and how we construct our identities in interactions with others.

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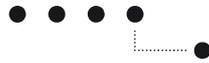
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