Working For the Same Purpose and Yet Against Each Other:

The Process of Identity Network Enactment in a Surgical System

by

Virgil W. Fenters

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Graduate Supervisory Committee:

Blake Ashforth, Chair
Kevin Corley
Margaret Luciano

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ABSTRACT

Individuals have multiple identities, and several of them may be simultaneously driving enacted behavior in a given context. Scholars have suggested that intrapersonal identity networks – the combination of identities, relationships between identities, and identity characteristics – influence enactment. However, very little is known about the process by which several components of one's identity network result in a single stream of enactment. This is important because different factors (e.g., leader actions) may impact this process and, in turn, change the way people act in organizations and interpret the actions of others. I examined a healthcare system designed to surgically treat cancer patients. Taking an inductive interpretivist approach, and using grounded theory methodology, I developed a process model of intrapersonal identity network enactment that also takes into account interpretations of other system members' enactment. My findings contribute to the social identity literature by suggesting that a common, highly central identity is not enough to align behavior in organizations. Instead individuals may enact a common "higher-order" identity in combination with the rest of their identity network in ways that actually work against each other, even as they genuinely work toward the same purpose. I also extend the literature on multiple identities by explicating a process by which four different identities, and four characteristics of each identity, foster enactment toward the surgical system. Finally, I show how one's intrapersonal identity network influences how they interpret the enacted behavior of others. In doing so, I extend the identity threat and opportunity literature by showing how one person's identity threat is another's identity opportunity, even when they share a common higher-

order identity. In short, my study shows how individuals can work against each other, even when they are genuinely working toward the same purpose.

DEDICATION

To my sweet wife, Christina Fenters, for providing unending support throughout this dissertation and my Ph.D. experience. Few people would have encouraged me to chase my dream of being a professor instead of taking the simple route into the airlines. Your love and kindness made this journey possible and enjoyable. Thank you for choosing to love me even when it's difficult, for supporting me even when it required you to sacrifice, and for being the best person I've ever met. I love you with all my heart.

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INTRODUCTION

> *I would hope that [patient care is] like* the *driving force. I actually worked at [a different hospital] prior to this and it was like printed on the wall, "The needs of the patient are the only needs to be considered." And that is the quote that runs through my mind all the time, and it disappoints me greatly when I see that that's not what people are doing. (105)*[1]
>
> *I mean I do think it's exciting to make something so that patients get better care. And I think [standardizing] things always is helpful for, for everybody for the most part. (105)*
>
> *I would tell you that I already talked to [my partner] and… I don't think we're going to [standardize] it. (105, change team meeting, 2019.07.11)*

Identities are self-definitions that answer the question "Who am I?" or "Who are we?" (Ashforth, Harrison, & Corley, 2008: 327). Identity enactment is the behavioral manifestation of one or more identities (Thatcher & Zhu, 2006), and such behaviors may involve verbal expressions as well as activities performed (Weick, 1995). Therefore, identities, when enacted, drive the behavior of individuals (Ford, O'Hare, & Henderson, 2013; Thatcher & Zhu, 2006). However, people have many different identities, many of which can be simultaneously salient in a given context (Ramarajan, 2014). These multiple identities influence each other (Bataille & Vough, 2020; Caza & Wilson, 2009; Creary, Caza, & Roberts, 2015) and the resulting enactment (Burke & Stets, 2009). Thus, having multiple salient identities in a given context means that individuals may display a wide variety of behaviors. This presents a challenge to teams and organizations as they seek to ensure that their members work toward a common overarching mission (Cable, Gino, & Staats, 2013).

[1] In order to maintain anonymity, each informant is represented by a three-digit identification number.

To address this challenge, organizations and scholars have typically focused on encouraging members to adopt a common overarching identity (e.g., Ashforth, 2007; Rink, Kane, Ellemers, & van der Vegt, 2013; van Knippenberg, van Knippenberg, De Cremer, & Hogg, 2004). The thought being that individuals hierarchically arrange their identities with less central identities (i.e., those with a lower assigned value or subjective importance, Brenner, Stryker & Serpe, 2014; Settles, 2004) being subordinate to more central or "higher-order" identities (Stryker & Serpe, 1994). Further, a higher-order identity serves to integrate and align the enactment of other identities (Caza, Moss, & Vough, 2018). Therefore, if the common overarching identity encouraged by the organization becomes the higher-order identity of its individual members, then all members will work to enact that identity (Gonzalez & Brown, 2006; Hornsey & Hogg, 2000), and in turn, the mission of the organization.

However, the three quotes above are all from the same person, and suggest that an individual's behavior does not always seem to align with their higher-order identity. As the first quote suggests, this person's higher-order identity was that of "care provider," and therefore she claimed that delivering quality patient care was the driving force behind all that she did. Further, as the second quote suggests, this same person believed that a change initiative aimed at promoting standardization within the medical system would result in better patient care. Yet, when presented with an opportunity to improve patient care by promoting standardization, as indicated by the third quote, she instead seemed to work against such efforts. Notably, she wasn't the only one. Many of her colleagues throughout a surgical system shared the same higher-order identity of "care provider" and, at the same time, often worked against each other in their attempts to improve

patient care. In other words, these individuals seemed to impede the very thing they claimed to value most. But why would they do this?

Research Question Development

Answering the question of why individuals with a common higher-order identity work against each other when enacting that identity has both practical and theoretical importance. From a practical perspective, it has been estimated that the average cost to onboard a new employee in the United States is between $973 (for hourly employees) and $8,299 (for salaried employees) (Bauer, Morrison, & Callister, 1998), and approximately 25 percent of U.S. employees are undergoing this process at any point in time (Bauer, Bodner, Erdogan, Truxillo, & Tucker, 2007). Thus, organizations are spending billions of dollars every year to onboard new employees in the U.S. alone. Additionally, much of this onboarding consists of socializing new members, which is largely aimed at getting them to adopt the organization's identity as their higher-order identity (Ashforth, 2001; Cooper, Rockmann, Moteabbed, & Thatcher, in press). Further, leadership development is a $366 billion industry (Westfall, 2019) that often involves training group and system leaders on how to get others to buy into a common vision or mission (Huang, 2013; Shamir, House, & Arthur, 1993). Hence, organizations are spending exorbitant amounts of money on programs that may not be fostering effective collaboration between employees.

Additionally, many organizations are in desperate need of change yet seem incapable of implementing needed changes. Perhaps one of the most critical areas in need of change is the healthcare industry, the context of this study, as highlighted by the convoluted responses to the recent global pandemic (Javanbakht & Capotescu, 2020). In

many cases, changes that help both hospitals and patients are well known. For example, Enhanced Recovery Programs (ERPs) have been around since the 1990s (Melnyk, Casey, Black, & Koupparis, 2011), and hundreds of studies have shown that such programs save hospitals money by reducing the length of stay and the cost of treating patients (Day & Aloia, 2015; Ljungqvist, Scott, & Fearon, 2017). Medical benefits include lower rates of morbidity and mortality, shorter length of hospital stays, and fewer hospital readmissions post-surgery. Patient benefits include higher quality of life, lower use of pain medications (especially opioids), fewer complications due to inhibited immune systems, higher patient satisfaction, lower medical costs, lower impaired functionality after surgery, and a faster recovery of full functionality (Day & Aloia, 2015; Ljungqvist et al., 2017). Put simply, patients placed on an ERP pay less for their treatment, recover faster and with fewer complications, go through less pain during treatment, and are less likely to die. Because of these benefits there has been a push to implement ERPs (e.g., Altman et al., 2019). However, the success rate of such implementation attempts is low (Nanavati & Prabhakar, 2016; Pearsall et al., 2015) and a major reason for failure to implement these programs is that it is difficult to get people within surgical systems to effectively work together while attempting to do so (Bartunek, 2011; Pearsall et al., 2015). Interestingly, this occurs even though healthcare is a strong context where most workers likely share the higher-order identity of patient care (Jotkowitz, Glick, & Porath, 2004). In sum, understanding why individuals work against each other when enacting the same higher-order identity may save organizations billions of dollars each year, and the lives of individuals.

From a theoretical perspective, the extant literature largely supports the idea that a common higher-order identity will result in coordinated behavior to achieve an organizational or group objective. For example, social identity theory suggests that individuals will sacrifice enacting their own personal identities in order to align their behavior with a group identity (i.e., a higher-order identity, Tajfel & Turner, 1986). Similarly, self-categorization theory suggests that individuals will strive to align their behavior with that which is considered prototypical of a given group's identity (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). Identity theory also suggests that individuals will work to align behavior with a higher-order identity (Stets & Harrod, 2004; Stryker & Serpe, 1994). According to that theory, individuals either reduce the centrality or change the meaning of lower-order identities that demand behavior that conflicts with the higher-order identity (Stets & Burke, 2009; Stets & Harrod, 2004). Outside of identity, the literatures on socialization (e.g., Bauer et al., 1998; also see Cooper et al., in press), faultlines (see Thatcher & Patel, 2012), and leadership (e.g., Hogg, 2001) all suggest that a common higher-order identity among individuals serves to align their behavior toward a common purpose. How is it then that, as noted above and as I will explain in greater detail in chapter 4, this was not the case among my informants?

One posible explanation comes from optimal distinctiveness theory (Brewer, 1991; Moon & Sung, 2015; Pickett & Leonardelli, 2006), which states that individuals attempt to maintain a balance of feeling as though they belong to a group and as though they are unique within that same group. Therefore, when an overarching identity is introduced, individuals may work against that identity if they feel it limits their distinctiveness, resulting in identity conflicts (e.g., Fiol, Pratt, & O'Connor, 2009).

Importantly, however, though the new identity may be presented as an *overarching* identity for the group, it likely never becomes a *higher-order* identity – an identity that comprises a large portion of one's self-concept (Brenner et al., 2014; Stryker & Serpe, 1994) – because the extent to which the individual actually defines themselves by it (i.e., identification, Ashforth et al., 2008) remains small. This is because individual group members feel as though their balance between belonging and distinctiveness is threatened by that identity (Leonardelli, Pickett, & Brewer, 2010), and identities that present such a threat are often reduced in salience (Petriglieri, 2011).

Another possible explanation lies in the dual identity model (Hornsey & Hogg, 2000), which suggests that having a common overarching identity will result in all members working toward the same objective except in cases where that identity increases the salience of two conflicting subordinate identities (Baysu, Phalet, & Brown, 2011). However, here too it is likely that the proposed overarching identity will fail to become a higher-order identity because individuals tend to avoid identity combinations that result in conflict and anxiety (Bataille & Vough, 2020; Ramarajan, 2014). Indeed, speaking about having a superordinate identity as a means of coordinating activities between groups, Hogg, van Knippenberg, and Rast (2012: 237) state, "The issue, however, is that as group memberships become more self-definitionally important to members and intergroup relationships become more precarious, attempts to establish a shared superordinate identity become less viable." They go on to present a theory of intergroup leadership based on building relational identities between groups. However, more recent research suggests that people often work in somewhat fluid systems in which group membership is not stable (e.g., Edmondson & Harvey, 2018; Valentine & Edmondson,

2015) and interactions often occur between group members instead of between the collectives themselves (e.g., medical systems, Humphrey & Aime, 2014; Luciano, Bartels, D'Innocenzo, Travis Maynard, & Mathieu, 2018). In such systems, developing specific relationships between clearly established groups is unlikely.

Finally, theories involving multiple identities have conceptualized that people simultaneously enact several identities, and this enactment is the result of some interaction between those identities (Bataille & Vough, 2020; Burke & Stets, 2009; Ramarajan, 2014). Therefore, perhaps these other identities somehow influence the enactment process in such a way that explains why system members with the same higher-order identity impede each other's enactment of that identity. However, there remains no small amount of confusion regarding the process by which multiple identities interact to influence enactment, resulting in specific types of behavior. For example, Burke and Stets (2009) suggest that a higher-order identity sets some sort of standard in accordance with the identity content and subordinate identities then interact with the environment in order to verify that standard (see also Stets & Harrod, 2004). Conversely, Blader (2007) suggests that enacted behavior is not so much a result of a hierarchical relationship, but a compromise between all salient identities in a given context in which one tries to enact them all. In one of the very few empirical studies that exist on the topic, Ramarajan, Berger, and Greenspan (2017) found that individuals engage in more prosocial behavior under some identity configurations (i.e., "focused enhancement") than others. They suggest that identities are enacted in specific configurations that may or may not involve hierarchy or compromise. Finally, other scholars suggest that identities are enacted as a "totality or gestalt of multiple identities" (Ashforth, 2009: 175).

Unfortunately, while scholars have shown that an individual's multiple identities interact to drive behavior, theory has yet to explain *the process* by which this happens. Importantly, until we understand this process, it is not possible to explain the phenomenon observed in my study – why individuals that have a common higher-order identity work against each other when enacting that identity. Given the above, my research questions are: 1) *How does the interaction of an individual's multiple identities influence enactment?*; and 2) *Why do individuals with the same higher-order identity work against each other when enacting that identity?*

Overview of Methods

In order to answer these questions, I conducted an inductive investigation using grounded theory methods (Charmaz, 2014; Glaser & Strauss, 1967). More specifically, I examined an identity-implicating event (Bataille & Vough, 2020) in the form of a change initiative for a surgical system within Cancercare (a pseudonym). Cancercare is a cancer treatment facility in the southwest United States. The surgical system I studied consisted of approximately 118 individuals. Of these individuals, 10 surgeons, two anesthesiologists, eight nurses, one pharmacist, one physician assistant, one nutritionist, two data analysts, and six operations personnel were chosen to be on the change team in charge of implementing the initiative. Therefore, these were the only people involved in the change initiative and, in turn, the only people who experienced the identity-implicating event. Fortunately, I was able to conduct a semi-structured interview with every person in the system who experienced the identity-implicating event at least once,

and I interviewed 23 of the 31 informants multiple times over the course of 11 months.[2] In all, I conducted 73 interviews for a total of approximately 53 hours of data and an average interview time of 44:06 (mm:ss). I also conducted 52.5 hours of meeting observations across 39 meetings with an average of 1.3 hours per meeting. Together, the interviews and observations were my primary sources of data. Additionally, I also collected various forms of archival data (e.g., meeting presentations, training and promotional materials) and conducted informal interviews with some informants.

Overview of Findings

My findings suggest that an identity-implicating event (Bataille & Vough, 2020) in the form of a change initiative within a medical system initiated a process of enactment. This process involved four salient identities (a common higher-order identity, role identity, relational identity, and system identity), together with four characteristics associated with each identity (convergence, centrality, construal breadth, and clarity), creating an identity network (i.e., the set of identities and their characteristics) for each individual. Different parts of one's identity network then combined to create the desire for enactment, influence the nature of enactment, and focus enactment on a specific target. As I will later explain, three different types of enacted behavior emerged from this process ("defending," "bending," and "mending"). Each type of enacted behavior attempted to either integrate, or guard against integrating, various components of the system with the common higher-order identity. Often, the same attempt at either integrating or guarding was then interpreted as an identity threat or an identity

[2] Three informants joined the change initiative toward the end of my study, three left the organization, and two did not respond to my attempts to schedule additional interviews. All of these members were only interviewed once.

opportunity (see Bataille & Vough, 2020) by different system members regarding their common higher-order identity, depending on each member's identity network.

Overview of Contributions

My findings make several contributions to the broader identity literature and the literature on multiple identities in particular. First, the literatures on social identities (e.g., Haslam & Ellemers, 2005; Hogg et al., 2012; Tajfel & Turner, 1986) and identity theory (e.g., Brenner et al., 2014; Stets & Burke, 2014; Stryker, 1980; Stryker & Serpe, 1994) suggest that individuals align behavior with their higher-order identities and, thus, when several individuals have a common higher-order identity they will work together toward a common objective. I challenge this and explain how individuals may still enact a common higher-order identity, along with the rest of their identity network, in ways that work against each other. Indeed, my findings suggest that this common, and extremely important, identity was the cause of great bewilderment and frustration because other members appeared to behave in ways that hindered its enactment even as they proclaimed its importance. As one member put it, *"That's blowin' my mind, right now" (401)*. In short, my findings indicate that a common higher-order identity or an overarching vision is not enough to align behavior. Instead, it is necessary to understand one's entire identity network, how enacted behavior emerges from that network, and how, in turn, such behaviors are interpreted as an identity threat or opportunity based on that network.

Second, I extend the literature on multiple identities by delineating a process by which one's identity network – consisting of four different identities, and four characteristics of each identity (i.e., convergence, centrality, construal breadth, and clarity) – becomes enacted. The current literature on multiple identities has shown that

one's intrapersonal identity network influences behavior (e.g., Ramarajan, Berger, et al., 2017). However, theory has yet to explain exactly how different components in one's identity network interact to determine enactment. Here, I explain how a set of these elements (i.e., an identity network) interact to result in either defending, bending, or mending behavior toward the system. Finally, extending the identity threat and opportunity literature (e.g., Ashforth, Schinoff, & Rogers, 2016; Petriglieri, 2011), I show at least one way in which identity threats and identity opportunities emerge within a system of individuals. Further, my findings help explain why one person appraises an experience as an identity threat while another appraises the same experience as an identity opportunity, even when both individuals share the same higher-order identity.

My dissertation proceeds as follows: I first review existing literature on the topics of identities, multiple identities, and identity enactment to help frame my research questions. Next, I present a more detailed explanation of the methodology used to investigate my research questions. I then present the findings of my study and, finally, discuss their implications for theory, practice, and future research.

CHAPTER 2

LITERATURE REVIEW AND RESEARCH QUESTIONS

Multiple Identities

Scholars have long acknowledged that individuals have multiple identities (Ramarajan, 2014; Stets & Burke, 2003). Indeed, as James (1890: 294) famously stated, a person has "as many different social selves as there are distinct *groups* of persons about whose opinion he [or she] cares." Moreover, scholars have equated these "selves" with identities (Gecas, 1982) – self-definitions that answer the question, "Who am I?" (Ashforth et al., 2008). Additionally, research has shown that individual behavior is driven by multiple salient identities in a given context (e.g., Ramarajan, Berger, et al., 2017), and an individual's need to construct and "live out" their identities by engaging in identity-congruent behavior may exceed their basic physical needs (Dutton, Roberts, & Bednar, 2009). Regarding quantity, Roccas and Brewer (2002) suggest that an individual can have between two and seven identities that are salient, and thus likely driving their behavior (Blader, 2007; Ford et al., 2013) at any given time. But what types of identities are most likely to be salient in a work context?

Because identities are self-definitions (Ashforth et al., 2008) based on a set of meanings ascribed by oneself and others (Ibarra & Barbulescu, 2010), they come in a multitude of different types. However, Dutton, Roberts, and Bednar (2010: 266) suggest that work-related identities involve those, "that are tied to participation in the activities of work (i.e., a job) or membership in work-related groups, organizations, occupations, or professions." Sluss and Ashforth (2007) introduced "relational identities," as an additional type of work-related identity. As I will explain in detail later (Chapter 4), of

these different types of identities, role identities, relational identities, and social identities were prevalent in my study. Additionally, a fourth identity that was prevalent in my study – that of "patient care" – was also prevalent in my study. This identity transcended any particular role, occupation, or social group, and therefore I refer to it as a "supra identity."

The identity literature is prolific, and different streams of research have different definitions of identities. Therefore, it is necessary to clarify how I conceptualize each type of identity in my study. A supra identity is a self-definition based on a value or deeply held belief that transcends organizations and groups such as serving others (cf. Sun, 2013) or helping animals (cf. Schabram & Maitlis, 2017). While an individual may enact their supra identity within groups, organizations, and occupations (cf. Berg, Grant, & Johnson, 2010), they may also do so outside of such structures. For example, an individual can serve others by giving food to the homeless. While this can be done in an organization (e.g., shelter), it can also be done outside of the organization. Hence, it is possible to identify as a servant of others and not identify as being a part of an organization or occupation that focuses on such actions.

In contrast to supra identities, role identities involve self-definitions based on specific sets of expectations (i.e., roles) given one's location in an organization (Caza & Wilson, 2009; Ibarra, 1999; Stryker, 1980). For example, defining oneself as a "surgical nurse" may include job-specific meanings such as drug administrator and instrument sterilizer. Therefore, role identities (e.g., Laura the nurse) are often nested within more abstract supra identities (e.g., Laura the care provider). Importantly, the difference between a role and a role identity is that while a role is a socially constructed set of

expectations, a role identity is a personalized definition of self that is based on these expectations. Due to the fact that role identities are personalized definitions, two liver surgeons may view that identity very differently, even though both are based on the societally defined role of "liver surgeon" (Stets & Burke, 2003).

Whereas a role identity is based on the role itself, a relational identity is based on "the nature of one's role-relationship, such as manager-subordinate and coworker-coworker. It is how role occupants enact their respective roles vis-á-vis each other" (Sluss & Ashforth, 2007: 11). Relational identities can be based on specific roles (e.g., Benjamin the surgeon and Christina the patient) – referred to as specific relational identities – or they can be based on more generalized relationships (e.g., how Tiffany, as a nurse, relates to patients in general) – known as generalized relational identities (Sluss & Ashforth, 2007). Relational identities can be differentiated from role identities in that the self-definition, while including aspects of one's role, is based on the affiliation *between* roles and not the roles themselves. Therefore, while "I am an average surgical nurse" is a role identity, "I am an exceptional nurse to Dr. West" is a relational identity because the self-definition is based on the relationship between the two roles, and not the roles themselves (Ashforth, Rogers, & Corley, 2011; Sluss & Ashforth, 2007).

Finally, social identities refer to self-definitions based on membership with a collective (Haslam & Ellemers, 2005; Tajfel & Turner, 1986; Turner et al., 1987), which may take many forms including that of a group (e.g., Postmes, Baray, Haslam, Morton, & Swaab, 2006), team (e.g., Van Der Vegt & Bunderson, 2005), or multiteam system (Porck et al., 2019). Social identities may be based on defining oneself by the individuals that comprise a group (e.g., "We are a group of young women"), by the processes, norms,

or other characteristics of a group (e.g., "We are the most efficient group in our organization"), or some combination that differentiates that group from other groups (Haslam & Ellemers, 2005; Haslam & Ellemers, 2011; Tajfel & Turner, 1986). Importantly, though scholars once believed that individuals enacted (i.e., behaviorally manifested) one identity at a time while all others were suppressed (Turner et al., 1987), more recent research has posited that individuals organize some or all of these identities into some sort of identity structure and may enact them simultaneously (Ramarajan, 2014; Stets & Burke, 2014).

Organizing Intrapersonal Identities

Currently, there are two major conceptualizations of how individuals organize their identities, corresponding to two different streams of research. The first is identity theory (Stryker, 1980; Stryker & Serpe, 1994), which suggests that individuals organize their identities in a hierarchical structure based either on centrality (i.e., the relative assigned value or importance of each identity, Stryker & Serpe, 1994) or salience (i.e., the likelihood of an identity being activated in a given context, Ashforth & Johnson, 2001). Although the two terms are often used interchangeably to describe the same phenomenon, centrality is more within-person while salience is more behaviorally focused (Brenner et al., 2014). Additionally, centrality has been shown to drive salience (Brenner et al., 2014). Because my research questions focus on within-person conceptualizations that drive individual behavior, I focus on centrality throughout this dissertation. Notably, there are subtle differences between centrality and subjective importance (see Brenner et al., 2014). However, using "centrality" to describe both relative assigned value and importance is an effective "simplifying tactic legitimated by

their frequent interchangeable use" (Stryker & Serpe, 1994: 19). Thus, I will use that term throughout this dissertation.

According to identity theory, an identity is a set of meanings (i.e., a self-definition) and "this set of meanings serves as a standard or reference for a person" (Stets & Harrod, 2004: 156). In the case of multiple identities, those at higher levels of the centrality hierarchy (i.e., higher-order identities) set a standard to which identities (i.e., sets of meanings) with lower centrality are compared. In cases where the lower-order identity meanings do not match those of the higher-order identity, it is necessary for the individual to adjust the meanings that comprise the lower-order identities, or deactivate that identity (Stets & Harrod, 2004). For example, one may have a higher-order identity as a "moral person" and a role identity as a "prolific loan manager" at a bank. However, if being a prolific loan manager means being willing to initiate loans for people without their knowledge (see Scharding, 2019), it may not match the high-order "moral person" identity. Thus, the individual will either change the meanings of their "prolific loan manager" identity to not include such immorality, or deactivate the identity altogether (e.g., by quitting his job).

Additionally, there is a second comparison loop in which individuals enact behavior based on their lower-order identities, derive meanings from how the environment responds to that behavior, and then compare those environmentally-derived meanings to both the lower- and higher-order identities (Burke & Stets, 2009). Hence, according to identity theory, enacted behavior is a result of a "hierarchy of control of meanings" (i.e., an identity hierarchy, Burke & Stets, 2009: 133) in which the higher-order identity "differs in that it does not control social behavior directly" (Burke & Stets,

2009: 136), but instead does so indirectly by dictating the content (i.e., sets of meanings) of lower-order identities. In short, identity theory views multiple identity enactment as a unidirectional hierarchy in which higher-order identities influence lower-order identities, which in turn influence enacted behavior, and lower-order identities do not influence higher-order identities. Because of this conceptualization, identity theory focuses much more on hierarchies than on the potential of reciprocal relationships between identities, and largely ignores exactly *how* multiple identities are enacted. Indeed, identity theory assumes that while identities may be simultaneously enacted, this enactment is a result of each separate identity at the lowest order of the hierarchy being enacted in relative isolation. As Stets and Burke (2014: 72, my emphasis) put it, "for identities at the same level, each of the identities *has its own* perceptual input, standard, and output, though the outputs of the two identities must be combined *in some manner* as there is only one person acting."

Building on identity theory and several other streams of research, Ramarajan (2014) introduced the concept of intrapersonal identity networks (hereafter, identity networks), defining them as an individual's activated identities and the relationships between them. A major difference between this approach and previous ones is that it "combines attention to specific identity content with a focus on the relationships between different identities" (Ramarajan, 2014: 592). Bataille and Vough (2020) both simplified and expanded identity networks. They simplified them by grouping identity relationships into the three broad categories of synergistic, conflicting, and compatible. They expanded theory relating to identity networks by explaining how identity work, specifically in response to identity threats and opportunities, may occur within and between identities in

one's network. In addition to focusing on relationships, theory on identity networks also conceptualizes identity content and identity structure (i.e., hierarchy) as meaningful parts of one's network, and assumes that identities at different levels are able to influence one another (i.e., lower-order identities may influence higher-order identities) (Bataille & Vough, 2020; Ramarajan, 2014). Further, in line with previous research that posits that "identities and identifications are likely to both converge and combine to some degree such that they become a loose gestalt: not one, perhaps, but a set" (Ashforth et al., 2008: 359), the identity network approach assumes that identities at all levels may directly or indirectly impact enacted behavior.

Enacting Multiple Identities

Though identity network theory differs from previous work on multiple identity structures (e.g., Burke & Stets, 2009) regarding its focus on relationships and multiple directions of influence within the hierarchy, it is similar in that it does not explain exactly how one's multiple identities come together to result in behavior. This is the case even though at least one empirical study, by Ramarajan, Berger, et al. (2017), has shown that different configurations of one's identity network do, in fact, result in different forms of behavior. In their study, they simultaneously examined prosocial, collective, and individualistic identities, and found that individuals displayed the most prosocial behavior when their prosocial and collective identities were mutually enhancing, but *not* related to their individualistic identity. These findings are in contrast to a long-held assumption that the more mutually enhancing identities are, the more positive the outcomes (e.g., Dutton et al., 2010). However, they did not explain how (i.e., the process by which) these different types of behavior emerged.

Similarly, in their ground-breaking theory paper, Bataille and Vough (2020) explained how changes to one part of an individual's identity network can reverberate throughout the rest. In line with previous research (e.g., Thatcher & Zhu, 2006), they conceptualized identity content as including enacted behavior and thus largely ignored the process by which multiple identities influence behavior. In contrast to conceptualizing behavior as part of an identity's content, Ashforth et al. (2008) suggest that it is more accurate to consider enacted behavior a probabilistic rather than deterministic result of salient identities, based on the idea that many things may influence the link between one's identities and their behavior (e.g., situational constraints, extrinsic rewards). As an example, scholars have suggested that individuals may use lying as a way of managing threats to their identities (Leavitt & Sluss, 2015). In this case, while the behavior of lying is certainly related to an individual's identity, they do not *define* themselves as liars and thus it is not part of the identity's content. The separation between identity content and enacted behavior is important because it is the necessary first step in delineating the process by which multiple identities manifest as behavior and, in turn, how this process may be influenced to the benefit of individuals and organizations.

Understanding how the interaction of an individual's multiple identities influence enacted behavior is important because there is currently an assumption that different identities, or identity configurations, will automatically result in desired behavior within an organization. For example, though there is some skepticism regarding the effects of having a common overarching identity – an identity that encompasses multiple attributes from other identities (Besharov, 2014) – the idea that a common higher-order identity (i.e., highly central) will align behavior within and between individuals is almost

universally accepted (e.g., Hogg, van Knippenberg, & Rast, 2012; Rink et al., 2013). However, as the quotes at the beginning of this dissertation suggest, that is not always the case. Additionally, there is a growing body of research that shows that an individual's behavior may actually be antithetical to one or more important identities (Conroy, Henle, Shore, & Stelman, 2017). Only by understanding the process by which multiple identities, and their associated characteristics (i.e., relationships, content, centrality, etc.), are enacted to produce behavior will it be possible for individuals and organizations to mindfully influence this process, and potentially reduce negative behavior while increasing positive behavior in organizations. Hence, my first research question is:

How does the interaction of an individual's multiple identities influence enactment?

Identity Networks and Enactment

As I will later explain in greater detail (Chapter 4), four specific characteristics of individuals' identity networks emerged in my study as playing a critical role in enactment. These were the convergence, centrality, construal breadth, and clarity of the four specific identities described earlier (supra, role, relational, and social). Scholars have previously considered two of these aspects in terms of identity networks (i.e., convergence and centrality, Bataille & Vough, 2020; Ramarajan, 2014), and the other two aspects (i.e., construal breadth and clarity) emerged from my investigation. In this section, I will briefly review the literature regarding the two more established characteristics and what may be inferred about the two emergent characteristics.

Convergence. Convergence is when there is some degree of overlap between the meanings of two or more identities, while the identities also maintain their respective

boundaries (Ashforth, 2007; Ashforth & Johnson, 2001). For example, an individual's role identity as a "doctor" may also involve developing and maintaining relationships with patients (i.e., a relational identity). In many cases of complete convergence, the meanings of one identity are nested within the meanings of another (i.e., identity embeddedness, Ashforth, 2007). For example, an individual's role identity as a "doctor" may be nested within her supra identity of "patient care." Convergence differs from identity holism (Rogers, Corley, & Ashforth, 2017) in that the boundaries of each identity are maintained whereas in identity holism the two identities merge into a single new identity. Importantly, individuals associate some behaviors with specific identities, both in their attempts to enact an identity through behavior (Ashforth, 2001; Dutton et al., 2009) and in interpreting behavior as indicative of having an identity (e.g., Ibarra, 1999). For example, if someone rides a mountain bike every day, that behavior may serve as both an expression of his "dedicated mountain biker" identity as well as be interpreted as an indication that he is indeed a dedicated mountain biker (Vough, Caza, & Maitlis, 2020; Weick, 1995). In the case of convergent identities, individuals attempt to enact both identities through behavior, and may associate observed behavior with the convergent area between the identities (Ashforth et al., 2008; Sluss & Ashforth, 2008). In this manner, the area of convergence between two or more identities influences one's pattern of enacted behavior and, conversely, observed enactment of another identity (e.g., behavioral processes within a group) can reveal discrepancies between that identity and others. For example, Ashforth and Reingen (2014) explain how natural food cooperative employees with an "idealist" identity interpreted one of the store's processes (sell non-healthy snacks) as indicative of non-convergence between the organization's identity,

which included pragmatism, and their "idealist" identity. In short, a lack of convergence reveals discrepancies between identities, and behaviors are used to interpret whether or not convergence between identities exists.

Centrality. As noted, centrality is the relative value assigned to an identity (Stryker & Serpe, 1994), and forms the basis of one type of structure individuals use to organize their identity network. Therefore, centrality determines the primacy of enactment in that individuals *seek* to enact their most central identities whenever possible (Brenner et al., 2014; Stryker & Serpe, 1994). Notably, centrality by itself does not necessarily determine which identities are actually enacted as other factors (e.g., situational relevance, Ashforth & Johnson, 2001) may prevent individuals from enacting one or more highly central identities. Research has suggested that the most central identity in one's identity network – here, the higher-order identity – may provide the purpose of enactment for all identities in the network (Burke & Stets, 2009; Koerner, 2014). Herein lies an important distinction between a common higher-order identity among group members and an overarching identity. Whereas group members' individual identities may be nested within an overarching identity for the group, that identity may not be very central to all group members (Fiol et al., 2009; Hogg et al., 2012), and thus not a common higher-order identity. This distinction is important because the two terms are often conflated, and such conflation may explain why some studies find that a common identity improves system performance (e.g., Cuijpers, Uitdewilligen, & Guenter, 2016) while others find that having more central *subgroup* identities results in better system performance (Porck et al., 2019). As explained later in Chapter 4, all

informants had the common *higher-order* supra identity of "patient care," which I simply refer to as the higher-order identity.

Construal breadth. Construal can be conceptualized as the way in which we understand something in relation to something else. For example, in developing construal-level theory, Trope and Liberman (2010) explain differences in how we understand the meanings of various objects in relation to psychological distance (i.e., construal levels). They present the illustration of playing ball. When psychological distance is short, playing ball may be understood as a specific game. However, when psychological distance is greater, playing ball may be understood as exercise or having fun. Thus, in reference to psychological distance, the specific meaning of something can be applied to various levels of abstraction (see also Carton, 2018). Similarly, Markus and Kitayama (1991) developed a theory of how individuals understand themselves in relation to others (i.e., self-construal). According to self-construal theory, the meaning of being "me" may apply to just oneself, and thus emphasize the differences between self and others (i.e., independent self-construal), or being "me" may apply to a collective, and thus emphasize the similarities between self and others (i.e., collective self-construal).

While construal level refers to the way in which we understand something in relation to psychological distance, and self-construal refers to the way in which we understand our self-concept in relation to others, construal breadth refers to the way in which we understand something (here, identities) in relation to its range of application (cf. Crocker & Wolfe, 2001). Though scholars have not explicitly examined construal breadth, it is implicit in some research regarding identity and other domains. For example, Rogers and Ashforth (2014) conceptualize respect (i.e., assigned value) as

either applying to individuals (particularized respect) or a collective (generalized respect) (see also Rogers et al., 2017). Additionally, Sluss and colleagues (e.g., Sluss & Ashforth, 2007, 2008; Sluss, Ployhart, Cobb, & Ashforth, 2012) conceptualize relational identities as applying to specific individuals (particularistic relational identities) or to a collective (generalized relational identity). Importantly, the meaning or content of something does not change when applied to different ranges of entities. For example, respect is still considered an assigned value whether it applies to an individual or a collective (Rogers & Ashforth, 2014). Hence, it is appropriate to consider the construal breadth of an identity (i.e., the range of application regarding a particular set of meanings or self-definitions) as an identity characteristic and thus separate from identity content.

Additionally, individuals may think of different activated identities in different ways. For example, an individual may think of two different identities in their network as more or less central (e.g., Stryker & Serpe, 1994), more or less distinct (e.g., Brewer, 1991), or more or less enduring (e.g., Kreiner, Hollensbe, Sheep, Smith, & Kataria, 2015). Therefore, it follows that individuals can also construe different identities in one's identity network broadly, narrowly, or perhaps both. However, scholars have yet to examine how differences in construal breadth may influence enactment.

Clarity. Identity clarity can be conceptualized as the lack of ambiguity regarding the content (i.e., meanings comprising) of an identity (Bartel & Wiesenfeld, 2012; Corley & Gioia, 2004). Put differently, identity clarity is the level of concreteness and fullness with which one understands an identity. Scholars have suggested that such concrete understanding of one's identities may enable individuals to effectively compare and contrast different identities (cf. Bolinger, Klotz, & Leavitt, 2018). For example, Bartel

and Wiesenfeld (2012) show how clarity regarding a group's prototypical identity provides a clear standard by which group members can evaluate how well they fit with the group. Without identity clarity, such evaluative efforts may not be possible. Additionally, clarity has been posited as a necessary condition for targeted action regarding an identity or identity work (Markus & Nurius, 1986; Markus & Wurf, 1987). For example, Corley and Gioia (2004) describe how corporate leaders were able to provide their employees with clarity regarding the organization's identity in the midst of a corporate spin-off. This clarity then helped employees develop a sense of who they were as individuals within the organization, and in turn, provided some stability throughout the change process. Hence, identity clarity enables effective comparison between identities and also provides a target for potential identity work.

Summary of identity networks. In sum, in my study, different characteristics of one's identity network – the convergence, centrality, construal breadth, and clarity of four different identities – played a critical role in informants' enactment processes. Convergence is the degree of overlap in the meanings of two or more identities and determines patterns of behavior which, in turn, are used to interpret discrepancies between identities. Centrality is the relative assigned value of an identity and determines the primacy of identities that individuals *seek* to enact, but not necessarily actual enactment. Construal breadth is one's understanding of the range of application of an identity, and scholars have not yet examined its impact on enactment. Finally, clarity is the lack of ambiguity regarding identity content, and enables effective comparisons between identities or identity elements. Additionally, clarity enables an individual to focus (i.e., target) their enactment on a particular identity or identity element.

Importantly, in addition to the impact of construal breadth on enactment being unknown, *scholars have yet to explain how all of these elements may work together to influence enactment and/or the interpretation of enacted behavior of others*. While my first research question addresses the former, I will now turn my attention to the latter (i.e., Why do individuals with the same higher-order identity work against each other when enacting that identity?).

Identity Networks and Interpreting Enactment

Scholars have long posited that individuals may interpret experiences based upon a salient identity (Markus & Wurf, 1987; Vough et al., 2020; Weick, 1995). For example, in her ground-breaking study examining the identities of musicians, Maitlis (2009: 63) notes how a trombone player started shaking while playing:

> With no other available explanations, he and his colleagues interpreted his shake as nerves, perhaps a result of being too long in the job or triggered by a demanding conductor. Gordon no longer saw himself as a reliable professional, but as a weak and nervous individual who could not meet the challenges of the job.

Importantly, Gordon went on to discover that the shaking was due to a medical issue and not because of him being "too long in the job." However, based on their musician identities, both he *and his colleagues* interpreted the shaking as a mental and not physical issue. In other words, both the individual experiencing the event and those who observed it interpreted it based on their musician identity. Similarly, Ashforth and Kreiner (1999: 422) explain how, based on their identity, "dirty workers may sincerely perceive positive attributes and derive personal fulfillment from tasks that many others consider repugnant." Thus, one's identities influence interpretation of behavior, sometimes resulting in different interpretations of the same behavior. However, this research is based

on a single identity (e.g., musician, work role). Scholars have yet to explore how one's identity *network* may influence their interpretation of behavior.

Differences in interpretation based on one's identity network may be particularly important regarding identity threats and identity opportunities (Ashforth & Schinoff, 2016; Petriglieri, 2011). An identity threat is an experience "appraised as indicating potential harm to the value, meanings, or enactment of an identity" (Petriglieri, 2011: 644). Scholars have suggested that identity threats have several negative consequences – including prompting individuals to lie (Leavitt & Sluss, 2015), inciting fear (Steele, 1997), or causing one to restructure the meaning of their identities (Petriglieri, 2011) – which has the potential to lead to a dysfunctional spiral into "cognitive destruction," "characterized as an emotionless state (Pennebaker, 1989; Twenge, [Catanese, & Baumeister], 2003) in which individuals actively avoid emotions" (Shepherd & Williams, 2018: 32). In contrast to an identity threat, an identity opportunity is an, "*experience appraised as indicating potential for growth in the value, meanings, or enactment of an identity*" (Bataille & Vough, 2020: 10, their emphasis). Identity opportunities have been associated with positive and self-enhancing behavior (e.g., Vough, Bataille, Noh, & Lee, 2015), inspiring positive feelings such as hope (Ashforth & Schinoff, 2016), and restructuring the meaning of identities in a way that leads to greater exploration and openness to possibilities (Shepherd & Williams, 2018). In other words, identity threats and identity opportunities may result in behaviors that contradict, or work against, each other.

Identity threats and identity opportunities resulting in behaviors that work against each other is problematic in organizations and teams because, as noted, individuals may

appraise the same experience or situation in different ways depending on the identities involved in the appraisal process. However, little research exists regarding the appraisal process itself. As Bataille and Vough (2020: 37) note, the question of "when will individuals appraise an experience as an identity opportunity versus an identity threat?" still remains. Indeed, the literature merely suggests that identity threat, and by extension opportunity, appraisal involves comparing an experience with an identity that is, at least to some extent, central to the individual (Petriglieri, 2011). Given this, it would make sense that if individuals share a common higher-order (i.e., highly central) identity, they would appraise the same experience in the same way regarding that identity and, in turn, work together to overcome a threat or take advantage of an opportunity regarding that identity. However, as we will see in my study, individuals with the same higher-order identity instead worked against each other. This conundrum led to my second research question:

> *Why do individuals with the same higher-order identity work against each other when enacting that identity?*

CHAPTER 3

METHODOLOGY

The aim of this study is to understand how an individual's identity network is translated into enacted behavior, and why individuals with a common higher-order identity work against each other in service to that identity. As noted, while there is some research that confirms that one's identity network does indeed influence enactment, there is very little theory explaining the process by which enactment occurs in both the identity network literature and the larger identity literature (Thatcher & Zhu, 2006). Additionally, the literature regarding a common higher-order identity largely addresses how such identities motivate people and groups to align their efforts toward a common goal (Hogg et al., 2012). However, little research has examined why this effect may not occur. Therefore, I employed an interpretivist paradigm to conduct an inductive qualitative study using a grounded theory approach to investigate my research questions. The goal of an interpretivist paradigm is to understand a phenomenon from the perspective of those experiencing it in order to build theory (Shah & Corley, 2006). Considering the subjective nature of identities, understanding the perspective of my informants is critical. Additionally, my study aims to build process-oriented theory in areas where little theory exists. Scholars have suggested that a qualitative, inductive approach provides the best methodological fit in such cases (Edmondson & McManus, 2007; Langley, 1999; O'Reilly, Paper, & Marx, 2012). Finally, my phenomenon of interest is not only processual in nature, but largely located within individuals. Thus, I employ a grounded theory approach because it is well suited for gaining "deep insight into a phenomenon and its connections with the context" (Corley, 2015: 600), and may be "most suited to

efforts to understand the process by which actors construct meaning out of intersubjective experience" (Suddaby, 2006: 634). Since constructing meaning and identities may be inextricably linked (Weick, 1995), a grounded theory approach likely provides a good fit with studies seeking to examine identity enactment processes.

In this section, I first describe the context and sample in which my study took place. Due to the somewhat complex and unique nature of the surgical system I examined, I will explain the context and sample in some depth. Next, I explicate how I collected my data and the method by which I analyzed the data. I end with a discussion of how I ensured trustworthiness of my findings throughout the process.

Context and Sample

The flagship organization. As noted, the context of my study was a surgical system centered around cancer treatment, which I refer to as "Cancercare." Cancercare is a partner member of a larger cancer treatment network in the United States. The flagship organization of the network is world-renowned and treats thousands of patients annually from all over the world. The flagship organization is divided into several departments, referred to as "disease site centers," that are based on what part of the body is affected by cancer (e.g., liver center, neurological center). Starting in 2012, some disease site centers at the organization headquarters implemented an enhanced recovery program (ERP), which, as noted, has several positive effects for both hospitals (e.g., reduced costs and increased revenue) and patients (e.g., less pain, fewer complications, fewer deaths). To plan for and implement the change to an ERP, each disease site center formed its own change team consisting of, at a minimum, a surgeon, anesthesiologist, physician's assistant, nurse, and pharmacist. Having had varying degrees of success at accomplishing

the ERP change, the flagship location's leadership invited an external consultant and her team to help them implement and improve their change implementation. I was a member of this team.

Cancercare. During the project at the flagship location, leadership asked the external consultant if she would help one or more of their subsidiary branches to implement an ERP as well. Cancercare was the first branch chosen for the ERP change and is a relatively small system consisting of approximately 118 individuals[3] embedded within a medium-sized hospital (approximately 200 patient beds). Of these, 24 belonged to the cancer division of surgery (16 surgeons, 6 operations, and 2 data analysts). Approximately 15 physician's assistants, 48 nurses, six pharmacists, and five nutritionists belonged to the hospital in which Cancercare was embedded and interacted with Cancercare patients, and approximately 20 anesthesiologists and certified registered nurse anesthetists worked for a contracted anesthesia group. Therefore, Cancercare was a surgical system consisting of members from three different organizations (cancer division of surgery, the hospital, and the anesthesia group), and eight different departments (surgeons, physician assistants, anesthesia, nurses, pharmacy, nutrition, operations, and data analytics), all of which needed to work together to effectively treat surgical patients. Such systems are not unusual in healthcare settings (e.g., Aloia et al., 2019).

More specifically, Cancercare was a surgical system that included all individuals and processes that a patient experienced from the time the decision was made to have

[3] The actual number of individuals in the Cancercare system fluctuated due to personnel changes throughout my study (e.g., floor nurses assigned to Cancercare patients during some time periods but not others). However, the members of the change team did not fluctuate, except in the case of exiting the organization or new hires.

surgery to the time the patient went home, and included any follow-up appointments necessary to ensure the surgery went as planned. This consisted of the initial decision to have surgery, which was made between the patient and a particular surgeon. The patient then went through an education process that included receiving specific information (e.g., expected pain medications) from one or more physician assistants and more general information (e.g., when to show up for surgery) from patient education nurses. Often, the patient also consulted with a nutritionist to best prepare their body for surgery. On the day of surgery, the patient reported to the hospital and underwent preoperative care by a nursing team as well as an anesthesiologist using various drugs provided by pharmacy. The actual surgery involved one or more surgeons, physician assistants, nurses, and anesthesiologists. Immediately after the surgery, the surgeon and physician assistant would fill out paperwork while nurses and the anesthesiologist would escort the patient to the post anesthesia care unit (PACU) where care was provided by another set of nurses. From the PACU, the patient would either go home, if the surgery was relatively minor (e.g., remove a cancerous mole), or to the "Floor," if the patient needed to stay in the hospital overnight. On the Floor, another set of nurses provided care. Additionally, pharmacists provided drugs as needed, and "on call" physician assistants and surgeons also provided care when necessary. Regular follow-up appointments were conducted by the patient's surgeon, physician assistant, and one or more nurses.

The change initiative. In order to examine the process by which individuals' multiple identities manifest in some form of enactment, it was necessary to either study individuals engaged in a form of ongoing enactment or to study individuals as they formed a new pattern of enactment. I chose to study the latter because new patterns of

enactment are likely the result of an identity-implicating event (Bataille & Vough, 2020). An identity-implicating event causes an individual to consciously relate the event to one or more of their identities. In doing so, the event often results in greater cognitive awareness regarding one's identities and their enactment (Bataille & Vough, 2020), which helped participants articulate their identity-related thoughts, feelings, and activities. Additionally, examining enactment as it was formed helped ensure that I was able to collect rich and nuanced data that spanned the entirety of one's enactment process.

The specific identity-implicating event that initiated enactment within my informants came in the form of a change initiative aimed at creating and implementing an ERP within Cancercare. ERPs involve coordinating a set of practices across several different functional areas that typically exist in silos. For example, one ERP contains 22 protocol items that require cooperation among 10 or more care providers per patient (Melnyk et al., 2011). These care providers are from different functional backgrounds (e.g., surgeon, floor nurse, nutritionist) and span several different areas of patient care (e.g., preoperative consultations, operating room, PACU, hospital floor, pharmacy). Therefore, to implement an ERP effectively requires coordination and cooperation between individuals with different functional backgrounds and in different areas of patient care who have rarely been required to cooperate extensively with each other before. Additionally, an ERP includes a set of practices regarding surgical patient care that represents a significant change from how such patients are typically treated (Day & Aloia, 2015). For example, most ERPs advocate the patient drinking clear liquids until just two hours before surgery (instead of the day before), the use of intravenous

anesthesia (instead of gas-based anesthesia), and the use of non-narcotic drugs (Ljungqvist et al., 2017).

My role. My role in the change initiative, as explained to informants, was to conduct a qualitative study of team dynamics in order to better understand how ERP programs can be successfully implemented throughout the Cancercare network (i.e., all partner members of the Cancercare network). However, I explicitly stated that I was not involved in implementing the change at Cancercare, and therefore would not share any information with either Cancercare leadership, the leadership of the parent hospital, or the external consultant, except in aggregated and anonymized form. On at least one occasion, the head of Cancercare directly asked me about information others had been sharing, and I explained why I was unable to share that information. Scholars have suggested that such exchanges, especially when interviewing well-educated and powerful individuals, actually helps build trust among all informants (Ostrander, 1993). The explanation of my role cast me as an "insider" regarding the system to gain familiarity with the context and informants, but enough of an "outsider" regarding those leading the change to overcome skepticism of where my loyalties lay (Corbin Dwyer & Buckle, 2009).

Sample. Because of my experience at the Cancercare flagship location, my expectation was that each disease site center – referred to as "service lines" at Cancercare – would form its own change team to plan and implement the ERP. This expectation was initially confirmed at a planning meeting involving the head of the cancer division of surgery and the Chief Medical Officer for the hospital prior to the beginning of my study. Therefore, I created a study design based on theoretical sampling (Strauss & Corbin, 1990) using a combination of the grounded theory approach (Glaser & Strauss, 1967;

Strauss & Corbin, 1990) as well as comparative cases in order to discover regularities in behavioral patterns (Langley & Abdallah, 2011). However, just prior to the change initiative kickoff event, Cancercare leadership informed me that instead of six to eight small change teams, they would only allow one large change team. Therefore, in the end, my sample included 10 surgeons, one physician's assistant, two anesthesiologists, eight nurses, six operations personnel, two data analysts, one pharmacist, and one nutritionist for a total of 31 individuals. The change team represented approximately one quarter of the total system, with specific representatives from each area of Cancercare. Tenure at Cancercare ranged from zero to more than 10 years (when Cancercare was created), 17 were females and 14 were males, and 10 were considered part of a minority group. Most importantly, my sample included everyone on the change team, and therefore everyone that was aware of, and experienced, the identity-implicating event (Bataille & Vough, 2020).

(Re)alignment of context, research questions, and methodology. Alignment between one's context, research questions, and methodology is critical in ensuring that a robust and relevant theory emerges from the data (Edmondson & McManus, 2007; Pratt, 2016). Though often portrayed as a linear model in which the researcher starts with a theoretical or "real world" problem, develops research questions, chooses a method of investigation, and then chooses a suitable context, Pratt (2016) suggests that this process may be rare. Instead, he suggests that the process is more circular in that any of the above components may initiate a need to adjust the others. In my case, the change in my sample from 6-8 small change teams to one large change team resulted in adjustments to my research questions, as well as my methodology. More specifically, after reviewing

additional literature, I adjusted my original research questions that were aimed at identity network development within and between individuals to instead focus on a phenomenon I had already encountered in my short time at Cancercare – individuals seemingly working against that which they professed to value most. This required me to also change my planned methodology from an in-depth comparative case study (Eisenhardt, 1989; Yin, 1994) to a grounded theory approach (Charmaz, 2014; Glaser & Strauss, 1967). I then submitted my new questions and methodological design to all three members of my research committee to gain an outsider's perspective regarding how well they aligned with my context. My goals in doing this were: 1) to gain approval to continue my study; and 2) to reduce the possibility that my own biases, pre-existing expectations, or desires were driving my decisions. Once we agreed to the new design, I continued with my study.

Context and theoretical sampling. The goal of theoretical sampling (Charmaz, 2014; O'Reilly et al., 2012) is to choose a context and sample in which the phenomenon or process of interest is "transparently observable" (Eisenhardt, 1989: 537). Thus, a surgical system undergoing a change initiative aimed at developing an ERP was particularly suitable for my study for reasons related to the change initiative and the change team. First, the change initiative focused on a system that spanned multiple areas of surgical care. Therefore, it had the potential to serve as an identity-implicating event for several different identities commonly found in work organizations, including supra, role, relational, and social identities (Dutton et al., 2010; Ramarajan, 2014). Second, almost three decades of research in the medical field showing that the proposed change (i.e., an ERP) would improve outcomes for both the hospital and patients (Day & Aloia,

2015) also increased the likelihood that the change initiative would implicate identities held by healthcare workers. Third, the change initiative aimed at improving alignment between different functional areas within the surgical system through standardization. In so doing, it provided a clear target for acceptance or resistance to the change. While acceptance of, or resistance to, the change was not the primary goal of my study, having that clear target enabled me to observe behavior that was clearly linked to the change, and it gave informants a referent for talking about their thoughts, feelings, and behavior regarding the change initiative. Fourth, and shifting to the change team, I was able to capture everyone involved in an identity-implicating event (i.e., the change initiative) that significantly impacted an entire system over a period of 11 months. Fifth, the change team was large enough to ensure a variety of perspectives, but not so large that it was not feasible to conduct multiple interviews over time with each member. Finally, the change team included at least one individual from every functional area in the Cancercare system, enabling me to capture both within- and between-person dynamics, the latter being essential to answering my second research question.

The Grounded Theory Approach

Grounded theory consists of "systematic, yet flexible guidelines for collecting and analyzing qualitative data" (Charmaz, 2014: 1), and then developing theoretical insights from the raw data (Suddaby, 2006). While some scholars suggest that it is necessary to strictly adhere to a specific set of steps in order to conduct grounded theory research (e.g., Glaser, 1978), others have suggested that the grounded theory approach offers "a set of general principles, guidelines, strategies, and heuristic devices rather than formulaic prescriptions" (Charmaz, 2014: 3; Strauss & Corbin, 1990). I fall into the latter camp, and

view the grounded theory approach as a set of core tenets that provide both guidance and flexibility (see Corley, 2015). These tenets include: 1) theoretical sampling; 2) inductive coding; 3) constant comparison; 4) theoretical saturation; and 5) theoretical sensitivity (O'Reilly et al., 2012). I addressed theoretical sampling in the previous section. I will discuss the remaining four tenets as they pertain to my study in the following sections.

Data Collection

The goal of data collection is to gather "rich data" on which the researcher can build strong theory (Charmaz, 2014: 23). Rich data are those that provide a detailed description of participants' lived experiences in a given context (see Pratt, 2008). In order to produce rich data, and to increase the trustworthiness of one's study, it is helpful to gather data from multiple sources (Shah & Corley, 2006). As noted, my primary sources of data were semi-structured interviews and meeting observations (Charmaz, 2014; Marshall & Rossman, 2006). However, I also gathered data in the form of archival data in order to further triangulate the phenomena of interest, as doing so enabled the strengths of one form of data to supplement the weaknesses of other forms. For example, observations enable the researcher to examine informants' reactions to each other in real time (Marshall & Rossman, 2006), which may help overcome one's desire to provide the "correct" answer in interviews. Importantly, all interviews and observations were conducted by one person (i.e., myself). Therefore, to help ensure I remained true to the data, I scheduled weekly meetings with a member of my dissertation committee who was familiar with the context but not the specific data who asked probing questions that challenged my assumptions regarding the data (Lincoln & Guba, 1985). On several

occasions, actual (anonymized) data were either shown to or discussed with the member along with field notes regarding specific interviews and/or observations.

Interviews. In-depth interviews provide a way of focusing on a given topic while still providing the flexibility needed to explore data as it is experienced by the participants. Hence, it fits grounded theory methodology particularly well (Charmaz, 2014). Therefore, as a primary source of data, I conducted 73 semi-structured interviews with 31 informants. The average length of the interviews was approximately 44 minutes, ranging from 16-129 minutes. In the majority of cases, each informant was interviewed multiple times, with five being interviewed on two occasions and 18 being interviewed on three occasions. Of the informants that were only interviewed once, three joined the change team just prior to my last round of interviews, and the advent of a global pandemic (COVID-19) prevented subsequent interviews, two did not respond to my attempts at scheduling additional interviews, and two experienced severe medical issues that prevented them from coming back to Cancercare for the duration of my study. Importantly, for those I only interviewed once, I was still able to observe all but one in several meetings.

All interviews were conducted in a private setting, most often in either the informant's office or a conference room I reserved for the purposes of the interview. On two occasions, the informant requested the interview take place over lunch. In these cases, the interview was conducted in a place away from all other people to ensure privacy and willingness to openly communicate. All but three interviews were recorded to ensure an accurate representation of the data, and each interview was professionally transcribed and proofread by me. One informant chose not to be recorded for all three of

their interviews. In these cases, I took extensive notes on the interview protocol being used for the interview and coded those notes. For the majority of the interviews I conducted, I created field notes to record any unusual insights or occurrences that took place during the interview. This occurred for almost every interview during the first round of data collection, and less often in the second and third rounds as I became more familiar with the emerging themes in my data.

In addition to field notes, I discussed interesting data points and observations as well as potential themes that tentatively emerged with a committee member throughout the course of my study. This allowed him to challenge any assumptions I was making regarding the data and also probe areas of potential insight that I may not have seen during the interviews. In the majority of cases, I coded each interview with a particular informant (initial coding) prior to conducting another interview with that same informant. Due to delays in the transcription process, this was not always possible. However, when it was not possible to code an interview prior to conducting another one with the same informant, I listened to the recording of the interview, and took notes regarding anything of interest.

Timing of interviews. In order to capture the enactment process to the maximum extent possible, I conducted the first interview with each informant as soon as they were made aware that they would be a part of the change initiative, and prior to the first change team meeting for all but two of the 23 first-round interviews. Those two members joined the change team shortly after the first meeting, and I was able to conduct an interview with them prior to the second meeting. Conducting interviews at this time enabled me to

gain insights regarding informants' identity networks prior to the identity-implicating event.

The beginning of the change initiative required observable behavior by informants in the form of discussions aimed at coming to an agreement regarding which aspects of the system they would integrate, and therefore standardize, and which aspects they would refuse to standardize. Additionally, this phase required agreeing on treatment "pathways" within medical specialties as well as across common areas of treatment (e.g., preoperative pain management). Therefore, I conducted a second round of interviews during this time as it made various identities salient and also forced informants to think about the reasons behind their behavior toward the system.

Following this phase, the change initiative focused on creating informatics and computer software that would aid informants in implementing the change. However, most informants had little to do with this aspect of the change initiative. Therefore, I waited to conduct the third round of interviews until just before the planned implementation as informants were preparing to explain the change initiative to their functional areas, and their identities regarding the system would likely be more salient and actual observable behavior was once again required. I did not wait until after implementing the change initiative to conduct the third round as I believed that implementing the change may be considered a different identity-implicating event, and therefore introduce the possibility of conflating the effects of one with those of the other. Whenever possible, I scheduled interviews with key informants shortly after change team meetings so that I could ask them about my observations during the meeting in addition to the other questions on the interview protocol. Due the unpredictable and busy schedule

of the informants, each round of interviews took approximately one month to complete. Prior to the first interview with each informant, I had them sign a written consent form approved by ASU's IRB (Appendix A) explaining the confidentiality of both the interview and the data that resulted from it.

Interview protocols. As noted, my research questions changed during the course of my study. Prior to the change, I had conducted five interviews using the interview protocol for my initial design (Appendix B). Fortunately, because both designs included a desire to understand one's identities, there was some commonality between this initial protocol and those used for my new design. Once the new interview protocols were developed, they largely remained the same, with minor adjustments that enabled me to pursue emerging concepts as the study progressed (see Gioia, Corley, & Hamilton, 2012). Two interview protocols were developed: one for the initial interview with a change team member (Appendix C), and one for subsequent interviews (Appendix D). Both protocols focused on informants' impressions of the change team, how the change team influenced relationships with and between different parts of the system, and the informant's activated identities in the context of the healthcare system. In addition, the initial interview asked questions aimed at the informant's understanding, or lack thereof, regarding the change team and also asked questions regarding the informant's work group. This enabled me to start understanding the various identities that were activated prior to the change initiative. Additionally, the subsequent interview protocol included questions regarding their perceptions of change team meetings and provided the opportunity for me to ask about any observations of interest during those meetings.

Observations. My second main data source was observations. Observations can provide more objective data than interviews, and overcome some shortcomings such as lack of awareness of an issue, the inability to effectively articulate a concept, biases when speaking with others, and immediate but less accurate reactions to questions (Corbin & Strauss, 2015; Eisenhardt & Graebner, 2007). Observations can also help detect identities that have been activated nonconsciously (e.g., Andersen & Chen, 2002). Indeed, one major advantage of observations is that they have the potential to "reveal what people cannot or will not express (Bechky, 2011)" (Eisenhardt, Graebner, & Sonenshein, 2016: 1114). Another objective of observations was to gain a better understanding of the context, and also to acclimate informants to my presence. One indication of such acclimation was that members often stopped to engage in small talk when they saw me in the hallway or at the local café. Observations, and my almost daily presence at Cancercare, also enabled me to learn the culture and build trust with key informants. Both of these are key elements of what Lincoln and Guba (1985: 301) refer to as "prolonged engagement," which helps ensure that the study results in credible findings.

In total, I conducted 39 observations totaling 52:28 (hh:mm), with each observation lasting an average of 1:20 (h:mm) (Appendix E). The majority of my time was spent observing 12 change team meetings, with an average observation time of 2:03 (h:mm) for a total of 24:46 (hh:mm). On average, these meetings were held once a month. However, I missed four of these meetings due to teaching obligations. Whenever possible, after missing a meeting, I asked several informants their impressions during the next interview or the next time I happened to see them at Cancercare. I was also invited to observe five faculty meetings that included all surgeons and physician's assistants. In

most cases, the change initiative was either not discussed or was discussed for less than five minutes in order to provide the surgeons on the change team an update or request that they turn in assigned materials (e.g., agreed upon standard pathways). However, I was able to stay for the entirety of each meeting, which helped me gain an understanding of how my informants related to each other and to others. The average observation time of these meetings was 1:11 (h:mm) for a total of 5:54 (h:mm).

Within the change team, there was also a leadership team consisting of two surgeons and three operations personnel, one being the external consultant requested by the flagship organization to help create the ERP program. This team discussed agendas and goals for the next change team meeting, and their impressions of other change team members and how to best create buy-in for the change initiative. Additionally, these meetings were most often held via phone conference. Therefore, my observations of these meetings were largely unobtrusive (on a phone line), and members often discussed the behavior of other change team members not present at the leadership team meeting. In this manner, I was able to gain some insight regarding how each leadership team member related to others on the change team, and also understand their frustrations and surprises regarding other members. I observed 19 leadership team meetings that lasted an average of 0:48 (h:mm), for a total of 15:15 (hh:mm). Finally, I observed three specialty meetings comprised of different members of the larger change team. These included an anesthesia education meeting, research meeting, and education materials meeting. The average observation time for these three meetings was 2:11 (h:mm) for a total of 6:33 of observation.

Observations may range from formal and strict protocols to more free-flowing observations that promote the recognition of new or more complex phenomena (Marshall & Rossman, 2006). I chose to use a free format in order to remain as open as possible to any interesting insights from informants. In order to promote open and honest discussions among change team members, and in case any sensitive data were discussed, I was asked not to record change team meetings. Therefore, I took detailed notes of all observations, making sure to distinguish between what I was seeing and my theoretical interpretations of what I was seeing. Additionally, I used quotation marks to distinguish between verbatim words spoken by informants and my paraphrasing of what was said. Because many individuals engaged in "side conversations" before or after a meeting, I showed up early to each meeting and stayed until all informants had left. During the formal meeting, I positioned myself in the back of the room so I could hear and see all informants, but they rarely noticed me. However, once the formal meeting was over, I positioned myself close to as many "side conversations" as possible without interrupting the conversation in any way. When this was not possible, I positioned myself next to key informants or informants that had a dynamic that was of theoretical importance to my research questions. I determined who this may be based on previous observations and interviews. In general, I was rarely paid attention to during observations except when informants greeted me as they entered or left the meeting space.

Archival data. Documents and other written materials are another useful source of data because they often indicate which ideas are shared, are backed by those with authority, or represent official purposes and objectives of a team (Charmaz, 2014). Additionally, archival data are useful for triangulation (Shah & Corley, 2006). My

archival data included change initiative materials that were generated by Cancercare or other sources (e.g., the flagship organization) such as meeting agendas, Power Point briefs, ERP goals, and progress reports. I also received some more general training materials (e.g., mission statement, vision statement, some onboarding material) from Cancercare and the parent hospital in which it was embedded in order to get a better understanding of the system identity. In total, I collected approximately 50 different documents totaling more than 400 pages of information.

Data Analysis

To begin analysis, I first reviewed all professional transcriptions for accuracy, and also to anonymize the data (e.g., remove names, educational institutions attended). I then loaded the anonymized transcript or observation into a qualitative data analysis program. I began by using NVivo for Mac version 11, and then updated to NVivo version 1.2.[4] Using a software program helped me organize large amounts of data, and also provided several different ways of comparing data (e.g., matrix comparisons). Throughout my analysis, I used memos to capture any insights I had while coding (Strauss & Corbin, 1990). As I will subsequently explain, during my initial coding of the data (i.e., open coding) I endeavored to remain as close to the data as possible, and not consider potential relationships between codes as doing so may have limited my openness to other possible relationships. However, my mind often leapt to potential relationships in spite of my efforts. In such cases, memos enabled me to "stop and catch meanings and actions" (Charmaz, 2014: 164), and then, feeling satisfied that a potential insight was written

[4] This version of NVivo is also specific to Macintosh computers. However, the label "for Mac" was dropped with this update.

down somewhere, I was able to return to coding the data with as much openness as possible. As my analysis progressed to more abstract levels, I was able to reflect on previous memos and how they informed relationships between codes. Additionally, I shared memos with a subject matter expert in the area of my study so that he could challenge my assumptions and ask probing questions that helped refine my analysis and, ultimately, the emergent theory.

Constant comparison. I used the constant comparison technique (Glaser & Strauss, 1967) in which "all new data are compared to earlier data iteratively" (O'Reilly et al., 2012: 249). This is an ongoing process throughout the course of a study and involves comparing different codes both with each other and more abstract themes that emerge (Glaser & Strauss, 1967). Additionally, data collection and analysis happen concurrently (Suddaby, 2006), with the researcher iterating between the two, and analysis from previous data directing future efforts of data collection. Using constant comparison helped increase my theoretical sensitivity throughout the course of my study, and also helped ensure my emergent theory was closely connected to the data.

Open coding. The first stage of coding is often referred to as open coding (Glaser & Strauss, 1967) and is the "part of the analysis that pertains specifically to the naming and categorizing of phenomena through close examination of data" (Strauss & Corbin, 1990: 62). Charmaz (2006: 45) refers to this as the process in which one creates the "bones" of the analysis. In this stage my "chunks" of coding ranged from a single line of text to as much as a paragraph. I coded each individual concept that was expressed by the informant and potentially related to my research question. Examples of open codes

include “patient care” and “always your fault.” In the end, I had 611 different open codes, many of which did not play an integral part in my final theory.

Open coding also helped me discover data that were missing. For example, early in my study I created the codes “standardization-buy in” and “patient needs.” In comparing the two, I realized that I did not have data regarding why some informants used their concept of a patient’s need to resist (i.e., not buy into) standardization. Hence, I started asking questions about this in interviews. Answers to these questions eventually led to an additional category of “data-follow or not” as data was invoked by informants as a reason for standardization of patient care.

Axial coding. Whereas in open coding one breaks the data down into its constituent parts and then groups those parts into more focused categories (Charmaz, 2014; Strauss & Corbin, 1990), in axial coding “the data are put back together in new ways” to discover more abstract *themes* (Strauss & Corbin, 1990: 96). This is the stage in which one connects the “bones” created by open coding into a “skeleton” (Charmaz, 2006). As I identified codes that tended to recur across many informants, I began to focus my analysis on these codes (Charmaz, 2014). In this manner, I was able to move toward more abstract themes (Strauss & Corbin, 1990). Examples of these themes include identities (e.g., “care provider,” “nurse”) and identity characteristics (e.g., “centrality,” “construal breadth”).

Importantly, I did not discover all of these themes in one iteration of coding. Indeed, it was in looking at the identity code of “care provider” that I discovered that some informants referred to all patients when describing themselves this way while others referred to a specific set of patients. Hence, I created a category of “care provider”

only to then split it into "my patients" versus "all patients," and eventually combined that code to a higher-level thematic code of "breadth of identity." I then discovered that my informants construed the same identity (e.g., role identity) as applying to different ranges of foci (e.g., tasks). Hence, I created more aggregate concepts such as "construal breadth."

Axial coding is also the stage in which one examines relationships between different codes. However, as Strauss and Corbin (1990: 97) explain, the researcher is "still concerned with the development of a category, but development beyond properties and dimensions" and into categories of relationships. In this stage, I was able to discover relationships between open codes identified in the previous stage. For example, the following quote is a surgeon's description of the relationship between two of his identities:

> *I'm a surgeon. I'm a physician… My [physician's assistant] is a provider. The nurses are providers... So, [am I] a care provider? Yes, I am, but I feel like I'm a whole lot more than that. I have interactions with the patients, the families, emotional support, there's physical support [that only surgeons provide]. (106)*

Open codes established that this member considered himself a surgeon and care provider. However, this quote suggests that being a physician is part of, yet identifiably separate from, being a care provider. Thus, an axial code of "convergence" (see Ashforth, 2007) was created to describe this, and other types of relationships between open codes.

During this stage of coding I also began to notice relationships between informants' identities and their behavior. As enactment is the manifestation of identities in the environment (Weick, 1995), I began tentatively separating informants into patterns of enactment while continuing to discover relationships between the various identities

that informants held. In line with constant comparison (Glaser & Strauss, 1967), this provided higher-level comparisons between themes and relationships instead of just between open codes or raw data. Using these comparisons, I began to move toward selective coding and theory development.

Selective coding. This final stage of coding involves selecting the core themes (developed in axial coding) and integrating them to tell a coherent theoretical story (Charmaz, 2014; Corbin & Strauss, 2015). This stage is often difficult because it requires the researcher to move beyond the data to bridge the gap between data and theory. Further, "conceptual leap*ing*" is more a process than a single mystical event (Klag & Langley, 2013: 151, their emphasis). In order to facilitate conceptual leaping, I routinely asked two subject matter experts to help me think outside of myself and creatively "play" with various possibilities through several iterations of diagrams and applying axial codes to key informants to create their "stories" throughout my study (see Miles, Huberman, & Saldaña, 2014). In this manner, I was able to "lift" the data to a theoretical level (Suddaby, 2006: 636), and integrate various themes into a processual model. For example, I was able to explain why one informant viewed an event as an opportunity to improve patient care while another informant viewed the same event as a threat to patient care (see Chapter 4).

Importantly, my diagraming and "story" telling involved several iterations that began at a phenomenological level, and were slowly raised to the level of a theoretical model. Additionally, I often returned to axial, and on occasion open, coding throughout this process. Finally, continual conversations with the two subject matter experts were

critical in ensuring my model was both theoretically sound and well-connected to the data.

Identity networks. After separating informants into their different types of enactment, I compared the identity networks of the informants that engaged in each type of enactment in order to discover commonalities and differences between them (Langley & Abdallah, 2011). As noted, four identities (i.e., supra, role, relational, and social) and four identity network characteristics (i.e., convergence, centrality, construal breadth, and clarity) emerged as important factors in both determining the type of enactment, the overarching process of enactment, and interpretations of behavior enacted by others.

An informant was coded as having an identity based on some sort of self-defining statement. For example, after talking about being a care provider, one informant was asked what that meant to her. She replied:

> *To me, it's such a weird question. It's like saying, "What does it mean to you to be female?" or "What does it mean to you to be [a certain height] and [brunette]?" It's just what you are and it's what I've chosen to be. (605)*

This was coded as her having the supra identity of "care provider." Similarly, in answering another question, one person stated simply, *"Because I'm a nurse" (603)*, which was coded as having the role identity of "nurse." Relational identity was determined based on statements regarding the relationship between patients and one's role. For example, after showing me several "thank you" cards displayed in his office from patients, and pictures of him with patients on his phone, one surgeon explained:

> *So being able to generate those kinds of relationships. Here's a woman [shows a picture on his phone], and her husband passed away. And she still comes and brings [me] food and visits the ICU where her husband stayed. That is why I do this. My absolute, positively, favorite part of this job is the human connection.*

> *And the upside of also getting to kick cancer in the teeth every now and again is just great. (104)*

This quote suggests that his relationship with patients went beyond just providing medical services and was coded as indicative of a relational identity. Finally, the social identity of the system was determined by statements of membership in the system. For example, a surgeon simply stated, *"I'm an employee of the system" (106)*.

Similar to coding for identities, coding for identity network characteristics was based on statements or observations that displayed that characteristic regarding a particular identity. For example, when asked about how his role relates to patients, an informant explained:

> *I think [being a pharmacist] is more part of the identity that I have in choosing [to be a care provider], and being able to contribute in [being a care provider] is that [being a pharmacist] is a role that I have…I feel like [in] anything that I am doing, if it ever were to take away from a patient experience, I become quickly aware of that and cognizant and thinking "Wait, why would we do this if this could counteract or counterbalance my whole purpose in being [a care provider]?" (401)*

This statement was coded as high convergence between the informant's "care provider" and "pharmacist" identities. As another example of coding identity network characteristics, when asked about caring for patients, one informant explained:

> *What do I want to be known as in this life? A healer… A healer in my opinion is the highest thing that we can do in this job. It's the most important thing that we can do is [be] a healer…So that's how I see myself. (202)*

This statement was coded as high centrality of the informant's care provider (i.e., healer) identity because it conveys a relatively large amount of importance assigned to that identity (see Brenner et al., 2014; Stryker & Serpe, 1994). Notably, as I will explain in the next chapter, the most central (i.e., important) identity was, by definition, at the top of

the centrality hierarchy. In my study this was the supra identity of "patient care." Thus, I refer to this identity as the "higher-order" identity throughout this study.

Construal breadth was based on statements and observations regarding the application of a given identity. For the higher-order identity, construal breadth was based on statements regarding the range of purpose for providing care (e.g., providing care for only my patients versus all patients in the system). For example, after stating that he looked forward to the change initiative being implemented, a surgeon went on to explain why: *"Because patients that aren't being protected from exposure to narcotics and things like that are now going to reap the benefits of that in other fields than just [my specialty]" (104)*. This indicates a broad construal of his higher-order identity. Given the novelty of the construal breath concept, exemplars of broad and narrow construals of each type of identity are provided in Table 1.

Insert Table 1 about here

For the role identity, construal breadth was based on a combination of statements regarding the actions an individual felt responsible for and actions they felt were within their ability to perform. As an example, when asked to describe her breadth of responsibilities regarding her role as a surgeon, one informant replied, *"[It's] immense. Everything is my fault" (109)*. She went on to explain that she was frustrated because, even though she felt responsible for everything, she had no control over some care her patients received:

> *I'm the one that says they get chemo. And then someone else has to put in the orders and schedule it, and put in the labs, and make sure the port is accessed… So, if the lab says we're three hours behind, I mean, I directed them to do it but I have no control over the hundred steps below that. (109)*

This combination of feeling responsible for a broad set of actions, but having the ability to control a relatively narrow set, was indicative of a multifaceted role identity construal (i.e., broadly construing one aspect while narrowly construing another).

For the relational identity, construal breadth was based on statements regarding the extent to which they cared for patients with a broad construal, meaning doing a few things for many patients, and a narrow construal, meaning doing everything possible for a small set of patients. As an example of a narrow construal, when asked what it meant to be a care provider, one informant answered:

> *It means caring for the whole patient; all aspects – mental, spiritual, physical, emotional. Because we're not always able to cure them and we're not always able to fix what's wrong, and we need to be able to help them still in any way that we can. (104)*

Finally, system identity construal breadth was based on statements regarding the range of the informant's understanding of the system (e.g., expresses knowledge of many parts of the system versus expresses ignorance regarding many parts of the system). For example, during a change team meeting, one surgeon showed narrow system identity construal when she frustratingly exclaimed, *"I don't know what my nurse even says to my patients, quite frankly" (109, change team meeting 2019.09.26)*.

Cycles of analysis. Like many qualitative studies, my study traveled a "messy, episodic, and non-linear path to creative insight" (Eisenhardt et al., 2016: 1120). In some ways, I completed the above analysis for three different models that were then merged into one. More specifically, I first went through open, axial, and to some extent selective

coding to relate identities to each other in identity networks and then identity networks to types of enactment. Then during a discussion, a subject matter expert asked me what happened in the space between the identity networks and enactment. So, going back to open, axial, and selective coding, and through additional conceptual leaping, I developed an overarching process of multiple identity enactment. After considering that model, I asked myself what happened *after* enactment. To answer this, I once again went back through the same levels of coding to develop a feedback loop from enactment back to identity networks. Throughout this process, with the help of the two subject matter experts, I integrated the "new" models with the existing tentative model in order to create a more complete theoretical story.

Theoretical saturation. Theoretical saturation is reached when gathering additional data no longer "sparks new theoretical insights, nor reveals new properties" of core theoretical categories (Charmaz, 2014: 213). As such, theoretical saturation is not so much a matter of time as it is of gleaning all the insights the data have to offer. In my study, I reached theoretical saturation in the beginning of my third round of interviews.

Unfortunately, as noted, COVID-19 interrupted my data collection, which limited an extension of my study wherein I planned on investigating how individuals chose to represent the change initiative to their respective functional areas. However, this interruption did not limit the investigation of the research questions in this study.

Theoretical Sensitivity

Theoretical sensitivity refers to "a researcher's ability to give meaning to data and to recognize data that have pertinent meaning to the emerging theory versus data that do not" (O'Reilly et al., 2012: 254). It is a personal quality of the researcher, and one that

can be developed (Strauss & Corbin, 1990). Prior to starting this study, I had some experience in the healthcare field while conducting other research. For example, I observed more than 20 surgeries in a medium-sized hospital, and therefore was at least somewhat familiar with the culture and language used in surgical systems such as Cancercare. However, to develop theoretical sensitivity related to Cancercare specifically, I went to the flagship organization. While there, I interviewed five individuals from different parts of the surgical system (e.g., surgeon, anesthesiologist). I also observed a 10-hour cancer surgery, and "shadowed" nurses and physicians in the clinic for eight hours. Therefore, this experience enabled me to observe almost every aspect of a surgical system specific to cancer surgery. Additionally, I attended a two-day conference on enhanced recovery programs in order to better understand the change initiative, and how it may implicate various identities of Cancercare members. I also reviewed the medical literature regarding ERPs to become aware of the evidence supporting the claimed outcomes and be able to speak the "language" in a familiar manner. Finally, I had two meetings with personnel at the same hospital as Cancercare, but not part of the Cancercare system, in order to get an idea of what the local culture within the hospital was like, and how it may differ from the flagship organization.

Trustworthiness

Lincoln and Guba (1985) present four criteria by which qualitative research may be judged as trustworthy: credibility, transferability, dependability, and confirmability (also see Shah & Corley, 2006).

Credibility. Credibility in inductive research is roughly analogous to the traditional requirement of internal validity (Shah & Corley, 2006) in deductive research.

However, while internal validity refers to the degree to which researchers may be assured of a causal relationship between an independent variable and a dependent variable (see Cook & Campbell, 1979), in inductive research credibility refers to the degree to which one can be assured that the emergent theory is grounded in the lived experiences of the participants. Lincoln and Guba (1985) suggest that prolonged engagement, persistent observation, triangulation, and peer debriefing all help ensure the credibility of one's findings.

Prolonged engagement involves learning the culture, being able to detect and test misinformation, and building trust. As noted, I conducted theoretical grounding at the flagship organization in order to begin learning about the culture of Cancercare and build theoretical sensitivity. In addition to time spent during observations and interviews, I also spent time in common spaces throughout Cancercare to learn more about the culture and to build familiarity with my informants. For example, I often conducted other forms of work in the cafeteria, different lounges, and the café. My goal was to become a familiar face to all Cancercare members and to be immersed enough in the context to recognize nuances that may be of theoretical interest and to increase my sensitivity to any changes that may affect my study.

Prolonged engagement also helped with persistent observation, which involves spending enough time in the context and with participants to identify data that are most important to my phenomena of interest and gain deep insights into this data. I was a familiar fixture at Cancercare for approximately 11 months. So much so that all informants referred to me by my first name, as did several administrative assistants and other staff members that resided in the same workspaces. Finally, one form of

triangulation is collecting multiple sources of data. As noted, I collected interview, observational, and archival data, all of which often pointed toward similar insights.

I also engaged in peer debriefing, in which the researcher subjects him or herself to examination by other, disinterested researchers so that they may challenge his or her assumptions and/or biases. In so doing, the researcher helps ensure that they are accurately representing the data instead of what they want to see or think they should see (Lincoln & Guba, 1985; Shah & Corley, 2006). As noted, I engaged in weekly debriefs with one of my committee members throughout the study. These meetings involved discussions related to data collection methods, possible biases in interviewing, data analysis, and tentative model development, among other topics. The main goal of the "peer" was to ensure rigorous data collection and analysis techniques, and to challenge any perceived biases or assumptions in order to ensure the emerging model was clearly grounded in the data. During the analysis stage, I also met several times with another member of my committee who challenged me regarding the theoretical level of my model (e.g., it was too phenomenological), and suggested some analysis techniques discussed above (e.g., building informant narratives).

Transferability. Transferability addresses whether or not the conclusions reached by the researcher may apply outside of the specific context in which the data were collected (Lincoln & Guba, 1985). While there is no one way of calculating transferability, it is possible to increase the likelihood of transferability by providing detailed descriptions of the concepts and categories that are created as well as the processes by which they were created (Shah & Corley, 2006). I have provided such descriptions in this chapter and in my findings (Chapter 4). Additionally, transferability

may be achieved "when readers feel as though the story of the research overlaps with their own situation and they intuitively transfer the research to their own action" (Tracy, 2010: 845). As I explained in Chapter 2, the work identities that were important to my informants are prevalent in organizations (Dutton et al., 2010). Also, intrapersonal identity networks exist within each individual (Ramarajan, 2014), and individuals seek to enact the multiple identities in their networks (Ashforth et al., 2008; Bataille & Vough, 2020). Therefore, it seems likely that my findings will be perceived as transferrable to other contexts. I provide a more elaborate discussion of transferability that is specific to my findings in the Discussion (Chapter 5).

Dependability. In inductive research, dependability addresses the question of how one knows that the resulting theory is well grounded in the data (Lincoln & Guba, 1985; Shah & Corley, 2006). I addressed dependability in three ways. First, as explained earlier in this chapter, I ensured there was alignment between my research questions, data, and sample. In doing so, I increased the likelihood that the phenomena of interest were represented by the data, and insights regarding the phenomena were brought to light by methods that were most appropriate for doing so (Pratt, 2016). Second, I used Microsoft Excel to document the details of all my interviews and observations, including the date, beginning and ending times, location, person, and role within the system. Additionally, the use of NVivo provided my committee with the opportunity to audit my data collection, management, and analysis to ensure I remained true to the grounded theory approach. Finally, I had all informants sign a consent form indicating that they understand the interviews are confidential and that no personally identifiable information would be shared either publicly or with anyone in their organization. This promoted a

free and open exchange that, in turn, maximized the amount of useful data collected during each interview.

Confirmability. Confirmability addresses the researcher's ability to remain impartial to findings (Lincoln & Guba, 1985). While complete impartiality is likely not possible (Charmaz, 2014; Pratt, Kaplan, & Whittington, 2020), I addressed this concern by having all interviews transcribed verbatim by a professional transcription service – thereby removing any danger of inserting my interpretation into the actual words that were said. I also separated open and axial coding within NVivo as well as in time (i.e., not on the same day) until all open coding had been completed and only then started organizing open codes into higher-order categories. Finally, I kept notes regarding methodological decisions throughout my study (Charmaz, 2014; Corbin & Strauss, 2015). Together, these actions helped ensure that the emergent theory regarding identity networks and enactment was well-grounded in the data.

CHAPTER 4

FINDINGS

Recall that my research questions are: 1) *How does the interaction of an individual's multiple identities influence enactment?*; and 2) *Why do individuals with the same higher-order identity work against each other when enacting that identity?* Two models emerged from my analysis. First, as summarized in Figure 1, is a model in which different identity networks resulted in three different types of enactment toward the surgical system. These different enactments were perceived by system members as either attempts to increase or decrease standardization within the system and, in turn, interpreted as either enhancing or threatening members' ability to enact their higher-order identity, depending on the member's identity network.

Insert Figure 1 About Here

As shown in Figure 1, all of my informants had at least four salient identities. These were a higher-order (i.e., supra) identity that involved defining oneself as a provider of patient care, a role identity, a relational identity with patients, and the social identity of the system. Further, each of these identities had four characteristics, including convergence with other identities, centrality, construal breadth, and clarity. Differences in the characteristics of members' identities created different identity networks that served as an input to an overarching process that resulted in one of three types of enactment: *defending*, *bending*, or *mending*. Those that engaged in defending lacked clarity regarding their higher-order identity. This led to shifting their referent identity to the area of

convergence between their role identity and either their relational identity or their system identity, and also led to a narrow construal of their role identity. The combination of the two resulted in enactment I refer to as "defending," which involved behavior intended to guard against system changes so as to prevent hindrances to the member's higher-order identity enactment. For example, in talking about her and her partner's reaction to a proposed system change, an informant said: *"No, they don't like a lot of these things that I don't like as well… I've even heard, 'Well, I'm just not gonna do it.' So, I mean, you're trying to force something down people's throat" (105)*. As I will subsequently explain in greater detail, due to the differences in the area of convergence between core and support members, each group engaged in "defending" against different things. The convergence between a core member's role and relational identities resulted in them interpreting attempts at standardization as a threat and resistance to such attempts as an opportunity for their higher-order identities. Conversely, the area of convergence between a support member's role and system identities resulted in them interpreting attempts at standardization as an opportunity and resistance to such attempts as a threat to their higher-order identities.

The second type of enactment was "bending," which was enactment intended to coerce short-term changes in specific system elements so that they better align with the member's higher-order identity. As an example, a member talked about his role in relation to others, *"[The] captain of the ship technically, it's not supposed to exist, but in reality, it still does" (113)*. This same member explained that, as the "captain," he tells other system members how he likes things and expects them to do what he says. For example, when talking about how he relates to anesthesiologists, he explained, "*I mean,*

you're the captain. Anesthesiologists, from what I understand, are kind of the outside helper" (113).

This type of enactment was a result of two key difference in their identity networks. First, they broadly construed their role identity, and in doing so felt both responsible for all medical care given to the patient and as though they had the ability to perform whatever actions were necessary to provide that care. Second, they had relatively high convergence between their higher-order (i.e., supra) and system identity. The combination of these two identity network differences led to the belief that all care flowed through core system members, and the rest of the system was a set of malleable resources ready to bend to the preferences of those members. Therefore, they interpreted any attempts at increasing standardization, through integrating system identity elements, as a threat to their ability to "bend" the system to their will, and thus a threat to their higher-order identity. Conversely, these members interpreted resistance to such integration attempts as an opportunity to enhance their higher-order identity.

The final type of enactment was "mending," which was intended to achieve long-term changes so that the system better aligned with the member's higher-order identity. As one member put it, *"I like being able to improve systems so that physicians can help more patients or help them better" (109)*. Those that engaged in this type of enactment had a multifaceted construal of their higher-order identity in that they viewed depth of care and breadth of care as interdependent. Additionally, these members also had a multifaceted construal of their role identities in that they felt responsible for delivering both depth and breadth of care, but believed they only had the ability to provide one or the other and not both. Hence, they attempted to integrate elements of the system identity

with their higher-order identity of "patient care" through standardization, because doing so represented an opportunity to enhance their higher-order identity. Conversely, they interpreted any resistance to their integration attempts as threats to their higher-order identity.

Importantly, these different types of enactment were not limited to a specific position in the organization. For example, some surgeons engaged in defending while others engaged in either bending or mending (see Table 2). Additionally, all three types of enactment emerged *even though all system members shared the same higher-order identity*. Finally, different members viewed the same attempt at integrating a system element (i.e., increasing standardization in the system) as either a threat or opportunity regarding the same (i.e., common) higher-order identity.

Insert Table 2 about here

In order to answer my research questions, I first describe the common aspects of every member's identity networks, pointing specifically to the presence of a common higher-order identity. Next, I explain how, due to the prototypical member dictated by the system identity, different members' identity networks resulted in them being perceived as either "core" or "support" system members. I then explain how key differences between identity networks resulted in the three main types of enactment toward the system described above. Next, I present a second model, presented later in Figure 5, of the overarching process by which individuals enacted their identity networks. Finally, I explain how the different types of enactment resulting from this process were perceived

by other system members as either an identity threat or identity opportunity regarding the higher-order identity (depending on their identity networks).

Identity Network Commonalities

Patient care as the higher-order identity. There were several commonalities in the identity networks of all system members. Perhaps most importantly, for every member, the most central (i.e., important) identity by far was being someone that cares for patients. For example, a surgeon stated, *"I'm gonna concentrate on patient care… I like to think this is all about patient care, and not about personalities and everything else" (108)*. Similarly, when asked how he determines the right thing to do in any situation, a nurse replied, *"I think the right thing is what benefits our patients" (603)*, and a physician's assistant explained it this way:

> *You have tough days, you have long days, you have unpredictable days, you have frustrating days, but at the end of the day, you can say, you know what, I had an interaction and a connection with a human being and hopefully I made their experience better. You know... if I can't fix the problem, at least directing them to someone who might be able to. And if you can't fix the problem at all, at least, helping them deal with the issue or at least decreasing some stress... The human body is amazing. The human spirit's amazing too. So at least in this, in this role, as a care provider... it's an amazing opportunity to be working with someone in such a unique time of life that can be very sad and also have a lot of joy as well. And just feel like, you know, maybe you made someone's day a little bit better. (301)*

Indeed, every informant expressed that "patient care" was the most central identity they held in that context. Additionally, the higher-order (i.e., supra) identity was also evident during change team meetings. For example, during a change team meeting in which several surgeons and anesthesiologists disagreed about which drug to use, an anesthesiologist emphatically stated, *"It's not about what's easiest for us. It's what's best for the patient" (202)*. This was met with agreement from all members, representing

every part of the system *(change team meeting, 2019.07.11)*. Given that it was the most central identity of everyone in the system and, as I subsequently explain, the role, relational, and to varying extents the system identities, were nested within it, I refer to the "patient care" identity as the higher-order identity for each member.

Centrality of the role identity. In addition to the supra identity serving as the higher-order identity, all system members had highly central role identities, often referring to these identities as an important part of who they are. For example, when asked what being a nurse meant to her, one member replied, *"So, what it means to me is, this is my calling. And this is what I'm meant to do. And I enjoy doing it" (605).* Because, as noted, centrality determines the primacy of enactment, all members felt the need to perform, and be responsible for, behaviors associated with their respective roles. For example, when talking about his role as a surgeon one member stated:

> *And then, [part of being a surgeon] is the decision making about whether to do surgery or what type of surgery, and often the, quote, success. You know, there may be complications or other things that may be beyond their control, but… a lot of [the] responsibility of the success is – yes, the anesthesia's very important and a lot of responsibility, nursing, rescue, all those pieces. But – a good chunk of the success of the journey – of the experience and the outcomes –is dependent on the surgeon's skill… what they did. (103)*

Convergence between the supra, role, and relational identities. Regarding convergence, every member's role and relational identities were nested within (i.e., complete convergence with) their supra identity of "patient care." Therefore, members equated performing actions associated with their specific roles with caring for patients. For example, a pharmacist explained his role in this way:

> *My role as a pharmacist… is to support the care needs of our patients and deliver the medication therapy that is needed for patients. So we don't administer it [but]*

> *we certainly prepare, supply, and deliver it to the administrator. So, we're part of that big equation. (401)*

Additionally, the convergence between their supra and relational identities resulted in equating building relationships with patients with caring for patients. Hence, it was important for members to care for patients by engaging in behaviors associated with their specific roles and, for those whose relational identity was also central, by relating to patients in some way. For example, one surgeon told a story of how he sometimes goes against standard medical procedures for the sake of his patients:

> *I'm thinking of a particular patient that, you know, in the next couple weeks he's got this tumor on his head and he's just like 'I just want this off. I don't care about getting another three hours of surgery to deal with lymph nodes.' And so, I said 'Yeah, you're 90 years old, you have the right to know the risks of that and move on with that. And I will support that.' I don't push him… it's his choice. I told him that there could be cancer in his lymph nodes, and he could, you know, have problems from that, but he just wants to deal with this. So, I think I pride myself on doing what makes sense for that patient. (107)*

The system identity. The high centrality of each member's higher-order and role identity, and also the high convergence of their higher-order identity with both their role and relational identities, created a common perception that the social identity of the system (hereafter system identity) consisted of individuals and processes that provide quality care to patients. Additionally, the leadership of the health organization in which the system existed encouraged members to focus on providing the best possible individualized care to each patient.

For example, training materials encouraged each member to think of "Christina," a fictitious patient for which everything from surgery to instrument cleaning is done. As one training program puts it, system members should equate Christina with *"your mother, brother, or friend. Or, maybe [even] yourself."* Further, Christina should be kept

"at the center of our decisions" regarding care. In this way, care that focused on the individual patient also became part of the system identity. Indeed, Christina was spontaneously brought up by members during interviews to exemplify quality patient care. For example, when talking about navigating the administration, an operations member described his job as making *"sure [care provision] runs as smooth as possible. So that way everything that we do does make it better for [Christina], as you may have heard." (801)*. Similarly, when asked if she felt that she shared in system members' successes, a nurse explained, *"If their success is the betterment of [Christina], which it is, then yes. It is my success" (605).* Seeking to discover if this idea of individual patient care was common for all system members, I mentioned Christina in several other interviews. Each mention of Christina was met with instant recognition, and she was associated with the idea that all parts of the system should work to provide her quality care. Hence, the system identity involved a group of individuals and processes that provided the best possible care aimed at addressing every area for a given patient. Here, I refer to this as "depth" of care.

Identity Networks – Core vs. Support

Because the system identity emphasized depth of care, perceptions of prototypicality were based on the ability to provide individualized care to specific patients (i.e., a prototypical system member). Thus, individuals that focused on depth of care were considered "core," while those that focused on "breadth" of care – providing the best possible care aimed at addressing a given area for all patients (e.g., pain management) – were considered "support." In my study, all core system members were also surgeons while support members consisted of anesthesiologists, operations

personnel, pharmacists, physician assistants, nutritionists, and nurses. Importantly, however, being core to the system was not just a question of occupational label as not all surgeons were considered core. For example, some surgeons had primarily administrative roles and several other physicians provided more generalized (i.e., breadth of) care during nights and weekends. Both groups were considered part of the system, but neither were considered core to the system. Nor were they afforded the power and status that one would typically associate with their occupational label. Indeed, they were rarely mentioned by other system members and largely ignored at system meetings. In contrast, over time, one of the anesthesiologists, a support member, wielded more power than any surgeon in my study, including those that were officially designated as leaders. For example, in multiple meetings surgeons and other individuals deferred to him when he spoke, even if the subject was not in his area of expertise and, on at least one occasion, this included the head of Cancercare (e.g., change team meeting, 2019.07.24). Instead of being based on occupation, power, or status, being considered core versus support was based on how individuals understood their role identity (e.g., a surgeon "should" focus only on his or her specific patients, a nurse "should" focus on any and all patients) and other identities in combination with each other.

Becoming core vs. support. More specifically, there were four key differences in identity networks that resulted in greater system prototypicality and, in turn, being core to that system versus support. First, core members construed their higher-order (i.e., supra) identity, at least in part, as being narrow whereas support members broadly construed this identity. These different construals meant that core members interpreted their higher-

order identity as applying to their specific patients. For example, when asked if she would do whatever is necessary to care for patients, one surgeon replied:

> *I think in general I always – for my patients, yes, I'll do whatever is necessary. But as far as… sort of being an advocate for all patients of all specialties; I don't think I'm able to do that because either I lack the knowledge that the other people have or like I said, I don't feel comfortable challenging them on yes, just have your patients do [what I'm doing]." (101)*

Whereas support members interpreted the same identity as applying to all patients in the system, and sometimes even beyond the system. When asked if he focused on providing care to specific patients, or all patients in general, a pharmacist replied:

> *I mean more the latter than the former. More everybody. I mean… the reason we get into healthcare is because we want to help patients… But I'm not out there to try and help [a specific set of] patients, you know. I'm passionate about helping [all] patients. (401)*

As noted, all members had a highly central supra identity. Therefore, it was important for both core and support members to enact that identity by providing quality care to their patients. However, due to the differences in construal breadth, while support members had to split their time and effort between many patients, core members spent a similar amount of time and effort on fewer patients.

Second, the centrality of core members' system identity was relatively low compared to that of support members, and the centrality of support members' relational identity was relatively low compared to core members. Therefore, core members felt the need to simultaneously enact their higher-order, role, and relational identities and felt that such enactment should take priority over their system identity. Thus, they chose to spend significant amounts of time developing a deep relationship with each of their patients,

even as they experienced considerable time constraints. As one core member explained when asked how he manages the administrative side of providing care:

> *Well it's the least care provider feeling part of my job… and it seems to be the part of my job that keeps growing and growing and growing. I refuse to be the guy who sits with the patient with the computer and filling it out while I'm in there. That is too impersonal and that is not the way I practice. (104)*

In contrast, support members prioritized simultaneously enacting their higher-order, role, and system identity over their relational identity. To them, caring for patients was a team sport that involved many system members working together to care for all patients. As one support member put it:

> *Sometimes we can get into what they call operating in your silo; these are my four patients. And we are really big on when people say "well that's not my patient." Oh, they're everybody's patient! They're all our patients... We try to encourage everybody... all the call lights that you see [from any patient] – don't walk past a call light without answering it or acknowledging it in some way." (608)*

This focus on providing care as a system meant that in enacting their higher-order, role, and system identities, support members prioritized time spent on developing relationships with other system members over relationships with patients. Indeed, though caring for patients in general was important to her, regarding relationships with patients, a nurse that worked primarily in surgery explained, *"So, [the] OR is isolated… We're the nurse that nobody remembers" (605)*. However, this same nurse also stated:

> *I feel that people need three things in their life when they go to their job. They need to be competent, they need to have a sense of purpose, and they need to have a sense of community. And so, I get all three of those things in this role. (605)*

She then went on to explain that she got her sense of community by connecting with other system members.

The narrow construal of their higher-order identity, combined with the high centrality of their relational identity, resulted in enactment that led to the third difference between core and support members identity networks. Core members developed a relational identity with their patients that was both highly central and narrowly construed while support members' relational identities were less central and broadly construed. Therefore, to core members the patient was not an abstract concept but a specific person with a family, job, and life outside of the hospital. As one surgeon, while describing his role, explained, *"I have interactions with the patients, the families, emotional support, there's physical support" (106)*. In contrast when asked if he developed strong relationships with patients, an anesthesiologist replied, *"No. You know as best I can with the time I've been given. We don't have a lot of time" (202)*. Thus, while patient care was still very important, support members did not get to know each patient well enough to provide individualized care as surgeons did.

The fourth key difference between core and support member identity networks was that core members had high convergence between their role and relational identities while support members had high convergence between their role and system identities. Therefore, for core members there was no difference between acting like a surgeon and improving or maintaining their relationship with their patients. As one surgeon explained when referring to what is unique about his role, *"Most often [surgeons] have some relationship with the patient. You know them, you know their family" (103)*. However, for support members there was no difference between being a nurse, pharmacist, etc. and improving or maintaining the system. For example, when speaking about different ways in which they provide care, a nurse explained, *"Getting people up after surgery, having*

them debrief and cough; a lot of those protocols are ingrained in pieces [of the system], it's just putting all those pieces together to make one big picture" (602).

Enacted networks and system member perceptions. The differences in members' identity networks regarding the construal breadth of their higher-order and relational identities, centrality of their relational and system identities, and convergence between their role and either relational or system identities, resulted in differences in enactment that determined which members were considered core and which were considered support by the system. More specifically, the members that enacted depth of care were perceived as core to a system that emphasized this type of care. In turn, the members that enacted breadth of care were perceived as being in support of those that were dictating care for the individual patient at the center of the system. For example, referring to Christina once again, a nurse explained:

> *So, I think that, ultimately, [Christina's] the center, right? I mean, I know it's a [parent hospital] thing to say, but I really believe it... And the next closest to that is the person dictating [Christina's] care. And there's a lot of support roles, with that. So, [for example] pharmacy – if there's a certain drug and a process, and they can do what they can to get that drug available, to be able to help with [Christina's] end results, then, that's their job to help with it. (605)*

The enactment of core versus support identity networks also created important differences in perceptions regarding power to change the system, understanding of the system (i.e., clarity), and who was either helping or harming patient care. As noted, core members focused on providing depth of care as opposed to breadth of care, and the system identity held such individualized patient care as being prototypical. Therefore, enacting the core member identity network represented the ultimate system member, and hence, these members held the most power within the system. This was true even in areas

for which core members were not directly responsible. As a pharmacist put it, *"So [it's] hard to bridge consensus with folks that are on the next level above you, that are having discussions about what they wanna do, even if they're medication related" (401)*. When asked what he meant by surgeons being a level above him, he explained:

> *In decision making for the care plan of the patient. So… for instance… we're talking about the use of the right medications, in the right ways, but with respect to, also, timing and consideration of sleep. And so, I mean, I can recommend an optimized plan, but if our surgeons say, "Look, from my patient experience, that might be optimal for analgesia at a medical level. But, for their overall experience in care, which I'm supervising, this is what I think is better for them and what I am hearing is more beneficial for them" [shrugs his shoulders]. (401)*

Ironically, however, even though core members held the power to change the system, they often did not wield this power. The relatively low centrality of their system identity combined with low convergence between that identity and their role identity meant that core members engaged with the system to the minimum extent possible, which resulted in relatively little understanding regarding the members and processes that comprised the system. One example was when a surgeon was asked about the role of anesthesia in surgery and she exclaimed, *"I think they have a huge role in it. Because the patients are under anesthesia for so much time that all the drugs that they give; I mean we have no idea how they work. That's their thing" (101)*. Finally, adding in the high convergence between their role and relational identities meant that core members perceived themselves and their specific patients as a team. Indeed, when asked if that was the case, one surgeon emphatically stated *"Absolutely!" (104)*. Further, at times core members viewed the system as an entity that hindered that team's objective of providing the best possible care for their patients. For example, in an attempt to help improve communications with patients during off hours, one surgeon suggested getting a single

"on-call" phone as the current practice was to write the relevant phone numbers on a post-it note each night. She was denied by the head of the physician's assistants because there was not a specific outlet designated for charging the phone. Leading her to exclaim, "*I feel like it's a roadblock – somebody help us do the right thing for our patients!" (109)*. This was just one of many instances in which a surgeon expressed frustration based on their perception that parts of the system were hindering care for their specific patients.

In contrast, support members' higher-order (i.e., supra) identities were highly central and broadly construed. Thus, their enactment of the higher-order identity focused on providing the best possible care across all patients. After being asked if she focused on all patients or a subset of patients, a nurse explained it this way:

> *All patients. I mean, my demographic is the surgical patients. I have [direct] patients [but] I'm also over the [instrument cleaning] department. And the Floor will use instruments. So will [Cancercare]. So will Labor and Delivery. So, they are my patients, indirectly, because they're use of my surgical instruments comes back to me. I mean, we process them and then send them back out. So, it's just a generic patient, a patient at the hospital [that I focus on]. (605)*

Because the system identity promoted depth as opposed to breadth of care, support members had relatively little power in the system. However, the relatively high centrality of their system identity combined with high convergence between that identity and their role identity meant that support members engaged with the system to the maximum extent possible, and therefore had much greater understanding of the members and processes that comprised the system. Indeed, in many meetings core members had no idea about who educated their patients regarding surgery (change team meeting, 2019.09.26), how to get access to a new drug (change team meeting, 2019.11.21), and

how to order treatment in the computer system (change team meeting, 2019.11.21). However, in each case a support member was able to clearly explain the system processes and members involved. Finally, support members had relatively high convergence between their role and system identities. Therefore, they perceived the system as a team working to provide quality care to all patients, and individual surgeons as rogue members that often hinder those efforts. As a support member explained regarding core members' engagement in a change initiative, *"The involvement of the [surgeons] – I mean, that's a much more rare thing. That doesn't happen" (401)*. Regarding this same initiative, another support member expressed the surprise and excitement of nurses, saying it was *"based on their working with a group of physicians who are engaged and wanting to be part of the changes; not just on the sidelines complaining about it" (602)*.

In sum, core members were perceived as having the power to change the system, but little understanding of the people and processes that comprise the system. Whereas support members were perceived as having little power to change the system, but greater understanding of it. Additionally, core members perceived that they worked with their patients to provide the best depth of care to each one, and the system had the potential to harm this endeavor. In contrast, support members perceived that they worked with the system to provide the best breadth of care to all patients, and the surgeons had the potential to harm that endeavor. Together, these different perceptions serve as a backdrop for the different types of enactment toward the system in which members engaged.

As I will now explain, these different types of enactment included defending, bending, and mending. Below, I refer to those that engaged in defending, bending, and mending as Defenders, Benders, and Menders respectively. However, it is not my intent

to suggest that these were organic groups that recognized each other. Instead, these labels were created by me to describe the different categories of enactment that emerged through my analysis.

Defending

Those that engaged in defending tended to view themselves as guards against all of the harmful or unnecessary things that the system may try to impose on their patients. The key distinction between these members as opposed to those who engaged in bending or mending, was that they had relatively little clarity – the concreteness with which they understood – their higher-order (i.e., supra) identity of "patient care." Instead, these members focused on the convergent area of the identities through which they lived out that identity (Figures 2a and 2b). For example, when asked if he considered himself a care provider, a surgeon answered, *"No! [I'm] a physician" (107)*. When asked what the difference was, he replied, *"Right, exactly; so then why call yourself a care provider… This care provider is just like flowery, post-modern crap. It really is" (107)*. Importantly, this same member considered caring for patients as extremely important, even though he could not clearly articulate his "care provider" identity. For example, he also stated, *"That's a very important aspect to this, doing what's right for the patient regardless of how it makes you feel" (107)*. However, he had a hard time explaining what he meant by "this." Similarly, when asked what patient care entailed, a pharmacist, after thinking for a while, described it using fairly vague or generic terms: *"I'd say caring for the patient is a big, huge picture of a lot of people contributing to the care of the patient and [pharmacists are] part of that" (401)*. When asked, again, how this related to patient care he explained, *"I would say I think that I'm a care provider because I am a pharmacist"*

(401). Thus, indicating that being a care provider encompassed his identity as a pharmacist, but still not clearly articulating what being a care provider meant to him.

Insert Figures 2a and 2b about here

In contrast to their descriptions regarding the higher-order identity, members that engaged in defending (hereafter "Defenders") described how they *lived out* their higher-order identity using much clearer descriptions. These descriptions focused on the area of convergence between their role identity and either their relational identity (for core members, Figure 2a) or the system identity (for support members, Figure 2b). As the surgeon above stated, *"A physician is a scientist who takes care of patients" (107)* – a description that clearly incorporates his role and relational identities. Similarly, the pharmacist quoted above also clearly described his role in relation to the system, stating *"My role is predominantly being able to support a team that makes sure that care is happening in the right ways" (401)*. Given the lack of higher-order identity clarity, Defenders shifted their focus of enactment to the area of convergence between identities that were both relatively high in centrality and clarity (see Figures 2a and 2b). As noted, for core members this area of convergence was their role and relational identities whereas for support members it was their role and system identities.

Shifting the focus of enactment resulted in a corresponding shift in the criteria for evaluating all other aspects of the system (i.e., the referent, Figures 2a and 2b). More specifically, other system processes and members were evaluated as either neutral, hindering, or helping the respective areas of convergence for core and support members.

Those system elements that were evaluated as neutral were largely considered irrelevant, and thus ignored. Those elements that were evaluated as hindering their area of convergence were guarded against, and those elements that were evaluated as helping were integrated into the member's conceptualization of their system identity. As I now explain, the shift in enactment focus, and its corresponding shift in evaluation criteria, guided the process by which a member's identity network and enactment toward the system mutually shaped each other in such a way that such members primarily engaged in defending.

As noted, the change initiative that took place during my study focused on increasing alignment between different parts of the system, and standardizing patient care that spanned several system areas (e.g., pain management). In other words, the aim of the change initiative was to achieve higher convergence between the system identity and other identities members held (e.g., higher-order, role). As expressed in the change initiative kickoff meeting presentation, *"[the change initiative] is uniquely multidisciplinary and involves efforts from numerous care providers from the decision to have surgery to discharge from the hospital,"* and more specifically it would not involve *"a coalition of separate teams [or individuals], rather a unified system of teams"* in order to reach a *"shared system of understanding."* Therefore, convergence initiated the enactment processes of members. Hence, I begin with convergence of the system identity in describing each enactment process.

Defending – enactment processes. Because Defenders evaluated each system element based on their respective areas of convergence, and because these areas of convergence differ between core and support members, I will first explain the enactment

processes of core members, and then highlight the differences regarding support members. Importantly, the processes involved are the same. However, the resulting patterns of enactment that emerged differed due to the differences in the identity networks of core and support members described previously.

Due to focusing on their respective areas of convergence, instead of their higher-order (i.e., supra) identity, Defenders did not consider the system as a whole, but only the parts of the system that directly impacted their area of convergence. Indeed, any part of the system that a member perceived as not directly impacting their area of convergence was deemed unimportant (i.e., having low centrality), even if the same member believed it would be good for patients in general, and therefore support their higher-order identity. As one surgeon put it, *"I think that everybody has a role to play. I see my role as helping cure [specialty] cancer. I'm not here to help the patients recover faster; I'm not" (107)*. This is important because it means that part of the system could become highly central, based on how it impacted their area of convergence, while all other parts of the system remained low in centrality.

As noted, centrality determines the primacy of enactment. Therefore, Defenders only felt the need to perform, or be responsible for, behaviors associated with the small part of the system that converged with their role and relational (or system) identities. For example, when asked if he felt responsible for treating a patient's cancer, one surgeon was very quick to respond, *"In regard to the [specialty] cancer, yes. But then if they need like chemotherapy, that stuff is going to be dealt with by medical oncology" (102)*. In this way, the focus on their area of convergence led to a narrowly construed role identity as well in that members only engaged in *and felt responsible for* a limited set of actions that

directly impacted their specific specialty area. Indeed, Defenders' refusal to perform actions outside of their area of convergence was often surprising. For example, after being asked to read approximately one page of general information about the change initiative, one surgeon exclaimed, *"If it's more than a paragraph, odds are I won't read it. Seriously, I won't read it" (change team meeting, 2019.08.15)*.

Similarly, support members only engaged in, and felt responsible for, actions that directly impacted the convergent area between their role and the system. For example, in describing her purpose in attending change team meetings, a nurse stated:

> *When we started it was more physician [driven] and I was more there [just] listening, "Where are we at? Is there anything that's going to impact us?" Speaking up… when we're talking about meds, "Okay, do I have those on my unit? What do I need to get? What's in formulary?" And, then now, [the topic is] more like patient education and nursing. So, more nursing [driven]… I feel like I have a more active role in what's happening with the team now… I feel like I have more to offer, more to say. Before it was just me gleaning information of where they're at with the program… and figuring out how it applies to my unit. (606)*

Hence, the combination of selective centrality of system parts based on the perceived impact to their area of convergence, and a narrowly construed role identity, resulted in Defenders that did not try to change the whole system, but only particular elements of it. Indeed, such members did not really care about changes in the system, as long as it did not impact their area of convergence. As one member put it:

> *I was told to do this [change initiative] because they needed a [specialty] representation. So, I'm doing it from that standpoint. But… do I view myself as somebody who's helping [the change]? No. But [another surgeon] does. [That surgeon] sees herself as somebody who's helping improve [the system]. All the power to her. She finds value in that. So, if she wants to be pushy about her situation, as long as it doesn't super come onto my toes, I'm fine with it. (107)*

Thus, the same combination of selective centrality based on their area of convergence, and a narrow role construal, manifested as an attitude of "live and let live" where they did not seek to impose their practices on anyone else, and expected the same in return.

Given this "live and let live" attitude, it was of little surprise that when others tried to impose changes that required greater convergence with the system, they were largely perceived as hindering the Defender's area of convergence, and thus Defenders felt the need to guard against such changes. However, it was surprising that this defensive mechanism occurred *even if they believed the proposed changes did not cause any harm to their patients*. For example, during one meeting a surgeon introduced the idea of having all patients drink a carbohydrate liquid prior to surgery because: 1) the literature suggested it helped most, and did not harm any, patients; and 2) uniformity across all patients would help reduce system errors. In response, a Defender agreed that it causes no harm, but stated she still will not give the drinks to her patients because, *"every extra step we ask a patient to do something there has to be value to it" (105, change team meeting, 2019.06.25)*. Instances such as these made it appear to other members that Defenders were going against the higher-order identity of patient care, which necessitated putting patients first. As one member explained after observing this phenomenon in a meeting:

> *If the evidence is there, it's not a big deal, just drink the drink, it's not that expensive, it makes [patients] feel better. As long as it makes them feel better then that's the biggest reason [to give patients the drink] and [members] should do it. (101)*

In contrast, Defenders believed they were enacting their higher-order identity, through the convergence between their role and relational (or system) identities, by engaging in such defensive behavior. Instead of having a general attitude that good is the

enemy of great, and therefore one should not be satisfied with just good, Defenders followed the mantra that great is the enemy of good, and therefore one should stop when you've reached "good enough." Indeed, upon asking one surgeon if he had ever heard the latter phrase, he replied, *"Of course; every surgeon has heard of that" (102)*. When then asked if he had ever heard the concept of "good being the enemy of great" he became confused, saying, *"No… Never heard it. I don't know if people use that phrase" (102)*. Thus, Defenders guarded against change as a means of protecting their patients from receiving care that they deemed as unnecessary for their particular patients. As one surgeon noted when explaining her behavior in a meeting:

> *I mean I'm trying to pick my battles in the meeting, but there are certain things that I just find so ridiculous for a [specialty medical procedure], I just can't sit there and let all of this apply to [my] patients. (105)*

Further, even when there was a clear demonstration that a change was beneficial to their patients, because all things were evaluated based on their specific area of convergence, on occasion Defenders still refused to adopt that change. For example, in one meeting a surgeon explained how he had three patients that woke up later than normal and concluded it must be because of the imposed change in the anesthetic drug used during surgery. He then declared to a room full of surgeons that he was not going to use the new drug even though multiple surgeons in the room explained that they had no issues with the drug, and the literature suggests that it is better for patient pain control (launch day training meeting, 2020.02.12).

When I asked a Defender why some surgeons seem to purposely go against the literature and their colleagues, he explained:

> *Behind every idiosyncrasy that we do in surgery there's an f-up somewhere along the road. You f-ed up once. You did that. You're never going to do that again… So think of it this way. Let's say something happens 1% of the time. But the first time you did it, it was that 1%. So, [if] you did it another 99 times after that and you didn't have the problem. But the first time you did it you had that problem. That's going to be your f-up that you will never forget. I mean there was a patient I remember very specifically when I was in residency that basically died; and I feel responsible for how they died. The reality is if you look at the situation he had a [problem] that was misdiagnosed; it took us a few extra hours to figure it out… He had [a] 50% mortality [rate] coming in the door with the surgeon ready to operate. Did the two- or three-hour delay actually lead to his mortality? Only God knows that. So, whenever anybody comes in with [the same symptoms as] what that guy came in with… Believe you me, my first thought every time is this guy's got [the same problem]… that's what happens. And so everybody digs [in] their heels. (107)*

Therefore, because of the focus on their area of convergence, as opposed to their higher-order identity, Defenders sometimes guarded against changes that their literature and colleagues had demonstrated were beneficial to their particular patients. Further, they did so in the name of protecting their patients and hence, in their minds, fighting against something that may actually help their patients was synonymous with providing them with the best care possible.

On occasion, a Defender evaluated some part of the system as potentially helping their area of convergence. Such opportunities were generally presented to them in some manner, rather than being the result of their exploring the system for the purposes of finding new ways of improving their area of convergence. For example, one member had experience using particular medications at a previous institution and wanted to integrate them into his practice at Cancercare. As he put it, "*There's a lot of medications that [are] used in [previous institution] and other places, other hospitals that they use for [this particular change] that we don't have access to" (102)*. However, once some part of the system was evaluated as helping their area of convergence, Defenders did engage in

system exploration for the purposes of figuring out how they could initiate the changes necessary to integrate that part of the system into their area of convergence. Continuing with the previous example, *"[I've] been pushing for [these medications], so if there's anything that I can do, whether it be speak with somebody, present on these different medications in terms of the benefits, I am willing to do that" (102)*. This system exploration resulted in both the expansion of their system identity construal to include additional people and processes, and also greater system identity clarity as they had a more concrete understanding of how the system worked. The greater clarity enabled the member to then shift their focus of enactment to these newly discovered parts of the system in an attempt to further integrate them with their area of convergence. In our example, after being rejected several times, the surgeon eventually learned of other pharmacy members that had more authority than those with whom he had been dealing. Therefore, when he ran into them in one of the change team meetings, he brought up the possibility of access to the drug again (informatics training meeting, 2020.01.29). Such change efforts were made possible by the additional clarity provided by other system members and focused on long-term changes in a particular system process or personnel. For example, during one meeting a pharmacist learned that the other system members were using many different medications for managing pain. As this particular system process was important to his area of convergence, he attempted to change it by saying, *"How would the group here feel about more standardly using Gabapentin [for preoperative pain management]?" (401)*. He then led a discussion that was ultimately successful in changing the process of preoperative pain medication (change team meeting, 2019.07.11).

Importantly, the process of widening their construal and improving the clarity of their system identity was focused on the parts of the system evaluated as helping their area of convergence. This, combined with the low centrality, and subsequent ignoring, of the parts of the system that had no impact on their area of convergence, meant that only the parts of the system that were integrated – or the member desired to be integrated – with their area of convergence formed the system identity. Therefore, in general, such members had a narrow construal of the system identity as compared to other system members. This, combined with their narrow construal of their role identity, meant that in most cases Defenders did not engage in system exploration on their own. Indeed, in all of the change team meetings, Defenders were the least likely to seek information from others about the system (e.g., 2019.07.11, 2019.08.06, 2019.10.24). The lack of exploration and expansion of their system identity meant that discovering additional areas of convergence with the system identity were minimal, and only occurred when other system members presented the opportunity. Indeed, the mere possibility that others could help them progress often came as quite a surprise to Defenders. For example, a Defender believed his practice was much more advanced than that of all the other surgeons, only to find out in one meeting that he was well behind them when it came to pain management. As he later explained, *"I thought there were some dinosaurs in the room, and I proved to be the dinosaur… [They were] like yeah, 'Are you calling me a dinosaur?' [and I was like] 'No, no, you're not a dinosaur. [I am]'" (107)*. Hence, the very people that were most skeptical of others proposing changes were the ones who most needed others to do exactly that if they wanted to progress in their practice.

In sum, Defenders lacked clarity in their higher-order (i.e., supra) identity. This lack of clarity shifted Defenders' focus of enactment and evaluation from their higher-order identity to the area of convergence between the next two most central identities that *was* high in clarity. For core members, this was the convergent area between their role and relational identities, and for support members it was the area between their role and system identities. The process of enactment involved evaluating the system elements being pushed by the change initiative, based on how they would impact the area of convergence if integrated. Because the primacy of their area of convergence also resulted in a narrow construal of their role identity, Defenders only performed, and felt responsible for, actions associated with their specific areas of convergence. Therefore, most system elements were evaluated as unimportant and either ignored or, if being pushed by the change initiative, guarded against. For the few system elements evaluated as helping Defenders' area of convergence, Defenders attempted to initiate change and integrate those areas into their area of convergence. In doing so, they gained more clarity regarding those specific system elements, and only those elements were considered central. Hence, they formed a narrow construal of the system identity as well. The narrow construal of their role and system identities, combined with all other system elements being low in clarity and centrality, resulted in Defenders engaging in very little system exploration in order to gain more clarity. Therefore, the majority of enactment from Defenders involved guarding against what they perceived as unnecessary system integration, even if such integration was largely considered beneficial to patients. When their enactment did involve system improvement, they focused only on a specific process or personnel improvement, and did not try to change the entire system.

Defending: Core vs. support. Although both core and support Defenders experienced a shift in focus from their higher-order identity to the area of convergence between identities that were both high in centrality and clarity, as noted, what that area of convergence consisted of was different. For core members, it was the area of convergence between their role and relational identities (see Figure 2a). Further, and also previously noted, core members had a narrow construal of their higher-order and relational identities, which resulted in an emphasis on providing depth of care to their specific patients. Therefore, they viewed system elements that were focused on providing the same type of care to all patients as either unimportant or a hindrance to their area of convergence. When viewed as unimportant, core Defenders largely accepted standardization of such elements. For example, in commenting on discussions in a recent change team meeting, one surgeon stated:

> *How much… IV fluid, how much pain meds – I literally don't give a care. So, if somebody tells me that some data shows that Toradol is fine and not causing bleeding, fine, I'll try it. And… I've noticed people being super opinionated [in the meetings]. It's like, "No. We give our patients this." Okay, fine, then give your patients this. I mean I think this is a practice that isn't actually going to [impact my patients]. [laughs] (107)*

However, when viewed as a potential hindrance, core Defenders guarded against standardization. For example, regarding a standardized fasting schedule before surgery, one surgeon explained:

> *I think some of the stuff, particularly a lot of the preoperative stuff in terms of like when they should fast, when they take this high caloric intake drink – to be honest, I think sometimes it's kind of complicated and cumbersome. I mean how much is that really going to help the patient?... It's like some of these patients are older, you know. They forget things. I mean sometimes even though you feel like "oh, this nutritional stuff is better"... I feel [when] talking to a patient in the clinic, like there's no way. I'll just be happy if this guy shows up for surgery. I*

> *don't really think I'm going to bombard him with the "drink this at this time; drink this at that time." (102)*

In contrast, support Defenders' area of convergence consisted of their role and system identities, and they had a broad construal of their higher-order and relational identities (Figure 2b). Therefore, they emphasized providing breadth of care to all patients and, in turn, viewed system elements that provided different types of care for the same procedure as rogue elements, and a hindrance to their area of convergence. As one member put it:

> *Overall, the standard is that something gets prepared safely and correctly, and it gets checked safely and correctly, and then it gets delivered to where it needs to be… And so now you have some surgeons that want you to have something ready for them; other surgeons that want you to wait until they call for it; some surgeons that don't even want something altogether and other surgeons that have to have it every time when it comes to a certain [medication mixture]. And if it's something that you're making that takes a lot of effort and there are surgeons that do the exact same case and don't need this, you have to manage frustrations with why do we have to do all this extra work for this doctor when this doctor does the exact same cases, sees the same patients, but they decide they don't need it? So why does this person need it? (401)*

He went on to explain how he tries to prevent such variance in the system. Hence, support Defenders guarded against what they considered an unnecessary lack of standardization.

Impact of enactment on Defenders. Interestingly, the main goal of both core and support Defenders in their enactment toward the system was to guard against that which may hinder their area of convergence. Indeed, they often used almost the same argument in explaining this. For example, when a core member was asked if he had been a good representative of his specialty area, he stated, *"I feel that I've represented [my specialty] fairly well in terms of making sure that we got the things that we wanted… and fought*

against some of the things that we didn't want in regard to [the change initiative]" (102). Similarly, a support member, when asked the same question, stated, *"I think, from [my area's] standpoint, [it's] really, 'Is the [change initiative] progressing in a direction that we're going to be happy with, that it will align well with what we want to do?'" (401)*. Hence, it was only the differences in their identity networks that resulted in one guarding against standardization and the other guarding against a lack thereof (Figures 2a and 2b). As a result, both core and support Defenders were enacting their identity networks in the name of providing patients the best care possible (i.e., their higher-order identity). As a nurse explained regarding the value of standardization:

> *One of the biggest things is going to be [that] you have whole service lines where the providers are doing consistently the same kind of care… You don't have to worry about four different [specialty] doctors doing things four different ways. If you have [specialty] patients, this is your pathway. I think that's really going to have a big impact… The nurses are going to be like 100% confident in what care they're giving to that patient… It's not dependent on the doctor. Why would you treat patients differently if they're having the same surgery and different surgeons? (606)*

In contrast, a surgeon explained, regarding increased standardization:

> *In the beginning, I would've not necessarily thought [attending change team meetings] was as important because there are so few components that [my specialty] patients need, truly. And now I'm seeing it as our [specialty] patients who need so few things are getting stacked with more and more and more stuff [due to standardization], and I don't know how to stop that train. So, I mean I'm trying. (105)*

As these quotes suggest, though enactment for both core and support Defenders was done in the belief that it would improve patient care, the outcomes of each one's enactment were perceived as a threat to the higher-order identity of the other.

Bending

As opposed to defending their patients against potential "evils" within the system, those that engaged primarily in bending (henceforth, "Benders") saw themselves as masters of the system, and therefore repeatedly attempted to bend it to fulfill the specific needs of each individual patient. Regarding their identity network, the key distinctions between these members and others was that, for both core and support members: 1) their system identity was more convergent with their higher-order (i.e., supra) identity; and 2) their role identity was broadly construed (Figures 3a and 3b).

Insert Figures 3a and 3b about here

As previously explained, Cancercare leadership pushed the idea that the system existed in order to provide individualized care to each patient. Because Benders' system identities were more convergent with their higher-order identity than other members, they saw such individualized care as synonymous with their higher-order identity. For example, when speaking about why system members should work together, one nurse stated, *"And really, it is for the patient if you think about it. We're talking about medications and all of this, but really our one goal is to improve* that patient's *life" (607)*. For core members, this conceptualization of their system identity combined with their narrow higher-order identity construal to result in the belief that they were responsible for directly providing individualized care to each patient. As one surgeon explained, *"As a surgeon, you're… responsible for the patient. So, if something's going wrong, it's up to you to fix it. [You have to] figure it out" (113)*. For support members, the system identity

was convergent with a broad conceptualization of their higher-order identity, which targeted providing the best possible care to all patients. Therefore, support Benders believed that the best way to care for all patients was to help multiple surgeons provide individualized care to their specific patients. For example, when asked how she cares for patients, a nurse explained:

> *The nurse is the one, first of all, that has to answer all the patient's questions when [surgeons are] not here, and second of all [surgeons] can't see the patient [all the time]. Obviously, if I'm talking to [a surgeon] on the phone and I had to call [them], [they're] obviously not here and [the surgeons] can't see [the patient] so I'm [their] eyes and ears. I'm [their]assessment tool. And we have to have that mutual respect and honor and just say, "Okay, I hear what you're saying. I'm not going to order anything right now. If it gets to this point then call me again." You know that kind of thing. Just give me some flat out – give me some orders, some instructions and we'll go from there. (608)*

Thus, all Benders believed that depth of care was the ultimate goal, and such individualized care flowed through the surgeon. Support Benders accomplished this goal indirectly by enabling multiple surgeons to provide individualized care to each of their specific patients. In this manner, support Benders focused on breadth of care in order to enable depth of care.

Because of the belief that all patient care flowed from the system, through the surgeon, to the patient, Benders felt responsible for their respective parts in this flow. For example, a support member, when explaining her behavior in a meeting, noted:

> *As you noticed about that meeting, like, even [this surgeon] got up to ask me, like, "Do we have this product or this product?" And I told her, "We have this product." [And then] she would have the clinical knowledge to speak to it after I verified what inventory we have. And that's kind of the role that a [nurse] plays, anyway. [Surgeons are] the painter – they're the artists. We provide them with the paint and the art supplies. (605)*

As another example, a core member explained, *"[Surgeons are] still captain of the ship… whatever happens, Anesthesia kills the patient, and Nursing does [a] miscount [of instruments so] we leave something in [the patient]. Yeah. No matter what happens… it's our patient, our death" (113)*. Therefore, core Benders felt responsible for everything that happened to the patient, and support Benders felt responsible for getting core members all of the things they needed to care for each patient. In both cases, this constituted an extremely broad set of actions.

In addition to feeling responsible for the broad spectrum of care that patients received, Benders also felt empowered by the system to provide this care. Because of the relatively high convergence between the system and higher-order identities, Benders viewed the majority of system elements as having the potential to contribute to patient care. Therefore, the system was something to be embraced and used to deliver individualized patient care. For example, a surgeon explained how he even directed other surgeons within the system to care for his patient:

> *So, I've got this case, and I'm gonna have G.Y.N. Oncology come in, and they're gonna do their thing, which is [to] take out [the] uterus and ovaries. And I've got the urologist coming in. They're gonna put in stents. So, yeah. Putting a team together that way, among specialists, happens. And that's kinda the cool part… If it's my patient, I'm gonna go, "Okay. Well, this is what we need from you guys, and then [this is what we need from] you guys." (113)*

As previously explained, support members had high convergence between their role and system identities, and also had highly central system identities that emphasized depth of care. Therefore, support Benders' system identity empowered them to perform their role by engaging whatever system elements were necessary to support surgeons. As one Bender explained:

> *So, if a doctor wants to be able to have - I'm just going to make an extreme [example] – an antibiotic, every hour, on the hour – nurses need to be able to provide that for them. So, how do you make that happen? You need to have the real estate. You need to have the education. You need to make sure that the nurses know where to go. It's like supply-chain management. I think there's a branch in the military that does that. They focus on, "How do I make sure the troops are fed and warm?" It's kind of the same thing. The doctor has a wish that they know is going to be great for their patient. How do I make sure that they can accomplish that wish? (605)*

Also previously noted, core members were empowered by the system based on their ability to provide individualized care. However, unlike most core members, Benders at least somewhat embraced this power due to how they construed their relational identity with the patient. Benders, more than Defenders or Menders, viewed the patient as an important, but relatively helpless, participant in their relationship. Therefore, it was up to the Benders to protect patients from anything that may harm them by using some of the power granted to them by the system. Further, this view of their relational identity was largely due to the differences in medical knowledge, with the surgeon role conveying much more knowledge than the patient role. As one Bender replied when asked what made him different from other care providers:

> *I think it's being a surgeon. I think [because I'm a surgeon] patients have to – I feel the patient will put a lot more trust in me because what I'm doing is very invasive and they have to feel comfortable with the relationship that we have. And usually that's only established within the first meeting and then you're setting somebody up for surgery. So, you have to develop trust; you have to develop confidence so there's a lot that goes in that to get somebody into the operating room. (106)*

Hence, core Benders saw no difference between the system supporting the patient and the system supporting their role identity. In essence, the surgeon's role identity became a proxy for patient care. Indeed, to Benders, the patient played a relatively minor part in their own care. This was made clear during an observation of a faculty meeting in

which multiple surgeons discussed whether or not they should tell their patients that they often do not perform parts of the surgery, but instead let their Physician's Assistant do it. Benders' arguments for not telling the patient was simply that the patient did not need to know (faculty meeting, 2019.05.14). Because the patient was the center of the system, and the surgeon was the proxy for the patient, then to Benders, the surgeon was the point through which all medical care flowed, and the system was the equivalent of a set of tools for the surgeon to use in providing that care. Thus, Benders felt responsible for either giving or enabling all care the patient received and also felt they had the power to perform all actions associated with giving or enabling care. In other words, Benders broadly construed their role identity.

Bending – enactment processes. As noted, the aim of the change initiative was to achieve higher convergence between the system identity and the other identities members held. Due to the high convergence that already existed between Benders' system and higher-order (i.e., supra) identities, they largely saw the change initiative as unnecessary. As a nurse explained:

> *And then the [proposed changes] are just the general things that we usually already do; getting patients up, getting them started off IV fluids and eating and drinking as soon as possible. Trying to get all those things, all those pieces started. We already do a lot of that stuff. (608)*

However, as previously explained, Benders viewed the system as a set of potential resources for individualized patient care. Further, Benders believed that patient care was an art. For example, one surgeon stated, *"So, you take 10 people, and you do the same thing, and you're gonna have 10 different results. So, that's why [it's] art, not science, [that] we practice, [medicine is] an art… two plus two often equals six" (113).*

Therefore, each patient may require a different set of system resources, and it was impossible to predict which of those resources would be important for any particular patient. Thus, unlike Defenders, Benders believed that the entire system was important. For example, as a nurse explained:

> *Those are my doctors and those are my anesthesia providers… I [don't always work with them] because it depends on their caseload… [But] we're all here for the patients. And it's not like we are working on different projects. I mean, there are different cases and different patients. But our ultimate goal is excellent patient care… Surgeons, or anesthesia providers, or pharmacists… we are a team. (605)*

Hence, the centrality of Benders' system identity was based on the system's *potential* to support their higher-order identity of caring for patients. This resulted in the system identity centrality for both core and support Benders being higher than their Defender and Mender counterparts. The relatively high centrality of their system identity, combined with the broad construal of their role identity, led Benders to feel responsible for the few parts of the system that did not already converge with their high-order identity. Indeed, the felt responsibility of Benders even extended beyond the system. As a surgeon put it, *"Well, you take an oath, and you're committed to a patient, which means, if there's an assault, meaning from whatever, could be government, health insurance plans… you've got the back of a patient" (113)*.

At the same time that Benders felt responsible for addressing the parts of the system that did not converge with their higher-order identity, as noted, they also felt as though they could manipulate the system for the purposes of providing individualized patient care. Thus, instead of trying to address this lack of convergence by changing a specific part of the system, like Defenders, or changing the system as a whole, they

simply assumed that whenever they needed that part of the system they could "bend" it to their will. In fact, even the idea that the system would not bend to their wishes was foreign to Benders. For example, when asked if he had concerns that some parts of the system (e.g., nutrition, nurses, other doctors) would not carry out his wishes when he was not around, a surgeon seemed confused and replied:

> *I have no concerns… as a surgeon who takes care of these patients, it's my patient. I can tell [others in the system] what I want and how I want it… so I don't have any concerns because it's ultimately my decision as I'm taking care of the patient. (106)*

Further, the idea that Benders could control the system was supported by many other parts of the system. For example, regarding the relationship between nurses and surgeons, one nurse stated, *"So, the doc dictates the care, and then, the nurse executes on it" (605)*. Therefore, even when a discrepancy between the system and their higher-order identity was noticed, Benders still felt little need to change the system in addressing it because they could simply bend those parts of the system to their will when necessary. This was obvious during a change team meeting in which some surgeons were complaining about how nurses do a particular procedure. While most seemed interested in changing the procedure, the Benders simply explained how they do not worry about the process because they just tell each nurse they work with how they like it done. It was telling that the Benders never sought the opinion of the nurses who were sitting in the room at that time (change team meeting, 2019.08.15).

The lack of a felt need to change system personnel or processes enabled Benders to continue to focus solely on providing individualized care to each patient. Hence, when Benders engaged in system exploration it was for the purposes of discovering new tools

they could bend to their will, and not for changing system processes or personnel. For example, in a change team meeting, the idea emerged of warming the patient prior to surgery. While most members focused on integrating a new process using specialized equipment in the system, Benders talked about what was already being done (e.g., electric blankets, warm IV fluids). They viewed the new equipment as one of many tools and saw no need to create a new system process to standardize its use. Instead, they suggested using what the surgeon believes would work best for each specific patient (change team meeting, 2019.08.06). Indeed, as Benders encountered new system elements, either through the change initiative or simply through encountering new aspects of the system, they simply broadened the construal of their role identity to include directing these new areas of the system as well. For example, when speaking about learning what the system can provide, one Bender explained, *"Over time, you get to know what you need [from the system] and when you need it. And they've got things called the Preference Cards, so they know what you need. And it's all professional. And [the system knowing your preferences is] for the benefit of the patient" (113)*. Hence, even if the clarity of their system identity increased, it did not prompt an increase in system identity centrality or a shift in the focus of their enactment. Nor did it identify processes or personnel within the system that they felt the need to integrate more fully into their higher-order identity. In other words, particular elements of the system being more or less integrated into their higher-order identity was not a major issue one way or another for Benders. Somewhat counterintuitively, those that considered themselves the masters of the system displayed indifference toward it, and neither attempted to improve system processes nor resisted the majority of proposed system changes. Benders believed that no

matter what processes and personnel the system was composed of, they would be able to bend them to their will. Therefore, to them, changes in the system did not hinder their ability to care for their patients. Thus, they were often willing to appease other system members by at least trying a change. As a Bender explained:

> *[My] patients go home, they're getting back to work, they don't have any pain, and where is the benefit for this [change] to my patient? I've questioned some things where I wasn't sure… "How is it going to impact my patients and the outcomes of my patients?" And I've acquiesced on a few things and said "fine, I'm willing to try"… There's nothing I've said "absolutely not" to. (106)*

Though changes that aimed to increase the convergence between the system identity and their higher-order identity were not overly important to Benders, the ability to practice the "art" of medicine by bending the system to their will for each particular patient was incredibly important as it was the key to providing depth of care to patients. For example, a Bender explained how interactions with system members resulted in better patient care:

> *The good [system members]… they're right with you, what sutures, needles. They anticipate… The person helping me, which is the PA, or the Scrub… whatever the experience level. And the more experience, obviously, the better, because then, they – they know what you want. They've seen the operation forever. They've seen [it] done different ways, so they just wanna know, "How do you like it?" (113)*

As noted, Benders believed that individualized patient care flowed through their role identity, and when the system changed, or new system elements were discovered, they expanded their role identity to include such elements. In doing so, they increased the convergence between their role and system identities. However, directionality mattered. While Benders were okay with coopting part of the system into their role identity in order to bend the system to their will, it was decidedly not okay for the system to coopt part of the *Bender's* role identity in order to bend it to the system. In this setting, such system

and role identity convergence took the form of a push for greater standardization, and it was either resisted or simply ignored. For example, when asked about the possibility of greater standardization, a nurse explained, *"Each surgeon [has] to individualize, you know, each care plan for each patient. So, it would be lovely if it were all, every patient we do [the same things], but that's probably not gonna happen… ever" (604)*. As another example, when asked to standardize specific procedures between surgeons, even in the same specialty, Benders resisted doing so. Eventually, this led to the consultant leading the change to exclaim, *"I [still] don't have information [regarding the standardized procedures] from [these individuals]" (805)*. All of the individuals were Benders, and the information was more than two months past due (change team meeting, 2019.10.24). Hence, while Benders were relatively indifferent when it came to system changes, in this one area they were intractable. As one surgeon explained when describing the level of standardization he hoped to achieve:

> *I think, even if the Leadership Team felt very strongly that we need to [be] very consistent and highly standardized and highly consistent – but we decided, for now, to build it not quite as tight as we want… Okay. So… flexibility is built in the [change initiative that], I think, again, will make this less standardized than we'd want, or that some may want. But, on the other hand, you get better buy-in and all that. (103)*

In explaining who were those that needed less standardization to achieve better buy-in, the majority of those mentioned by the consultant and the surgeon quoted above were Benders.

To summarize, both core and support Benders had higher convergence between their system and higher-order (i.e., supra) identities than their Defending and Mending counterparts. As such, Benders viewed the system as a set of tools that could be drawn

upon to provide individualized care to each patient. The combination of this convergence and their construal of their higher-order identity led Benders to believe that all care flowed through core members, and the job of support members was to engage the system to ensure that the flow of individualized care occurred for all patients. Thus, Benders broadly construed their role identities in that they felt responsible for, and also felt they had the ability to perform, whatever actions were necessary to deliver depth of care to each patient. Regarding enactment processes, having broadly construed role identities translated into Benders viewing the change initiative as unnecessary. They did not need more convergence between their higher-order identity and the system because there already was relatively high convergence, and the areas of the system that were discrepant could be "bent" to their will when needed. Therefore, there was no need to change system processes or personnel to improve patient care. In turn, Benders did not engage in system exploration for the purposes of making such changes. However, when new system elements were discovered, Benders simply expanded the construal of their role identity to include control over those elements as well. In doing so, they integrated them into their higher-order identity and consequently did not view them as discrepant; reinforcing the perception that change was not necessary. Interestingly, their broadly construed role identities also meant that Benders were generally indifferent toward system change as no matter what form the system took, they could still bend it to their will. Thus, Benders often accepted proposed changes aimed at integrating the system and higher-order identities as a means of appeasing other system members. However, for both core and support Benders, any changes that limited the autonomy of core members was viewed as a hindrance to caring for patients and was therefore resisted or simply ignored.

Bending: Core vs. support. As noted, both core and support Benders believed in providing depth of care to patients. However, while core Benders focused on providing depth of care to specific patients, support Benders focused on enabling that depth of care by doing what was necessary to enable core members to deliver it. Indeed, support members embraced their enabling role as they had no desire to actually be a core member. As one nurse explained:

> *I didn't want to be a doctor because I don't like to have the - if someone's going to die, I don't want to be the one responsible for trying to prolong that life. I don't want that responsibility. So, I like to help… but I don't like the authority. (605)*

Impact of enactment on Benders. As previously explained, for Benders, enacting the combination of their higher-order, role, and either relational (core) or system (support) identities meant providing individualized care to each patient. However, in their view, it was not possible to provide such depth of care unless core members had large amounts of autonomy. Therefore, Benders exercised autonomy to provide depth of care, even when such individualized care went against the prevailing thought in that area. In explaining why he sometimes doesn't follow what others consider standard procedures, one Bender stated:

> *So one of the things was the use of drains. And I said I "use my drains in all of my [specialized procedures]" and… a study was shown to me that said "oh, drains are looked down upon. That shouldn't be used because it doesn't prevent any [problematic] issues." And I said "but I'm not using it for that indication. My drains are for a different indication, which I think is worthwhile and the right indication for this procedure." So [I] just kind of tailor it a little bit more to what I'm doing as opposed what the data says, because if you just look at the hard data, I don't think it's the outcome that I'm looking for, for my patients. (106)*

Unlike Defenders, where core members resisted while support members promoted greater standardization, *both* core and support Benders resisted or ignored any changes

that would increase standardization among surgeons. Such standardization went against both their higher-order and system identities, which focused on indirectly enabling (support) or directly providing (core) depth of care to each specific patient (see Figures 3a and 3b). Indeed, when asked about following the data as a way of achieving standardization, a nurse explained:

> *The data has to get to a certain point. And then after that, the data stops. And so then, you have to figure out, well, I don't have data. So, how am I supposed to make this decision? And there's always going to be gray. Like, people like to believe that they understand everything about the body, but we don't. And we like to understand everything that's going on in the patient, but we don't. So, [if I were a surgeon, and] I was responsible for the livelihood and the medical health and well-being of this patient, I need to go with what I personally believe would be best. And that may, in the end, become a gut decision. But I think that, knowing that data is so helpful, that these surgeons are doing their best to try to get to that point. And then when the data fails them, or the data's been exhausted or there's nothing on it, then they're taking that responsibility very seriously and that's why [medicine is] a lot of feeling. (605)*

The idea that practicing medicine involves a lot of "gut feeling" or is an "art" was a prevailing theme among Benders. This view came from a combination of the centrality, convergence, and construal of their higher-order, role, relational, and system identities. For Benders, enacting their identity network meant providing depth of care for each patient. Due to the wide variety of medical issues patients may have, having the autonomy to bend the system in unique ways for a particular patient was critical. Therefore, Benders resisted or ignored any attempt to standardize their practice, as it was seen as a threat to their ability to care for patients (i.e., their higher-order identity, Figures 3a and 3b).

Mending

While Defenders sought to guard against specific system processes or personnel, and Benders sought to control individuals within the system, those that engaged in mending (henceforth, Menders) sought to better integrate the system with their higher-order (i.e., supra) identity. The key distinctions in the identity network of Menders were that they had a multifaceted construal of both their higher-order and role identities in that they both broadly *and* narrowly construed these identities (Figures 4a and 4b). Their higher-order identity encompassed both depth of care (narrow construal) and breadth of care (broad construal). Similarly, their role identity involved feeling responsible for a broad set of behaviors (broad construal) while also feeling like they had the ability to perform a relatively narrow set of behaviors (narrow construal). The combination of multifaceted higher-order and role identity construal led to a desire to "mend" any perceived gaps (i.e., lack of convergence) between their system and higher-order identities, as well as to continual frustration because they believed they could not accomplish this mending on their own.

Insert Figures 4a and 4b about here

Menders, like Benders, had a higher-order identity that was relatively high in centrality and clarity. For example, in explaining why he cares for patients, a Mender told this story:

> *Cancer is a little bit of a soft spot for me… As a [young] child… my Mom was diagnosed with cancer. [A little while later] my Mom passed away from that disease. So as a boy who lost his mother at a very young age [that] had a lot of*

> *impact… This is kind of my opportunity to give back to people who are going through that same process. People who are vulnerable, scared, frightened, don't know what the future holds for them, and this gives us an opportunity to give them something to hold on to, to hope for, grasp on to and more importantly, maybe alleviate and lessen a little bit of their stress in life. That way they can kind of hopefully continue with somewhat of a normal lifestyle, you know. Whether they have a terminal illness that's going to take their life or curative where they'll be able to get back to normal life all together. So, this is an opportunity for me to kind of give back and relieve suffering that maybe my family and I didn't have the luxury when I was younger… That's why I'm doing it. I need to pay back some of those cancer patients that suffered like my mother. (202)*

However, unlike Benders that had either a narrow construal (core) or broad construal (support) of their higher-order identity, Menders had a multifaceted construal of this identity. As a core Mender explained:

> *Or maybe we were all brought to the table as negotiating for our own specialty, rather than figuring out the best way for all of our patients to be taken care of. Yes. I think that's how we were all brought to the table, as negotiating for our own specialty rather than, "How do we make this pathway as smooth as we can for all of our patients?" And take advantage of the fact that, while [my partner] and I could do everything we want, if we do things very different than everyone else, nobody else is benefiting from what we build. But if we all build it together, all of our patients are gonna benefit. (109)*

As another example, in explaining his perception of challenges to the change initiative, a support Mender stated:

> *I think the immediate challenge is… what are the key elements that are important for every patient and what are the key elements that are specific for certain patients, and how do [we] identify those certain patients and define that? (602)*

This multifaceted construal was the result of previous "identity jolts," which are events that alter the way in which someone construes an identity (Wellman, 2017: 610). Such jolts caused Menders to shift their focus from *either* depth or breadth of care to *both* depth and breadth. In doing so, Menders realized that the two different approaches to

patient care are not mutually exclusive, but instead, are dependent upon each other to provide the best possible care to patients.

For core Menders, the shift in their higher-order identity construal most often began with their inability to care for a patient with the depth required by their higher-order identity. As a surgeon explained:

> *You just feel defeated. You can't be professionally fulfilled. I wanna be the best doctor I can be, but [the system is] putting me in, essentially, a clinic that's filled with water [laughs]. You know? It's almost like an underwater clinic. How can I [provide depth of care], when everything I do [involving the system] is hard? (109)*

These types of difficulties in caring for patients led Menders to the realization that they were dependent upon the system to enact their higher-order identity. More specifically, core Menders realized that to provide depth of care to their patients they needed the system to provide the best possible breadth of care to all patients. For example, after a change team meeting, a core Mender was asked by another system member why some surgeons were resisting changes in breadth of care, to which she replied, *"We need to get the message across that [standardized breadth of care] is in the patient's best interest. That it has nothing to do with our abilities as surgeons. It's for our patients' own good" (101, change team meeting, 2019.09.26).* As another example, a core Mender explained how depth of care for his patients would improve with improvement in breadth of care:

> *The other very important thing about this place is that… failure to rescue is a problem… and very critical to [achieving] great outcomes in complex surgical cases [is] identification of a patient that's deviating from the norm. And, if everyone is doing everything differently, based on the phase of the moon, then, it's very difficult for anyone, let alone the staff nurse, to know whether a patient is behaving or having a condition that is a deviation of the standard [and therefore in need of rescue]. (103)*

Thus, Menders expanded the construal of their higher-order identity to include both depth and breadth of care (i.e., multifaceted).

As noted, the combination of high centrality and convergence between core system members' higher-order, role, and relational identities, as well as the narrow construal of their relational identities, meant that they felt responsible for all of the behaviors necessary for providing depth of care to each patient. This core member identity network, when combined with the multifaceted construal of core Menders' higher-order identity, resulted in them feeling responsible for ensuring that adequate breadth of care was provided by the system as well. For example, in one core Mender's office, there was paper that covered an entire wall with outlines for initiatives aimed at improving the system even though such work did not help her in any way. As she later explained, the time spent trying to improve the system actually cost her money because it took time away from performing surgeries, for which she earns a certain amount for each one and is evaluated by Cancercare for how many she performs in a given time period *(109 interview, 2019.11.21)*.

At the same time, however, the lack of clarity regarding their system identity prevented them from being able to perform all of the actions necessary to ensure the system provided such care. For example, in a change team meeting, a Mender explained:

> *If we don't get nursing [educated on the changes] – all of the nurses that are going to touch our patients from preop to postop – you're going to get someone that says, "Why are they making these changes?" And it's just a downward spiral from there. (109, change team meeting 2019.09.26)*

However, educating nurses, and thereby ensuring that patient care improved, was no easy task due to her lack of clarity regarding the system. As the same Mender went on to

express, *"[Patient education nurses] could pass me in the hall and I would have no idea" (109, change team meeting 2019.09.26)*. Therefore, core Menders had a multifaceted construal of their role identity in that they felt responsible for a broad set of behaviors, but only felt that they could perform a narrow set of actions.

Similar to core Menders, support Menders also experienced a shift in their higher-order identity construal by realizing that depth and breadth of care were intimately linked. As one support Mender explained in a change team meeting after asking for as much standardization as possible, *"It's going to simplify for my little brain so we can be consistent. If we can get it consistent, then I can get my people to do it" (202, change team meeting 2019.06.25)*. The subject came up again in the following meeting, prompting the same Mender to state, *"If you guys can get consensus as to what the [surgeons] in your [specialty] need, then we can provide you exactly what you want" (202, change team meeting 2019.07.11)*. In other words, the Mender requested consistency regarding breadth of care so that he and other support Menders could better support the depth of care being provided by core system members. The realization regarding the interdependencies between breadth and depth of care was most often preceded by a change in position that expanded support Menders' perception of the system. For example, the Mender quoted above had just started working with Cancercare in his position. As another example, after taking a lead role in his department, another support Mender explained how he preferred standardized breadth of care as it reduces errors in patient care. However, he then went on to state:

> *But at the same time, I expect the nurse to use their judgment and… if someone's coming for a liver resection maybe look at certain things [like] was blood ordered? I don't expect them to go and wonder if blood was ordered for someone*

> *coming in for minor breast biopsy. But if it's a bigger case they should be using their critical judgment for that... But then if on Monday, Dr. "A" orders blood in this preop lab for this liver case on Tuesday, I'm hopeful that Dr. "B" has that same protocol, and the next doctor – for that specific [type of surgery] but not for all surgeries in general. (602)*

In this way, identity jolts that caused support Menders to expand their conceptualization of the system often led to the realization that providing breadth of care was only part of the overall process of caring for patients, and depth of care was needed as well. Hence, support Menders developed a multifaceted construal of their higher-order identity which included focusing on both breadth and depth of care.

As noted, support system members had higher-order, role, and system identities that were relatively high in both centrality and convergence. Therefore, support members felt responsible for enacting their higher-order identity by engaging in behaviors that also improved the system. Further, because of the multifaceted construal of their higher-order identity, for support Menders improving the system meant improving both breadth and depth of care within the system. Also previously explained, support members had greater clarity regarding the system and thus had a better understanding of how to improve it but lacked the power to make lasting change. Indeed, support Menders often attempted to improve the system, but such initiatives frequently failed. As one support Mender explained:

> *You know, a lot of times people won't object. "Yeah, it's fine" because in their mind, they think, "This project's gonna fail." You know? Because there's been so many projects… Everybody has great ideas, but who executes it? Nobody. And then it never goes anywhere. (202)*

Hence, support Menders, like core Menders, felt as though they could not perform all the actions necessary to meet their responsibilities. As a support Mender explained regarding progress brought about by the change initiative:

> *I still think it's amazing that you can get all these people to facilitate this one project. I think it's awesome. I would have never in a million years [thought that was possible] — I'm just impressed. I mean… you're working with pharmacy, with anesthesia, with nursing in the clinic, with nursing in the hospital, with [Physician's Assistants, and with] surgeons… This is an undertaking. It's exciting to see. It's, you know, it's progression. (301)*

Hence, like core Menders, support Menders also had a multifaceted construal of their role identities in that they felt responsible for improving the system but did not have the ability to do so.

Mending – enactment processes. The combination of a multifaceted higher-order and multifaceted role identity resulted in Menders being almost continually frustrated with their enactment processes. As noted, their multifaceted higher-order identity came with the realization that the entire system was important for delivering depth and breadth of care as the two were interdependent. Thus, Menders engaged in exploration of the system and, in doing so, discovered areas that were not convergent with their higher-order identity. For example, when asked about previous change efforts, one Mender responded, *"We've tried to implement [changes] in [my specialty] but [discovered] we can't do it completely because things aren't in order. Meds aren't there or the team at the hospital doesn't understand. There are so many barriers" (301)*. Because of the importance of delivering both depth and breadth of care derived from a multifaceted higher-order identity, Menders also developed a multifaceted role identity. This involved the belief that it was their responsibility to fix the lack of convergence

between the system and their higher-order identity and, at the same time, the belief that their role did not include performing the actions required to achieve this convergence. As one Mender explained:

> *I want to give excellent care, the best excellent care to every patient, but, at some point, I have to let go. Accept I can't do anything about the financial stuff. Accept I can't do anything about how your insurance is gonna deny the CT scan that I think you should have. Accept I can't do anything about the fact that the nurse in the hospital called the wrong doctor, and… unless you have the same goal amongst the whole hospital system, that, "Hey, we identified this thing. We're gonna make it better." You have to sort of limit what you think excellent care is, because… less and less of it is under your control. And I guess that's sad, but it's sort of true. (109)*

Thus, Menders were often caught in a cycle of feeling responsible for doing everything necessary for delivering both depth and breadth of care, but experiencing frustration because their role did not include performing all of the actions necessary to do so. The result was feelings of helplessness or being "stuck" in their attempts at change.

As previously explained, the purpose of the change initiative was to increase convergence between the system and other identities (e.g., higher-order identity), and one way it sought to accomplish this was by creating a change team comprised of representatives from each part of the system. For example, according to the change initiative annual report, the change initiative, *"took a unique approach to developing [the change initiative], utilizing a multidisciplinary leadership system with representatives from all oncology surgical specialties as well as key care provider and support roles [throughout the system]."* For Menders, this was a golden opportunity to help them create the changes they so desperately wanted. As one Mender explained when asked why she volunteered to be on the change team:

> *And as I started to try and just figure out how to [change the system], I kept hitting roadblock after roadblock after roadblock, figuring out who even is the right nurse to talk to, who can help me with putting together what we do preoperatively, in this building, and peri-operatively and postoperatively, in that building. It seems that they would be connected, because there's a shared sidewalk, but there really is no overlying umbrella that has a shared mission or shared goal to make things best for patients. So, I started trying to work on it, myself, and just, like I said, I couldn't do it, and then found that… someone was gonna figure out the way to do it. And it just was something that I've been telling people from the first moment I got here, that I wanna be a part of, and there you go. (109)*

This was in stark contrast to the majority of Defenders and Benders on the change team. For example, when a Defender was asked the same question (i.e., why she volunteered to be on the change team), she replied, *"How I got involved in [the change initiative] is I was 'voluntold.' I had to do it and nobody else wanted to do it" (105)*.

Over time, the hope that Menders had in the change initiative came to fruition in that it helped them learn more about other parts of the system. For example, when asked if the change initiative had influenced her practice, one Mender responded:

> *I mean it has in terms of some of the meds and stuff we use for sure. And I think anytime you're a part of a group and you're around more group dynamics, it's just good practice to know how different groups function. (301)*

By learning about other system members, core and support Menders were able to find each other and, over time, work together to integrate their system and higher-order identities. Indeed, over time, Menders became the nucleus of the change initiative while Defenders and Benders reduced their engagement. As a Mender stated, *"I expected a little bit more participation from some of the other [surgical specialties]… and I don't see them attending the meetings. So, I feel like showing up is like 90% of it. Just show up" (101)*. When asked about those that were showing up, she went on to explain, *"Of the people who show up, there's commitment [to changing the system] and critical*

thinking that you can see" (101). Although attendance at every change team meeting varied, during that time the vast majority of those who "showed up" were Menders.

In finding each other within the system, core and support Menders both helped "unstick" their respective enactment processes as core Menders gained clarity regarding the system from support Menders, and support Menders gained access to those with the power to change the system. For example, during one change team meeting, a surgeon was asked if she had been giving her patients epidurals. However, she was unaware of how her patients were prepared prior to surgery, prompting her to state, *"I haven't been doing it. [Wait], have I been doing it?" (301)*, to which a support member replied, *"No, you haven't been doing it" (301, change team meeting 2019.09.06)*. Together, core and support Menders believed they could perform all of the actions for which they felt responsible, and that would enable successful enactment of their multifaceted higher-order identities. As a Mender explained:

> *[The change initiative is] not all about just anesthesiologists and it is not all just about surgeons. It is not all just about the administration wanting this project to go through. It is not all just about [the head of Cancercare] wanting this to go… It's about all of us. It's about every person in that group being successful and at the same time getting every one of their needs accomplished. And most importantly, most importantly… [it's about doing] what's best for the patient, [which] is best for everybody. And if we are doing what's best for the patients, everybody wins. (202)*

Thus, in finding each other, Menders were able to collaborate in a way that facilitated their individual enactment processes.

Working together also resulted in Menders broadening the construal of their system identity and identifying additional non-convergent areas of the system. In working together to integrate different system areas into their higher-order identity, core and

support Menders learned more about these areas, and in doing so gained clarity. Because, as noted, clarity determined the focus of enactment, as Menders gained this additional clarity they expanded their mending efforts to include these areas as well. For example, during a change team meeting, a core Mender stated, *"I don't even know where the [nurses] that do patient education sit" (109, change team meeting, 2019.10.24)*. A nurse then explained how patient education worked and who was in charge of it. In a subsequent interview the core Mender explained, *"It was so clear to me in that moment how much room there is for improvement above and beyond just physician care. And how much that's been either neglected or not understood to be part of good patient care" (109)*. Over the next few weeks, the core Mender worked with other support members to contact all of the key players and set up a day-long workshop to revamp patient education for all surgical patients *(patient education training, 2019.12.12)*. Therefore, unlike Defenders who focused on long-term change of very few system processes or personnel, or Benders who focused on short-term manipulation of specific system members, Menders had an expanding focus for long-term change involving any system processes or personnel that were identified as non-convergent with their higher-order identity.

In sum, due to an identity jolt, Menders developed a multifaceted construal of their higher-order (i.e., supra) identity. This, in turn, led to a multifaceted construal of their role identity and the view that Menders were responsible for both breadth and depth of care as they were intimately linked. Therefore, Menders engaged in exploration of the parts of the system with which they were unfamiliar, and in doing so discovered a lack of convergence between their higher-order and system identities. The lack of convergence combined with the centrality of the system identity and their multifaceted construal of

their role identity caused Menders to attempt, and frequently fail, at "mending" the gap between their system and higher-order identities. The upshot was that Menders felt "stuck" in a cycle of futile attempts to change the system and experienced large amounts of frustration. However, the change initiative helped core and support Menders connect, and in doing so they were able to help each other "unstick" their enactment processes. Engaging in change attempts together led to greater system exploration and clarity, which identified additional areas of non-convergence between Menders' system and higher-order identities, which then expanded the focus of enactment to include these new non-convergent areas. Thus, Menders focused on repeated cycles of change with the overarching objective of long-term changes that fully integrated their higher-order and system identities.

Mending: Core vs. support. Because both core and support Menders had multifaceted higher-order identities (Figures 4a and 4b), the ultimate objective was to provide both breadth and depth of care. More specifically, Menders wanted to provide standardized breadth of care in all areas that involved common treatment and individualized depth of care in all areas that were specific to a particular disease. For example, in a change team meeting, a support Mender stated, *"Let's not take away every ability of a [surgeon] to make care unique… We want to make things standardized as much as possible but [not at the expense of individualized care]" (202, change team meeting, 2019.07.24)*. However, the focus of enactment in making system changes to achieve this objective differed between core and support Menders due to differences in their identity networks. Core Menders' high centrality of, convergence between, and clarity regarding their role and relational identities resulted in depth of care being their

primary focus. As one core Mender explained, *"I would be amazed if any of us [surgeons] said that he didn't have a particular affinity for the patients that specifically saw him and all that" (104)*. Thus, their enactment often involved attempts at convincing other core system members to standardize their practice in *common* areas of treatment because doing so would ultimately enable better depth of care. For example, when asked about the resistance from surgeons regarding standardizing the use of preoperative pain medication, a core Mender put it this way:

> *I don't know where that [resistance] comes from. I mean some of these things are like no brainers. I mean it's Ibuprofen. Why are we sitting here talking about all the nuances of Ibuprofen? Just get over it. Let's just make it easier on ourselves. And I don't know why there's all this talk about it. Everyone wants a special caveat. They want an exit strategy so that they can still do whatever they want [throws hands up in frustration]. (101)*

Conversely, support Menders' high centrality of, convergence between, and clarity regarding their role and relational identities resulted in breadth of care being their primary focus. This was seen in one change team meeting when the discussion turned to all of the possible exceptions to standardization. A support Mender interrupted the surgeons to argue for as much standardization as possible in all common areas of treatment, and at the very least that they create standardized procedures for each type of surgery *(change team meeting, 2019.07.11)*. Therefore, their enactment often involved either educating core system member regarding what types of standardization would help breadth of care or creating the conditions necessary to implement such standardized care. This was illustrated by a story told by a support Mender:

> *The other day I was promised and assured that we would have infusion pumps in every operating room, so that way we could [all] do the propofol infusions and these things that the literature suggests is helpful. And I said "Has that even been accomplished?" I went and asked the leadership, "Do we have [the pumps]?"*

> *And they said, "Yes." And I said, "Okay, I'm going to go find out." Less than half of the rooms had the equipment that needed to be there [to provide the standardized care]. So right now [Cancercare] is grossly underprepared for [standardized care]. And I am scrambling right now to get it prepared. So, I had just gotten off a 24-hour shift and I could have gone home at 10:00 o'clock… I stayed until 3:00 in the afternoon – five hours – running around the hospital finding this equipment in closets, down in the basement of the hospital, and gathering this equipment… Five hours of time that I should have been resting from a long shift. So, I care. (202)*

Thus, unlike Defenders and Benders, both core and support Menders enacted their identity networks to promote standardization within the system in order to improve the delivery of breadth of care, even if the primary concern that led to this promotion and the focus of enactment regarding it were not necessarily the same.

Impact of enactment on Menders. Unlike Benders, who believed that standardization decreased the quality of care provided to patients, Menders believed that standardization *increased* the quality of the overall care (depth and breadth) provided to patients. More specifically, they believed that standardization in common areas of treatment served as a foundation for depth of care in specialized areas of treatment. As one Mender explained when asked why he wanted to standardize care:

> *It helps us just not miss things. That's my fear is we're going to miss a step somewhere and get someone in there – someone who should have gotten blood, we didn't think to check, the order got missed, nobody questioned it, they get into the back and they run into a bleed, the surgeon calls for blood and now it takes two hours to get it because we weren't ready. I wouldn't want to miss something like that. (602)*

Therefore, Menders sought to standardize breadth of care as this would help them better enact their higher-order (i.e., supra) identity.

Indeed, their desire to increase standardization was so strong that, when Defenders and Benders resisted such standardization, Menders attempted to push the

issue more and more forcefully. For example, in earlier meetings a Mender would simply mention that the data suggest that a specific procedure should apply to every surgery *(change team meeting, 2019.06.25)*. However, as time went on her language became stronger, progressing to directly asking how they could standardize various procedures *(change team meeting, 2019.07.24)*, and in a later meeting frustratingly blurting that surgeons do not see how standardization greatly benefits everyone because they only think about their specific patients *(change team meeting, 2019.09.26)*. However, due to differences in identity networks, such attempts only garnered more resistance from Defenders and Benders. When asked about the Mender above's behavior in meetings, a Defender commented:

> *She's pushy. She's pushy. She pushes the envelope and insists that her data is clear and concise and the best and should be the ubiquitous answer for everybody. Do I care? I don't care. I'm like she does friggin [easy surgeries]. If she wants to focus on what is the best IV fluid and what is the best IV management, she clearly isn't busy enough in her surgical situation. (107)*

Interpreting this type of resistance as a threat to their higher-order identity (Figures 4a and 4b), Menders pushed standardization even more and, over time, reached a point of trying to force compliance. For example, at one change initiative leader meeting, a Mender blurted, *"I mean what is the shed we're going to take people to? [laughs] We need a shed" (109, leadership team meeting, 2020.02.17)*, referring to the proverbial woodshed where people are taken to be punished for non-compliance. As another example, when asked how to persuade people to standardize parts of their practice, a Mender replied, *"You just have to [tell them to] do it" (104, change team meeting, 2019.09.26)*. Thus, in their newfound success at changing the system, Menders actually increased resistance from other system members to implementing those changes.

Through the greater amount of interaction fostered by the change initiative, core and support Menders were able to find each other within the system. Together, they gained the clarity and power needed to change the system in such a way that it better supported their higher-order identity. This resulted in greater convergence between the two identities, increased awareness of other non-convergent areas of the system, and reinforced a deep desire to continue improving the system. However, at the same time, it also garnered resistance from other system members (i.e., Defenders and Benders). Thus, Menders' desire and ability to make lasting changes in the system was tempered by the negative reactions to such attempted changes from their fellow system members.

Overarching Process of Enactment

Though differences in members' identity networks resulted in three different types of enactment toward the system (i.e., defending, bending, and mending), they all followed the same overarching process of enactment. As summarized in Figure 5, this process involved different identity network characteristics creating the *desire* for enactment, shaping the *nature* of enactment, and selecting the *target* (i.e., focus) of enactment. As a preview, the enactment process was initiated by an identity-implicating event (Bataille & Vough, 2020) – here, the change initiative – which revealed elements of the system identity (e.g., system processes) that were not convergent with a highly central referent identity. When a non-convergent system identity element was evaluated as either a help or a hindrance to the referent identity, it took on a level of importance that was proportional to the centrality of the referent identity. For helpful system identity elements, it became important to integrate them into the referent identity, and for hindering elements it became just as important to guard against such integration. In this

way, convergence, or lack thereof, and centrality created the desire for enactment (Figure 5). The construal breadth of the higher-order, role, relational, and social (i.e., system) identities then shaped the specific nature of enactment. More specifically, the construal breadth of these identities influenced the purpose of enactment, the specific set of enacted behaviors, the depth of enactment, and the felt need for partners in enactment, respectively (Figure 5). Finally, the clarity of the system identity, or specific elements of the system, determined the target of enactment. In this section, I will provide a detailed description of this enactment process that was common across Defenders, Benders, and Menders.

Insert Figure 5 about here

Desire for enactment – Convergence and centrality. As noted, the desire for enactment resulted from a combination of recognizing non-convergent elements of the system identity and the centrality of a referent identity imbuing those elements with importance (Figure 5).

Convergence. In my study, convergence strongly influenced patterns of enactment. In doing so, it also enabled the recognition of what parts of the system do not fit those patterns. Put another way, convergence revealed both dependencies and discrepancies between identities. As one surgeon noted, *"I can't do everything that the system is asking me to do. And, sometimes, excellent patient care has to take a back seat to me finishing with the paperwork that I still have, from the past two weeks" (109)*. As noted, such lack of convergence between their system identity and other important

identities was recognized, to one extent or another, by all system members (i.e., Defenders, Benders, and Menders). However, convergence alone, or lack thereof, did not result in a desire for greater integration of the system identity. Indeed, both Defenders and Benders recognized many areas of the system that were non-convergent with their area of convergence or higher-order (i.e., supra) identities (respectively), yet often had no desire to integrate these areas. For example, during a change team meeting while others were pushing for convergence regarding the type of fluid used in preoperative IVs, one Defender stated, *"I don't care either way" (107, change team meeting, 2019.09.05)* because the differences in fluid had no effect on his patients. Similarly, another Defender stated, *"For [my specialty] it doesn't matter… so we'll go with whatever" (105, change team meeting, 2019.09.05)*. As these quotes imply, only non-convergent areas of the system that were also central to the member resulted in the desire for integrating these areas.

Centrality. Centrality strongly influenced the primacy of enactment. In my study, centrality also inspired behavior aimed at improving one's ability to enact an identity or identities (e.g., Menders) and behavior aimed at guarding against perceived threats to enacting an identity or identities (e.g., Defenders and Benders). Once non-convergent elements of the system were recognized, system members evaluated them based on their ability to help or hinder other central identities. Importantly, only identities that were both central and had enough clarity to make useful comparisons were used for evaluation of non-convergent elements. As noted, for Defenders the area of convergence between their role and either relational or system identities was used for evaluation and for Benders and Menders their higher-order identity was used. Based on these referents, the

non-convergent system elements with the potential to help a central identity took on the centrality of that identity. For example, during a leadership team meeting, a Mender stated, *"Something I didn't realize is here we're standardizing everything, but we're not standardizing the consent form" (103, leadership team meeting, 2020.02.17)*. He went on to explain that such standardization is important because it helps ensure patients receive the care they need (e.g., surgery is not cancelled because they forgot to sign the form). In other words, centrality was, to some extent, fluid in that the system identity could increase in centrality as system elements with the potential to help enact a highly central identity were recognized. For example, in the same meeting, a system member stated, *"And then there are things that I don't even know what their role is [in the system], but I know they're really important. Like the booking sheet" (109, leadership team meeting, 2020.02.17)*. Thus, integrating such system elements became very important to these individuals. As noted, this desire for integration was most often the case with Menders, and on occasion with Defenders. Conversely, it was just as important for individuals to guard against or resist integrating system elements that had the potential to hinder the enactment of a highly central identity. For example, when asked why she chose to speak up in meetings regarding some subjects, but not others, a Defender explained:

> *[I think] "Okay, I'm gonna pick my battles and this isn't going to do anything. It's not going to make a difference [for my patients]. It's just going to make us sit in this meeting an extra 20 minutes." So, I'll hold back. But if it's something where I think it affects my patients or, you know, something legitimate, then I won't hold back. (105)*

Therefore, while the centrality of a given identity could increase the importance of integrating a given system element, it could also increase the importance of resisting such integration. This was most often the case for Defenders and, to a lesser extent, Benders.

While some system elements became important to different system members, many other elements were considered as having little importance, even if they were recognized as being discrepant with a referent identity. As noted, Defenders largely ignored the majority of such elements because they did not directly affect their area of convergence, and therefore did not take on its centrality. Alternatively, Benders believed they could coerce integration between non-convergent elements and their higher-order identity by bending them to their will whenever they wanted. As one Bender explained:

> *So, what [anesthesia members] do has an impact on you, but I only get involved in [their area] as far as making sure that the patient's stable, that they get enough fluid, that they're not hypotensive because their fluid volume is down, and [the anesthesiologists] haven't kept up. And then… hopefully, after they kinda know what you like [they do what you want]. But in my mind, it's not like – it's not vanity… it's about the patient. (113)*

Therefore, to Benders, non-convergent areas of the system had relatively little import until they were needed to treat a specific patient, and large changes to the system aimed at integrating these elements were unnecessary.

Given the above, the combination of convergence, or lack thereof, and centrality resulted in either no desire to even consider a given system element, a desire to integrate it into a referent identity, or the desire to guard against such integration. Indeed, at times the same system element evoked each of these reactions from different system members. For example, during a change team meeting it was discovered that no one really knew when patients were told to stop drinking liquids prior to surgery. Three Menders (109, 202, and 602) joined the conversation to push for a standardized time (e.g., 4 hours prior to surgery), and three Defenders (105, 107, and 108) argued against having a

standardized time. The Bender who was present (106) said nothing, even though he was often vocal on other topics *(change team meeting, 2019.06.25)*.

Interestingly, the combination of a lack of convergence and high centrality resulted in a desire to integrate or defend against the system. However, at times members did not attempt to do either, even when a system element was both non-convergent and central. As one member explained:

> *That's why I don't even want to contribute to [some important discussions] because I'm going to be like, "Well my patients did this." [Others will say], "Well prove that with data. Why is that better?" So, if you don't have [data that applies to all patients] to support yourself, and it's an argument, then you're out of luck. (107)*

Because this member considered only his specific patients, while other members considered all patients, he chose not to try and change a part of the system that he considered important. Indeed, for all members, actually engaging in integration or defensive behavior regarding their system identity depended on the purpose for which members enacted their identity network, what behaviors were involved in this enactment, the extent to which enactment occurred, and with whom a member wished to enact their identity network; all of which were determined by the construal breadth of the member's identities.

Nature of enactment – Construal breadth. While convergence and centrality resulted in a desire for some type of enactment, the construal breadth of the higher-order, role, relational, and system identities shaped the specific nature of the enacted behavior (Figure 5).

Construal breadth. Construal breadth determined the range of various aspects of enactment, depending on the identity being construed. Once an area of non-convergence

was recognized and some sort of importance was assigned to it through the centrality processes described above, how and why the member attempted to integrate or defend against it depended on the construal breadth of one or more of their identities.

Higher-order identity construal breadth. For members' higher-order (i.e., supra) identities, construal breadth determined the range of purposes for enactment and answered the question, "For who or what am I doing this?" For example, when asked which patients he considers when thinking about caring for patients, one member answered, *"It should be all patients. I mean… I don't want to sound all kumbaya and lovey-dovey and stuff like that, but… we've got to take a global approach [to patient care]" (202)*. However, when discussing the same topic, another member answered, *"[Surgeons] care about their patients [only]" (102)*. As noted, core Defenders enacted their identity network to deliver care to their specific patients, and support Defenders did so to provide care for all patients. Therefore, it was not surprising to find that core Defenders viewed attempts at increasing standardization as a threat because it reduced their ability to provide individualized (i.e., depth of) care to their patients:

> *The part that I am not that excited, or kind of discouraged, or whatever about, is that we're gonna completely lose individualized care in this process… So, we're gonna lump everyone together in one big box and we're gonna… practice mindless medicine where we don't even think about the individual characteristics of the patient. You click the order set and everyone gets the same thing whether they need it or not. And I'm not here to practice mindless medicine. (105)*

It was also not surprising that support Defenders viewed a decrease in standardization as a threat because, as noted, it reduced their ability to provide breadth of care to all patients. However, what was surprising is that not all core members wanted less standardization – and thus did not resist proposed integration efforts – and not all

support members wanted more standardization – and thus resisted integration efforts. Because Menders had a multifaceted construal of their higher-order identity, they wanted to provide the best possible care for all patients (i.e., breadth of care) and the best individualized care for specific patients (i.e., depth of care). Additionally, as previously explained, Menders believed breadth of care formed a necessary foundation for providing depth of care. Thus, core and support Menders wanted to increase standardization within the system and viewed resistance to such attempts as threats to their higher-order identity. For example, a core Mender stated what is needed to enact their higher-order identity of patient care:

> *Medicine is often surgical care. It's complex [with] many, many, many steps, and it – unfortunately, it tends to be done in a very haphazard way. It's not very process-oriented and not very standardized, and [is instead] based on how we're trained, based on egos, based on who knows what pressures. And so, things are done in a very variable way. And so… my belief is the fundamental tenet or premise to developing outstanding, low-cost, high-quality, complex surgical care is standardization. (103)*

Alternatively, core Benders narrowly construed, and support Benders broadly construed, their higher-order identity. However, both believed that the system was not a solid foundation upon which depth of care depended, but a malleable set of resources that existed to accomplish the wishes of core members. Therefore, as previously explained, both core and support Benders believed that autonomy, especially of the surgeons, was the key to providing both breadth and depth of care and viewed attempts to increase standardization as a threat to providing the best possible care to all patients. Indeed, in explaining why he was against standardization, a Bender told a story about how a push for standardization at his previous hospital, so that patients would go home earlier, actually caused more errors in surgery because surgeons were trying to do surgery on one

patient in the same way as on every other patient. He ended with, *"So, does it matter to a cancer patient that they went home a day sooner? I don't know. If we botched the operation [shrugs]" (113)*. But why did Menders see the system as a foundation that supported depth of care and Benders see it as a set of malleable resources in which autonomy was critical? The answer to that depended on the construal of their role identity.

Role identity construal breadth. For role identities, construal breadth determined the range of behaviors involved in enactment. More specifically, role identity construal breadth was a combination of the answers to the questions "What am I responsible for doing?" and "What am I able to do?" As one Defender put it:

> *I also feel that everybody has their role to play. My role in that operating room is keeping that patient alive, doing my best to extirpate their tumor. I don't claim to know other [areas of the system]. And I've been in departments – like I said, even at [a prestigious medical system] we didn't claim to know [everything]. We claimed to know [our specialty]. We claimed to know cancer care. Beyond that, we didn't claim to know anything. (107)*

As this quote implies, Defenders had a narrow construal of their role identities, and therefore felt responsible for only those actions that were clearly associated with their area of convergence. As noted, for core Defenders, this meant integrating system elements that improved depth of care in their specific specialty only and guarding against any elements that do not, and for support Defenders it meant integrating system elements that improved breadth of care in their particular part of the system and guarding against those that do not. Further, both core and support Defenders were often frustrated with others in the system that tried to push integration, and thus infringe upon their area of

convergence. Indeed, when asked his opinion about a Defender's behavior in the change team meetings, another Defender explained:

> *She seems irritated; irritated, that's the word. She seems irritated by the process and by [others'] insistence upon making her somewhat less complicated life a little bit more complicated. I think she likes the simplicity of [her specialty] and she probably sees some of this as complicating what she's doing. I'd like to actually support some of her concerns, but I'd probably do it a little more gently. I think her approach is a bit more brash than I would be – her facial expressions, her general tone seems a bit more that way. But I tend to support her when she's trying to be like, "Look, what about my patients? They go home the same day." (107)*

Interestingly, like Defenders, Benders' construal of their role identity also resulted in a general lack of interest in integrating system elements. However, unlike Defenders, Benders had a broad construal of their role identities. Therefore, Benders believed that they were responsible for, and could perform, all actions necessary to force any part of the system – whether or not it was convergent with their higher-order identity – to provide individualized care to patients. Thus, as noted, Benders saw no reason to integrate system elements as there was no benefit in doing so. This indifference also meant that Benders experienced very little frustration with the system because it represented a set of controllable resources. Hence, both the narrow construal of Defenders' role identities and the broad construal of Benders' role identities often led to a lack of attempted integration regarding their system identity.

Finally, Menders had a multifaceted construal of their role identities, resulting in them feeling responsible for both depth and breadth of care. However, Menders, unlike Benders, believed they were only able to perform actions associated with one or the other but not both. Hence, Menders depended on others to provide one type of care to serve as a foundation for the other. This interdependence resulted in Menders' continual desire to

integrate as many system elements as possible and in Menders being the most frustrated by the system. A Mender expressed her frustration as follows, *"When I was sitting at that meeting with [other system members], everyone was trying to do their best, but nobody was working to coordinate us all together so we're working together for best patient care" (109)*. She went on to explain:

> *So, I did not know what other nurses were doing as preoperative education. I did not know that they were giving out this nine-page document that is not at all up-to-date, and it's actually quite confusing to read. I didn't know that patients were going home with this and nobody was going over it with them. And that it was last updated in 2012. I didn't know that the PAT – which, I don't even know what that stands for – are going over 45 minutes of information that they're doing from memory. It's just – it's not a coordinated effort. (109)*

<u>*Relational identity construal breadth.*</u> The construal breadth of one's relational identity determined the range of enactment depth for each patient, and answered the question, "How much should I do?" For Defenders, the answer to this question was that they should do everything possible *within their narrowly construed role* to address all the unique needs of each patient (core) or the common needs of all patients (support). For example, when asked if the system should do everything it can for patients, a support Defender emphatically replied, *"Absolutely" (401)*. However, at the same time, he wanted to make sure that whatever was done did not infringe upon his area of the system. This became clear when discussing the change initiative, "*I'm happy that I don't feel like any of the proposals and things [the change team wants to] do… are contrary to what [my area of the system] wants" (401).* Hence, in reality he only wanted changes that improved patient care *and* did not infringe upon his area of convergence. For Benders, the answer was that they should do everything possible *within the system's capability* to address all the unique needs of each patient. Indeed, there were several times when a

Bender coerced other system members to provide care that was not necessary but would help their patient in some minor way. For example, during a change team meeting, a Bender explained that he made the anesthesiologist place an epidural higher up on his patients than they wanted to. When asked why he did this, he simply stated, *"to cover up the incision"* so the patient only had one scar instead of two *(106, change team meeting 2019.10.24)*. Finally, for Menders, the answer to how much they should do for the patient was everything possible within the system's capability to address all the unique needs of each patient *and* the common needs of all patients. However, their construal of their role identity resulted in their belief that they were only able to do one or the other. Hence, it was necessary to work together, with core members addressing the unique needs of each patient and support members addressing the common needs of many patients. As one core Mender explained:

> *I would like to rely on anesthesia's expertise, and nursing's expertise, as well… I actually want those people to have more autonomy to make decisions. Unless, they're [incompetent]. I have no patience for that shit. But no. I think [the system] works better when I'm not in charge of everything. When I don't know [I] go to [a nurse and say], "I don't know what to do with this. Go nurse that up. I don't know. [Physician's assistant], can you fix this? I don't know how to fix this." I think we do better when we allow the people working around us to work… But to have their own autonomy… When you try to control people and you yell at them for doing stuff, that's not – that's not good. (109)*

Thus, while the construal of one's higher-order (i.e., supra) identity determined the set of patients a system member wanted to care for, and the construal of their role identity determined the actions in which one would engage to provide this care, it was the construal of their relational identity that determined the amount of care that was provided. Therefore, regarding enactment toward the system, core Defenders and Benders put the most effort into actions that they believed would help address the unique needs of each

patient, and support Defenders and Menders put the most effort into actions that they believed would help address the common needs of all patients.

Social identity construal breadth. Finally, the construal breadth of the social identity of the system (i.e., the system identity) determined the range of perceived dependence on others for enactment, and answered the question, "With whom must I do this?" One member explained his ideal scenario of how healthcare should work:

> *The best scenario [is] to have is where it's a team. The doctor, the nurse, the care provider, and the patient are in harmony with one another. Just like a marriage. You've got [two people]… And the marriage should be a beautiful thing. It should be an amazing thing when it's a team. Sometimes one has to be a little dominant and kind of push while the other one takes a back seat, and the [other] one sometimes has to be [dominant], but they have to be in harmony. They have to be on the same page, they have to be at peace with each other, and they have to be working together. (202)*

As noted, the combination of their shift in evaluation referents and a narrow construal of their higher-order, role, and relational identities led core Defenders to develop a siloed mentality. Therefore, most system elements were deemed as either a threat to or irrelevant to their area of convergence and the answer to whom they must enact their identity network with was "as few people as possible" (i.e., a narrow construal of their system identity). Indeed, on the way to lunch after an interview, one core Defender explained that he generally prefers to not work with anyone he doesn't have to, and often even eats lunch outside to avoid interacting with other system members *(informal interview, 2019.04.30)*. In contrast, support Defenders' evaluation referent included part of the system identity. However, they also had a broad construal of their high-order identity and a narrow construal of their role identity. Thus, their answer to the same question was "anyone willing to support the system" (i.e., a broad construal of their

system identity). Thus, core Defenders tended to come to the defense of their area of convergence or attempt to improve a specific system process or personnel, and then wanted to be left alone. However, support Defenders welcomed anyone that would support the breadth of care provided by the system, and often expressed a desire that core members would eventually join the system to do this. As one support Defender expressed (sadly):

> *I don't know if [core members] have that same level of feeling of team that we feel, because there's a number of us that were a team already. And our [core members] are part of that team [but] I don't know if they always feel that way. (401)*

Importantly, he considered core members as part of the system, but was saddened that *they* did not consider themselves to be part of the system. He went on to express both his desire for, and skepticism that, core members would change their views:

> *I would ask [core members], "Do you want to be on a team? Because if [you] don't, that might be a major contributor as to why you don't feel like you're part of a team – because you want to be independent." (401)*

Similar to support Defenders, Benders also had a broad construal of their system identity. However, this construal was not based on convergence between their system and role identities, but was instead based on Benders' view of the system as a set of resources. As such, it behooved Benders to understand all of the resources at their disposal as doing so provided greater flexibility in which they could practice the "art" of medicine. For example, when asked if the change initiative has influenced relationships he has with other parts of the system, a Bender replied:

> *I think that it's been good because I don't know that we get much of a chance to sit down with [other system members]. So, this provided a forum for that… It helped me overall because you get to know these folks and then it's better. If stuff happens in the OR it's easier if you know that person and they kind of know where*

> *you're coming from and all that. Not necessarily [this specific change] but in general with [caring for] patients. (113)*

Additionally, Benders directed whichever system elements were necessary to provide depth of care, and the more system elements that could be employed, the more flexibility they had in providing that care. Hence, over time they developed a broad construal of their system identity. Notably, Benders engaged the system with a spirit of authority in which all system elements were expected to bend to the will of the surgeon, and not in a spirit of mutual dependence. As one Bender explained when asked about his relationship with nurses:

> *Yeah. Well, their orders are all standard… It's all scheduled stuff. There's some thought on their part… But most of what they're lookin' at is, "Give this dose here. Give this" – I mean, they're orders. So, they're being ordered – they have marching orders, and they do it… And if they see something awry, they call somebody. (113)*

Thus implying that the critical role of being a nurse is not thinking for yourself, but following orders to bend to the will of the surgeon.

Uniquely, Menders' system identity construal breadth changed over the course of my study. As noted, these changes were based on multiple cycles of enactment that resulted in a growing awareness of system elements and their dependence upon them to provide both depth and breadth of care. Therefore, during the study, Menders expanded the construal of their system identity. However, unlike Benders, Menders engaged these areas in the spirit of mutual dependence and respect. For example, when asked about joining new groups to learn more about the system, one Mender told a story about a group of people from different system areas, commenting, *"I look forward to being in*

groups like that where it's okay to ask questions, [to] have healthy disagreement but also be very respectful [and] look at things from other perspectives" (101).

Target of enactment – Clarity. While the combination of centrality and lack of convergence provided the *desire* for enactment, and construal breadth determined the *nature* of enactment (i.e., specific behaviors), clarity determined the *target* (i.e., focus) of enactment (Figure 5).

Clarity. In my study, clarity regarding the system identity resulted from exploration, either voluntary or forced. For example, Defenders lacked clarity regarding the majority of the system identity. However, once made aware of a system element with the potential to help their area of convergence, they engaged in exploration of the system to learn more about that element and thus gain some clarity. Only then did Defenders attempt to integrate that into their area of convergence. As a Defender explained:

> *Because [of] a lot of the stuff that we talked about [in the system meetings], I used to use Lyrica, the pharmacist says "use Gabapentin, it's cheaper." And then [an anesthesiologist] came out, "Yeah, it's better, [patients are] not as loopy… use this." [So you] start using it right away. You start standardizing it and using it. (102)*

In contrast, as noted, Benders engaged in system exploration to better understand the resources at their disposal. In doing so, they gained clarity about specific resources that they then used to enact their identity network and provide individualized care to each patient. However, even though Benders had a system identity that was relatively high in clarity, as previously explained, because of the broad construal of their role identity, they were indifferent toward its integration with their higher-order identity.

Menders, on the other hand, had relatively low clarity regarding the system identity and felt a great need to integrate it with their higher-order (i.e., supra) identity.

Therefore, they began with integrating the parts of the system that were clear. For example, early in the change initiative, core Menders attempted to get other core system members (i.e., the clearest part of the system) to increase standardization between their practices based on following the data *(change team meeting, 2019.07.24)*. Referring to her efforts in that meeting, one Mender explained, *"I said it at the meeting. And I don't know, it wasn't really addressed. It was like, 'How are we going to, as a group, keep each other accountable for following the data?'" (109)*. However, as noted, through the process of integrating a given system element, Menders gained clarity regarding other parts of the system. Menders then attempted to integrate these areas as well. Thus, Menders created a self-perpetuating cycle of increasing system identity clarity, leading to the identification of additional non-convergent system elements, and therefore starting the enactment process aimed at system integration over again. In contrast, Defenders most often engaged in only one cycle of enactment in an effort to integrate their system identity. While it was possible that they gained additional clarity regarding non-convergent areas of the system, unless these areas directly and positively impacted their area of convergence, no additional enactment cycles ensued to integrate these areas. Meanwhile, Benders were most often indifferent toward system integration and rarely engaged in cycles of enactment to do so. Therefore, clarity determined the target of enactment, but did not always ensure enactment would occur.

Summary of overarching enactment process. All system members (i.e., Defenders, Benders, and Menders) began their process of determining enactment toward the system with convergence, and more specifically, the recognition that parts of their system identity did not converge with a highly central referent identity. The non-

convergent system elements that had the potential to help a member enact the referent identity took on the centrality of that identity, and in doing so created the desire for further integration between the referent identity and the system identity. For those elements that had the potential to hinder the enactment of the referent identity, it became just as important to the members to guard against or resist integration. All other non-convergent elements were deemed unimportant and were largely ignored. In this manner, convergence and centrality determined the desire for enactment. However, the nature of enactment (i.e., which behaviors were actually enacted) was determined by the construal breadth of system members' higher-order, role, relational, and system identities. Finally, the clarity of various parts of the system determined the target of members' enactment. Hence, the process of enactment involved multiple identities (i.e., higher-order, role, relational, and system identities) and also multiple characteristics of one or more of these identities (i.e., convergence, centrality, construal breadth, and clarity).

Working Against Each Other to Achieve the Same Purpose: A System of Identity Network Enactments

Importantly, Defenders, Benders, and Menders all enacted their identity networks in an attempt to provide the best possible care to patients, and the vast majority believed other system members were doing the same. As one member simply stated, *"I don't think you would find very many people at the hospital that wouldn't say patient care is the top priority" (606)*. Indeed, this view was echoed by many other system members, both core and support alike. Additionally, all members followed the same overarching process in enacting their identity networks. However, even though members engaged in the same overarching process for the same overarching purpose, the differences in their enactment

worked against each other in achieving that purpose. Indeed, one type of enactment was often viewed as a threat to the higher-order identity of a system member engaging in another type of enactment. Indeed, for some, standardizing medical procedures represented a great improvement in enacting the higher-order (i.e., supra) identity of patient care. For example, during a change team meeting a surgeon told a story about how, during his residency, he worked at one place where each surgeon did procedures differently and then moved to another hospital in which each procedure was standardized. He went on to explain how patient care was much better at the place with more standardization, stating, *"That left a very powerful impact on me" (104, change team meeting, 2019.09.26)*. However, for others, standardization represented a huge danger to patient care, *"We're talking constantly about individualized care and personalized medicine on all of that. And that's my worry, that this system-wide, 'every kind of surgical patient is going to get one thing,' it completely obliterates individualized care" (105)*. Thus, in attempting to enact their higher-order identity (i.e., patient care) within a system, members actually threatened that same identity for other system members.

Defenders. In general, Defenders were perfectly happy with the status quo and, except for a few cases, did not seek change. For example, when asked why system members were resisting standardization, a Defender replied:

> *I guess it depends on what things you're trying to standardize. If there are certain things that you just normally do… For example, you put your right sock on before you put your left sock on all the time. Someone comes in [and says], "Nope, you've got to put your left sock on now before you put your right. That's how we're always going to do it." And you're going to be like, "Well, why?" (102)*

Therefore, the ultimate goal for Defenders was to prevent anyone from changing their specific area, and they actively worked to do this. In fact, Defenders often became

frustrated with others for not guarding against changes. For example, telling a story about how she was trying to get others to help her stop some changes from happening, a Defender stated, *"And I said, 'Do you want all of your patients who have 40-minute cases to have this, this, and this?' He was like, 'Of course not.' I was like, 'Well then you better say something next time'" (105)*. However, because there were several Defenders in the system, this desire to guard their area against change resulted in several members trying to prevent change in several different areas. For example, in a single change team meeting, various Defenders fought against standardization regarding giving a carbohydrate drink before surgery, giving patients a gift bag, managing IV fluids, giving patients Gabapentin in preop, how to prepare certain patients' bowels before surgery, and whether to give Heparin or Lovenox *(change team meeting, 2019.07.11)*. This resulted in different Defenders working against whomever was attempting to push integration of a part of the system that affected their area of convergence, even when such integration would help improve depth of care in another member's area of convergence, or breadth of care throughout the entire system. As one Mender explained, regarding the discussion about Heparin versus Lovenox:

> *I mean, I like my left sock on before my [right, but there is] no data [to say which is better]… [It's] obvious that it doesn't even matter… Someone says, "Well, I don't like Lovenox, but I like Heparin." [Another says,] "Well, I like Heparin" versus, "I had a bleed once, and I don't [like Heparin]." Everyone doing it the same, that is the value because [it reduces] error rates… Processes are standard. [There is] consistency across the board. The value [for the entire system] is in the standardization, not in whether you picked A or B. (103)*

Hence, in protecting their area of convergence, and thereby the enactment of their higher-order identity, Defenders actively resisted standardization. In doing so, they threatened

the higher-order identity enactment of Menders, who pushed for standardization, and also, under certain circumstances, other Defenders.

Benders. Benders were also happy with the status quo, but were not necessarily against change. As one Bender put it:

> *Like some of the stuff, it doesn't really matter to me what it is, and if you feel there's going to be a better outcome, great. I'm going to sit back and not say anything… If other things that I see, "Oh, this preoperative anti-coagulation is something I never do. Show me good data why this is [better]." So I think that there is some risk to giving preoperative anti-coagulation. So that was an important part to me so I'm going to be up talking about that. Other things – you want to give 5 cc's an hour versus 2 cc's an hour – I don't care. (106)*

Indeed, in most change team meetings, he didn't seem to care either way and did sit back and not say anything. This indifference toward change meant that Benders were often considered both a minor annoyance and a pleasant surprise by Defenders – who wanted them to actively engage in resisting greater system integration, and also by Menders – who wanted them to engage in promoting system integration. For example, after observing several times in which a Bender was willing to accept change in a change team meeting, a Mender commented, *"[This person] is like, 'Okay, fine.' I thought he was going to be so rigid" (103, change team meeting, 2019.07.24)*.

Not discounting this Mender's pleasant surprise, in general, Benders were passive members of the system who were considered as having little value by both Defenders and Menders. As an example, a Mender explained how those who felt as though they were part of a team working toward change did not include any Benders because they rarely contributed, and when one did, *"I sort of feel like [he was there] to just tell us 'no'" (109)*. However, as noted, Benders did actively engage in resisting any initiative that they perceived would increase standardization and therefore limit their ability to practice the

"art" of medicine. Hence, for some integration being pushed by others, Benders did very little while they actively opposed other integration efforts. As noted, those integration efforts Benders actively opposed were most often pushed by Menders.

Menders. In general, Menders were not happy with the status quo and actively worked to integrate their system identity with their higher-order identity. However, unlike Defenders, Menders wanted to do this for all non-convergent system elements. Indeed, as also previously explained, Menders believed that such integration was the key to ensuring both depth and breadth of care throughout the system, and thereby important for enacting their multifaceted higher-order identity. Therefore, Defenders' resistance to their integration efforts was viewed as a threat to the enactment of their higher-order identity. Referring once again to the change team meeting in which Defenders fought against the use of Heparin:

> *Things like Heparin, for example, and I think that if we had that as a thing we gave to 98 percent of patients, rather than each individual nurse or anesthesiologist or whoever, remembering, "Oh, [one doctor] likes it, but [another doctor] doesn't. And only on Tuesdays does this doctor [use it]." It just makes for more error and missing things that are helpful [for patient care]. (109)*

However, as noted, Defenders only resisted integration efforts to their specific areas of convergence. Thus, in most cases Menders viewed each Defender as a relatively minor threat to their higher-order identity. As noted, Menders believed that both breadth and depth of care were important, and standardization was critical in improving breadth of care in the system. Therefore, and in contrast to their view of Defenders, Menders viewed Benders as an almost constant threat to their higher-order identities. For example, in discussing a particular Bender:

> *[He] is just a very rigid person. I mean [a] very rigid personality [and] just way off, I think, the mark of how [patient care is] managed… [He's] not somebody that's, "Okay. Fine. I'll do something differently." So, he's gonna be somebody that, I sense, is gonna be a real challenge to adjust to [these changes] and will elicit a lot of frustration from the others in the team. (103)*

Summary. The change initiative pushed alignment and standardization within the system, and Menders' identity network enactment involved attempts at integrating these changes throughout the system. To Menders, this was necessary to provide the best possible care to patients by ensuring both breadth and in turn depth of care. Therefore, anything that worked against such integration and standardization was viewed as a threat to their higher-order (i.e., supra) identity. To Defenders, however, providing the best possible care involved protecting their area of convergence. Thus, the enactment of Defenders' identity networks most often worked against Menders' efforts at standardization, and vice versa. Hence, both viewed the enactment of the other's identity network as a threat to the same higher-order identity of patient care. Similarly, Benders' enactment of their identity network involved resisting any efforts at standardization as, to them, the most important component of caring for patients was having the flexibility necessary to tailor that care to each patient. Therefore, both Benders and Menders also worked against each other in the system and each viewed the other's identity network enactment as a threat to their higher-order identity.

CHAPTER 5

DISCUSSION

The main purpose of this dissertation was to better understand an observed phenomenon that theory has yet to explain – namely, individuals with the shared higher-order (i.e., supra) identity of "patient care" seemed to work against proposed changes that literally hundreds of studies have shown to improve patient care (Ljungqvist et al., 2017). To do that, I investigated a change team comprised of 31 members from eight different organizational functions. This group represented everyone within the larger surgical system who was involved in the proposed change, and thus experienced what Bataille and Vough (2020) refer to as an identity-implicating event. I focused my investigation on two related research questions: 1) *How does the interaction of an individual's multiple identities influence enactment?*; and 2) *Why do individuals with the same higher-order identity work against each other when enacting that identity?* Here, I provide a brief summary of my findings and how they answer each research question. I then discuss the theoretical implications of my findings, transferability, and avenues of future research. I end this section with implications for practitioners.

From an Identity Network to Enacted Behavior

In answering my first research question, my findings revealed that each member's identity network consisted of the common higher-order identity of "patient care," a role identity (e.g., surgeon, nurse, nutritionist), a relational identity with patients, and the social identity of the system. Further, each of these identities had four characteristics: convergence with other identities (or lack thereof), centrality (relative assigned value), construal breadth (understanding of applicable domain), and clarity (concrete

understanding). Upon experiencing the identity-implicating event of a proposed system change (i.e., the reason they were on the change team), each member engaged in the same overarching process of enacting their identity network. This process involved recognizing elements of the system identity that were non-convergent with a referent identity. The centrality of this referent identity then combined with convergence to result in either a desire to do nothing, a desire for further integration, or a desire to guard against integration. This desire was then directed by a combination of the construal breadth of all four identities to form the nature of enactment (i.e., the purpose, set of behaviors, depth, and partners of enactment). Finally, once the desire for and nature of enactment was formed, the clarity of the system identity, or elements within it, determined the target of enactment.

Through the enactment process described above, three different types of enactment toward the system emerged: defending, bending, and mending. Defending involved enactment aimed at guarding against integrating system elements into the member's area of convergence between their role identity and either their relational identity (core) or system identity (support). Interestingly, Defenders guarded against some system elements that they believed may improve patient care in their area, but not enough for them to risk changing anything they had already deemed as "good enough." Because Defenders' identity networks encouraged isolation within their silo, Defenders saw little need to engage in system exploration. Thus, Defenders were dependent on others to introduce changes even as they were frustrated by them for doing so in most cases.

Bending involved enactment intended to coerce short-term changes in specific system elements so that the system better aligns with the needs of a specific patient at a specific point in time. Benders' identity networks resulted in the belief that they had both the responsibility and ability to bend every part of the system to their will in order to fully address the unique needs of each patient. Because of this, they were generally indifferent toward changes that did not impact their ability to do this and often acquiesced to the desires of others. However, Benders adamantly resisted, or simply ignored, any system integration attempts that involved standardization as this was antithetical to their narrow construal of the higher-order identity of patient care, which emphasized depth of care. Further, Benders believed that medicine was an art as much, or more so, than a science. Hence, by and large they were skeptical of any data that suggested standardizing system elements would lead to improved patient care. Thus, they were often frustrated by, or simply ignored, Menders and support Defenders who pushed standardized care.

Mending involved enactment intended to achieve long-term changes to any and all system elements that did not converge with the higher-order identity. Their identity network resulted in the belief that: 1) depth and breadth of care were interdependent; 2) it was their responsibility to improve both types of care whenever possible; and 3) they did not have the ability to do that on their own. Therefore, in contrast to Defenders, Menders believed that all areas of the system impacted their ability to enact the higher-order identity, and in contrast to Benders, they believed that non-standardization was hindering breadth of care, which in turn hindered depth of care. Further, Menders' belief in the interdependency of depth and breadth of patient care motivated them to engage in system exploration so that they could identify additional non-convergent system elements and

target them for integration as well. Additionally, their belief in the need for others to provide the full spectrum of patient care led them to seek partners in changing the system. Hence, Menders' zeal to collectively change the system actually hurt their ability to do so because their attempted changes repeatedly frustrated both Defenders and Benders, who comprised a significant portion of the system.

In sum, the interaction of an individual's multiple identities influences enactment through a process in which convergence and centrality influence the desire for enactment, construal breadth influences the nature of enactment, and clarity influences the target of enactment. However, because of differences in convergence, centrality, construal breadth, and clarity within members' identity networks, different forms of enacted behavior emerge from this process.

Working Against Each Other for a Common Purpose

In answering my second research question, my findings revealed that one's identity network did not just determine the type of enactment, but also how one interpreted the enactments of others within the system (i.e., their attempts at increasing standardization or guarding against such increases). In the cancer care setting studied here, the identity-implicating event (i.e., the change initiative) took the form of changes aimed at aligning different parts of the system (e.g., preoperative and postoperative care). In order to achieve this alignment, some system members engaged in enactment aimed at integrating the processes of other members (i.e., integrate system elements). Ideally, these attempts at integration would result in a standardized process at the interface between members focusing primarily on breadth of care (aimed at addressing a given area for all patients) and those focusing on depth of care (aimed at addressing every area for a given

patient). Thus, in integrating a specific system element (i.e., system process), both types of members would increase the convergence between their system identity and the higher-order (i.e., supra) identity of patient care.

Support Defenders perceived enactment aimed at increasing standardization (by integrating additional elements of the system identity) as an opportunity to improve their specific part of the system, and in turn, patient care (broadly construed). Menders perceived enactment aimed at increasing standardization as an opportunity to improve both breadth and depth of care as, in their minds, the two were intimately linked. Therefore, both support Defenders and Menders engaged in such enactment, and viewed similar enactment by other members as an opportunity to enhance their higher-order identity. Further, they viewed any resistance to such efforts as a threat to patient care. Conversely, core Defenders and Benders most often perceived attempts to increase standardization as a threat to depth of care for their specific patients. For core Defenders, this was because they saw no value to their patients, and therefore it was an unnecessary burden. For Benders, this was because they believed standardization limited their ability to bend the system to their will in order to tailor medicine for each patient. In both cases, enactment aimed at increasing standardization was viewed as a hindrance to providing the best care possible to patients – and thus a threat to their higher-order identity – while enactment aimed at resisting standardization attempts was viewed as an opportunity to ensure their patients continued to receive the best care possible – and thus an opportunity for their higher-order identity.

In sum, Defenders, Benders, and Menders were all working toward the same higher-order identity while simultaneously working against each other in doing so. More

specifically, Menders regularly advocated for greater integration of the system identity and the corresponding increase in standardization, Benders regularly advocated against it, and Defenders did both, depending on the area of convergence that they were defending.

Contributions to Theory

The social identity literature (e.g., Dovidio, Gaertner, & Saguy, 2009; Tajfel & Turner, 1986) posits that, "If it is possible to engender a sense of shared superordinate identity, this should work to foster productive intergroup collaborations" (Hogg et al., 2012: 237) within a system. The social identity literature (e.g., Haslam & Ellemers, 2005; Turner et al., 1987), along with the socialization literature (e.g., Kane, 2010; Rink et al., 2013) and identity theory (e.g., Burke & Stets, 2009; Stets & Harrod, 2004), also suggest that a shared higher-order identity will create productive collaboration among individuals in a group or system. My findings support these literatures in that all members of the system I studied were sincerely attempting to provide the best patient care possible, and thus were working to support their common higher-order identity. However, my findings challenge these literatures in two ways. First, they indicate that the common higher-order identity may not be the referent identity (i.e., the identity to which non-convergent elements are compared) for all system members. For example, Defenders shifted their referent to the area of convergence between their role and relational or system identities. Hence, while they equated supporting their respective areas of convergence with supporting the higher-order identity, their shift in referents greatly narrowed the focus of their enactment. Conversely, other members (i.e., Menders and Benders) equated a relatively wide set of enacted behaviors as supportive of, or destructive to, the higher-order identity (e.g., any attempted standardization). However, Defenders viewed only a

small subset of those behaviors as supportive or destructive to the same higher-order identity. As a result, to other members, Defenders seemed to work both with them and against them in their attempts to improve patient care. In other words, one's higher-order identity may dictate the ultimate purpose of enactment without also being the referent by which one defines their success at achieving that purpose, and differences between the two can hinder collaborative effort between members with the same higher-order identity.

The above leads to an interesting question. To date, the literature on identity validation assumes that an individual enacts an identity in a given environment, observes the reactions of others to such enactment, and then makes judgments regarding the validation of that identity based on those reactions (e.g., Burke & Stets, 2009; Swann, 1983; Weick, 1995). However, if judgments about information pertaining to one's higher-order identity are dependent upon other identities in one's network, then is this validation cycle really so simple? My findings suggest that such validation of one identity in an individual's identity network may depend on criteria associated with one or more *other* identities in the same network. Perhaps more importantly, my findings also suggest that the idea of validating a single identity may be more of an artifact imposed by researchers than a realistic representation of the phenomenon. Is it possible that individuals validate identity networks instead of singular identities within a network? Future research, and particularly experimental research, is needed to examine these possibilities.

In the same vein, scholars have long suggested that identity conflict is a function of *two or more* different identities demanding enactment that is contradictory in nature (Hirsh & Kang, 2016), thus creating a "degree of tension, or opposition, among a person's identities" (Ramarajan, Rothbard, & Wilk, 2017: 2209). Such conflict can exist

between identities within an individual, or between those held by two different individuals (Horton, Bayerl, & Jacobs, 2014), and they often result in negative consequences for both the individual and the organization or group (e.g., anxiety, lower performance, Hirsh & Kang, 2016; Horton et al., 2014). In contrast to conflict always being between two or more identities, my findings suggest that different construal breadths of the *same identity* may also result in incompatible enactment demands. Therefore, many strategies proposed to resolve identity conflict may not be effective in such cases. For example, Hirsh and Kang (2016) propose strategies such as suppressing one of the conflicting identities or, alternatively, enhancing a dominant identity, both of which would likely be ineffective if the conflict is the result of the same identity. Other scholars have suggested that segmenting identities, either temporally for intrapersonal identity conflict or physically for interpersonal identity conflict, may help mitigate the negative effects (see Horton et al., 2014). However, this too assumes conflict between two different identities. Future research needs to address questions regarding how identity conflicts involving the same identity may be resolved. Is it possible to suppress one part of an identity while promoting another? Is there a benefit to splitting an identity (e.g., by separating out emotional support from the larger "care provider" identity), and does such a benefit outweigh the possibility of losing an overarching identity? If so, how would such identity splitting be accomplished without causing damage to an individual's or collective's sense of self?

The second way my findings challenge these literatures is by showing that members may not enact their higher-order identity in isolation or in a hierarchical fashion with one identity dictating the goals and enactment of subordinate identities (e.g., Burke

& Stets, 2009). Instead, each member enacted their entire identity network, or the gestalt of all contextually salient identities (cf. Ashforth et al., 2008), with hierarchical relationships encompassing only one aspect of that enactment. Indeed, subordinate identity characteristics may influence higher-order identity characteristics as well. For example, a Mender described how, through the change initiative, he learned about other system members and processes that were using old techniques to treat patients. This increase in his system identity construal breadth and clarity made him realize that there was large number of patients who were receiving suboptimal care, which, in turn, led to an increase in the centrality of his higher-order identity. As he explained:

> *My conviction towards [patient care] has gotten greater…Whereas before this whole project, my practice had been such that I come to work [and] I do what I know is best for the patient…All [the] people around me, I don't know what they're getting…So I've spent my time trying to [ensure they're getting high quality care also]*. (202)

Thus, even though all members were enacting a common higher-order identity, the enacted behavior of some members impeded that of others (e.g., Benders vs. Menders). Indeed, in these cases, the high centrality of the higher-order identity for each member actually *harmed* collaboration because it imparted great importance on integrating system identity elements (e.g., the preoperative use of Heparin for pharmacological VTE prophylaxis) – thus increasing standardization – *and* on guarding against such integration, depending on one's identity network. Further, research has suggested that highly central identities may make it more likely that individuals interpret their own behavior as supportive of those identities while also limiting their ability to see alternative points of view (Weick, 1995). Therefore, having a common higher-order (i.e., supra) identity that was highly central to all system members both reinforced each member's conviction that

their enactment was the correct path, and reduced their ability to see how other members' enactment could also contribute to patient care.

The potential for a common higher-order identity to decrease collaborative efforts among individuals in a group has far reaching implications, especially regarding the literature on newcomer socialization. In general, the literature suggests that a key goal of socialization is getting new members to adopt a common higher-order identity (Ashforth, 2001; Cooper et al., 2020). However, my findings suggest that over time, such efforts at socialization may actually cause more harm than good. As members enact behavior that they believe reflects the higher-order identity, other members may interpret that enactment as being detrimental to the same identity. Interestingly, a ground-breaking study by Cable et al. (2013) suggests that employees have better performance over time when the socialization process emphasizes enacting their "authentic best selves" (Cable et al., 2013: 8). My study suggests that these findings may be attributed, at least in part, to a lack of emphasis on a common higher-order identity as opposed to an emphasis on an authentic identity. Future research is needed to examine this possibility. Additionally, because identity networks serve as the initial input to the enactment process, and also shape that process, future research should consider how organizations may shape newcomers' identity networks prior to them establishing an enactment pattern within that specific context.

I also extend the literature on multiple identities by delineating a process by which multiple identity enactment (i.e., enactment of one's identity network) occurs. The idea that people simultaneously enact multiple identities, and that such identities interact in some manner, is prevalent in the literature (e.g., Caza et al., 2018; Creary et al., 2015;

Pratt & Foreman, 2000; Shipilov, Gulati, Kilduff, Li, & Tsai, 2014). However, the process of identity enactment largely remains a mystery (Ramarajan, 2014; Thatcher & Zhu, 2006). What little work has been done mostly focuses on how enactment shapes identities (e.g., Creed, DeJordy, & Lok, 2010) and less so on the process by which multiple identities come together to drive enactment. My findings revealed such a process (Figure 5). More specifically, they suggest that given an identity-implicating event (Bataille & Vough, 2020), the level of convergence and centrality of one's referent identity and the identity associated with the trigger will combine to create either a desire to do nothing, a desire to integrate, or a desire to guard against integration. The construal breadth of the higher-order and other identities (in my study, the role, relational, and system identities) will then determine the nature of enactment, specifically, its purpose (higher-order identity construal breadth), specific set of behaviors (role identity construal breadth), depth of effort (relational identity construal breadth), and with whom enactment will occur (social identity construal breadth). Finally, the clarity of one's identities help determine the specific target of enactment. In my study, exploration of the system – whether self- or other-initiated – created additional identity-implicating events (e.g., recognition of additional non-convergent system elements), thus, starting the process over again. Importantly, iterations of this process stopped when either: 1) the convergence and/or centrality of an identity-relevant trigger resulted in a desire to do nothing (e.g., it did not influence a Defender's area of convergence); or 2) exploration ceased (e.g., no one presented Benders with additional non-convergent system elements). Hence, my study contributes to the literature by revealing a process by which individuals develop a

desire for enactment, shape the nature of enactment, identify an enactment target, and either continue or discontinue enactment.

The process that connects one's identity network to enactment has important implications for both the identity and leadership literatures. Regarding the identity literature, the long-held assumption that there is a direct line between an identity and enactment (e.g., Ford et al., 2013) may not be accurate. Indeed, it may be more important to consider the identity network as a whole instead of just a single identity when it comes to predicting behavior. Another interesting question is what are the relative effects of the different identity characteristics? For example, if the same identities were enacted but the hierarchical relationship between them was manipulated (e.g., in an experiment), would this change the referent identity and in turn the type of enactment? Future research is needed to tease apart these and the relative effects of other identity network characteristics.

The leadership literature has often suggested that a key function of a leader is to cast a unifying vision for their followers (e.g., Huang, 2013; Shamir et al., 1993). However, my findings suggest that such a vision may be of limited use unless a follower's entire identity network is considered as well. Indeed, the overarching identity enactment process that emerged from my study may provide specific mechanisms for leaders to target in order to shape followers' behavior. For example, leaders looking to increase follower motivation (i.e., a desire for action) may focus on convergence and centrality within their identity networks. Additionally, if a follower is motivated, but their behavior is not quite what it should be, then a leader may focus on the construal breadth of one or more identities to shape that behavior. Finally, if the follower is simply

focusing on the wrong target, a leader may provide more or less clarity regarding different identity elements to help shift their focus. The point here is not to delineate specific actions of leaders (e.g., Morgeson, DeRue, & Karam, 2010), but to note that the identity enactment process that emerged in my findings may integrate both inspirational (e.g., tranformational leadership, Kunhert & Lewis, 1987) and behavioral approaches to leadership (see Derue, Nahrgang, Wellman, & Humphrey, 2011). More specifically, convergence and centrality seem to be core elements that leaders can influence to inspire followers' behavior, and the construal breadth of various identities as well as identity clarity may be important levers that leaders can use to channel that desire into the specific behaviors in which they want followers to engage. However, future research is needed to test the extent to which these different leadership approaches map onto identity enactment processes.

Finally, I extend the identity threat and opportunity literature (e.g., Ashforth et al., 2016; Bataille & Vough, 2020; Petriglieri, 2011). As noted, an identity threat is "an experience appraised as indicating potential harm to the value, meanings, *or enactment* of an identity" (Petriglieri, 2011: 644, my emphasis), whereas an identity opportunity is an "*experience appraised as indicating potential for growth in the value, meanings, or enactment of an identity*" (Bataille & Vough, 2020: 10, their emphasis). Recently, scholars have conceptualized the differences between identity threats and opportunities (e.g., Ashforth et al., 2016), and how each can impact one's intrapersonal identity network (Bataille & Vough, 2020). However, a question that remains is "when will individuals appraise an experience as an identity opportunity versus an identity threat?" (Bataille & Vough, 2020: 37). My findings suggest that such appraisals may depend more

on one's identity network than the actual event as the same behavior (e.g., attempt at standardization) was appraised as both a threat and an opportunity to the same higher-order identity. For example, Benders' identity networks resulted in a deep-seated belief that individual, and especially core member, autonomy was essential for providing the best possible care to patients (i.e., enacting their higher-order identity). However, Menders' identity networks resulted in an equally deep-seated belief that both breadth and depth of care were critical in providing the best possible care to patients (i.e., enacting their higher-order identity) and breadth of care was greatly improved through standardization. Hence the same identity-implicating event was appraised as both an identity threat and opportunity due to differences in one's identity network.

Importantly, in this example, the differences involved construal breadth, but other examples indicate that different contrasts in identity networks resulted in similar results. For example, standardizing the use of Heparin was appraised as an identity opportunity by Menders for the same reasons described above, and as an identity threat by some Defenders because their referent identities for making such appraisals did not include the higher-order identity, but a subset of identities high in both centrality and clarity through which they lived out their higher-order identity. Hence, my findings indicate that both centrality and clarity are necessary to develop a referent by which an event is appraised as an identity threat or opportunity; this referent does not have to include the actual identity that is being threatened or given an opportunity, and the construal breadth of other identities in one's activated identity network also influences this appraisal. In doing so, my findings reveal at least one way in which identity threats and identity

opportunities emerge within a system of individuals, and why one member's threat may be another's opportunity.

Given the positive effects associated with identity opportunities (Ashforth & Schinoff, 2016; Bataille & Vough, 2020) and the negative effects associated with identity threats (Petriglieri, 2011), understanding why one versus the other emerges in a system may shift the way we think about forming teams and systems. For example, teams are often formed based on individuals' roles (Mathieu, Tannenbaum, Kukenberger, Donsbach, & Alliger, 2015). However, these may represent one of many identities in a member's identity network. Because, as shown, different identities and characteristics of one's identity network interact, forming teams based on complementary and supplementary fit (cf. Kristof-Brown & Guay, 2011) of their identity networks may result in higher performing teams. Indeed, it may be possible to form a team in which all members view the team's mission as an identity opportunity while no members view it as a threat. It's at least plausible that this would result in less team conflict, which, in turn, would increase team performance (De Dreu & Weingart, 2003). It is also possible that identity networks form at the collective level (cf. Ployhart, Nyberg, Reilly, & Maltarich, 2014). For example, similar to the concept of transactive memory (Ren & Argote, 2011), different team members may grant a team access to one or more of their personal identities, thus creating a team identity network that consists of a subset of the identities that form its constituent members' identity networks. Indeed, a team may consider itself a "software engineering team" when only one or two of its members' identity networks include the "software engineer" identity while the networks of its other members may include marketing, finance, and leader identities. Examining collective identity network

fit between different teams in a system may illuminate how both an entire system and its component teams may simultaneously optimize performance – something that the current literature has yet to fully explain.

Finally, the literature has often shown that individuals engage in organizational citizenship behaviors that have positive effects on job satisfaction and performance (e.g., LePine, Erez, & Johnson, 2002; Organ, 1997), and people also engage in counterproductive work behaviors that have negative effects of job satisfaction and performance (e.g., Kelloway, Francis, Prosser, & Cameron, 2010; Marcus, Taylor, Hastings, Sturm, & Weigelt, 2016). My theory suggests that one person's identity opportunity may be another's identity threat. Extending this to behaviors associated with one's organizational identity, it is possible that one person's organizational citizenship behavior is another's counterproductive work behavior. For example, in a creative organization one individual may construe "being a creative person" as a collaborative process and thus continually drop by a co-worker's office to generate new ideas. Meanwhile, the co-worker may construe "being creative" as an insular process and therefore view the same behavior as a threat to their creative identity (Elsbach & Flynn, 2013). Future research should examine how differences in identity networks, *and their associated characteristics*, influence these and other important constructs that impact performance and satisfaction in the workplace.

Transferability, Limitations, and Future Research

Transferability refers to the extent to which findings apply across contexts (Lincoln & Guba, 1985). As noted in the Methods section, Cancercare involved a strong context (Johns, 2006) in which every person I spoke with had a common higher-order

identity of "patient care." Unfortunately, a common higher-order identity among the vast majority of organizational members is a goal of many organizations, but rarely occurs (Hogg et al., 2012). However, I suggest that it is not necessary to have a common higher-order identity throughout an entire organization. Indeed, because my theorizing takes place at the individual level, I posit that my findings would transfer to any group or system with any number of members that share a higher-order identity. This may be the case with other organizations involving a strong context such as the military (e.g., Horton, McClelland, & Griffin, 2014), emergency room doctors (e.g., Klein, Ziegert, Knight, & Xiao, 2006), the clergy (e.g., Kreiner, Hollensbe, & Sheep, 2006), or other ideologically based organizations such as many non-profit organizations (e.g., Ashforth & Reingen, 2014). Alternatively, my findings may transfer to smaller collectives with a common higher-order identity such as teams (e.g., Rapp & Mathieu, 2019) and multiteam systems (e.g., Porck, Hollenbeck, & Lee, 2018), especially those operating in an emergent environment (see Mathieu, Luciano, & DeChurch, 2018). Indeed, my findings may even transfer to dyads where two individuals have a shared higher-order identity, but different identity networks. As such, examining identity networks may be important to literatures examining dyadic interactions such as leader-member exchange theory (Dulebohn, Bommer, Liden, Brouer, & Ferris, 2012). One particularly fascinating avenue for future research would be to extend the work of Creary et al. (2015) by investigating how different identity networks influence LMX and other leadership theories.

I also suggest that my findings will transfer to contexts where certain individuals are perceived as core, and others as support, regarding the organization's mission as such perceptions may be based on different identity networks that contribute to a common

higher-order identity. In my data, perceptions of being core or support were based on an individual's enactment of their identity network (i.e., depth vs. breadth of care) and not on their specific role. However, the two are likely to be highly correlated. For example, in a sales organization, the salesperson may be considered core as they interact with the customer while other parts of the organization (e.g., finance) are considered support. Other examples of contexts with strong core and support functions may include academic departments (supported by operations and administrative personnel) and athletic teams (supported by training staff). Because different groups within these organizations often involve individuals from different collectives interacting, as opposed to interactions between the collectives themselves (see Mathieu, Hollenbeck, van Knippenberg, & Ilgen, 2017), it's possible that pairing personnel with either matching (e.g., two Menders) or complementary (e.g., Defenders and Bender) identity networks may influence inter-departmental conflict and goal accomplishment. For example, a Bender may acquiesce to system integration in a Defender's area of convergence while the Defender may agree to reduced standardization outside of their specific area of convergence. In this manner, system changes may be quickly realized with little resulting conflict. However, which identity networks best supplement or complement each other has yet to be investigated. Future research may integrate my theory with Kristof-Brown and Guay's (2011) idea of supplementary and complementary fit to create a typology of interactional fit, and in doing so build on Humphrey and Aime's (2014) conceptualization of teams as organized interaction.

The context of my study was a surgical system. As such, members were highly educated and experts in their field and my informants often thought critically about how

they could improve or maintain providing the best possible care to patients. In other words, they had a vested interest in doing the best they could in their job as opposed to simply doing what was necessary to pass the time at work (e.g., Roy, 1959). Therefore, my findings may be less likely to transfer to jobs that are monotonous or to individuals who have little interest in doing the best they can within their job. However, as noted, individuals are motivated to enact highly central (i.e., higher-order) identities (Stets & Burke, 2009). Thus, to the extent that individuals in monotonous jobs have a common higher-order identity, my theory remains transferable.

Additionally, in my context, face-to-face interactions were required to perform their jobs, and while the healthcare industry is highly regulated, members of a surgical system enjoy a very high amount of discretion when caring for patients. Researchers have suggested that individuals may still form identities with virtual work groups or in highly regulated environments (e.g., Dutton & Dukerich, 1991; Fiol & O'Connor, 2005). However, observing the enactment of these identities may be limited in virtual settings, and it may be hard to know if the observed behavior of others is a result of their identity networks or of their requirement to follow strict policies in regulated environments. Thus, I suggest that the process of identity enactment may still transfer to such contexts, but it may do so to a lesser extent, and individuals may be less likely to interpret the enactment of others as an identity threat or opportunity. Instead, they may be less aware of others' enactment, or perceive it as the individual having little choice but to follow regulations. However, future research is needed to understand how discretion and physical interaction, or lack thereof, influences the type of identity network they enact in a given situation.

My findings revealed how individuals enact their identity networks. However, dyadic relationships and collectives also have identities that are separate from the individual identities of their constituents (Ashforth et al., 2008; Sluss & Ashforth, 2007). Therefore, similar to the idea of transactive memory systems (Austin, 2003) or collective cognition (DeChurch & Mesmer-Magnus, 2010), it is possible that teams and other collectives have an identity network that is both unique to the collective while being comprised of individual member identities. Indeed, it is possible that there is collective cognition regarding the convergence, centrality, construal breadth, and clarity of various identities at both the team level (e.g., what we think of our identities) and the individual level (e.g., what we think of your identities) that goes beyond just validation or non-validation of such identities. Given that one may have a clear idea of something while the collective does not (Mesmer-Magnus, Niler, Plummer, Larson, & DeChurch, 2017), then at a minimum the clarity of a given identity should differ between the individual in which the identity resides and the collective. For example, an individual's "software engineer" identity may mean programing in Python only, whereas the team's "software engineering team" identity may include the more ambiguous meaning of general programming. Future research is necessary to understand how different identities, and the associated characteristics, in an individual's identity network may transfer to a collective, thus resulting in a collective identity network that drives collective interactions. This may be particularly important in organizational forms where collectives regularly interact with each other, such as multiteam systems (Mathieu, Marks, & Zaccaro, 2001).

In my study, I was able to capture every member of the change team, and therefore every member that experienced an identity-implicating event regarding the

surgical system. However, this was a fairly small system that on occasion only had one representative from a particular group. While they integrated or resisted the integration of various system identity elements, others within the larger system did not. My intent was to also capture the proliferation of these elements as different group members attempted to implement the agreed upon changes throughout the larger system. Unfortunately, the advent of a global pandemic (i.e., COVID-19) prevented the completion of this aspect of my study. Hence, I call for future research to investigate how members' identity network influences their enactment regarding change implementation within their representative groups, and how responses to that enactment then change the informant's identity network – and, in turn, change their enactment within the change team. Understanding how identity networks both influence and are influenced by the entire system throughout a change may help revolutionize what we know about change in general.

As noted, the primary data source of this study was semi-structured interviews, which, while providing rich data and enabling insight into "the internal life of participants" (Langley, 2009: 411), also suffer from some limitations. These include reliance on a person's memory of specific events, the possibility of impression management, and their dependence on the quality of the rapport between the researcher and the informant (Charmaz, 2014; Marshall & Rossman, 2006). In order to mitigate these limitations, I also collected observational and archival data, which have strengths that help address such limitations (Langley, 2009). However, future quantitative and qualitative research is needed to gain additional insights. For example, one could conduct an ethnographic study in which they are embedded in the system on a daily basis, or use computer aided text analysis (CATA, see Luciano, Mathieu, Park, & Tannenbaum, 2018;

Mathieu, Hollenbeck, van Knippenberg, & Ilgen, 2017) to examine large communication streams (e.g., internal emails) regarding an identity-implicating event. Additionally, quantitative research can focus on initially asking participants to list important identities (e.g., Kuhn & McPartland, 1954), and then taking repeated measures of the convergence, centrality, construal breadth, and clarity of these identities. While, to the best of my knowledge, measures for construal breadth and clarity have yet to be developed, measures for convergence (e.g., Bergami & Bagozzi, 2000), and centrality (e.g., Brenner et al., 2014) already exist. Additionally, these quantitative measures may be accompanied by having members draw their identity networks (see Bataille & Vough, 2020) during each data collection period. In this manner, researchers may be able to quantify one's identity network, and begin testing how different types of networks relate to important outcomes such as performance in particular contexts, job satisfaction, and well-being.

Another limitation of this study is that I did not examine individual differences and other constructs in terms of how they may relate to identity network enactment. For example, is a person that is high in openness (see Judge, Higgins, Thoresen, & Barrick, 1999) more likely to develop a multifaceted construal breadth of their higher-order (i.e., supra) identity? Similarly, is a person high in perspective taking (e.g., Parker & Axtell, 2001) more likely to have greater clarity regarding social identities? Finally, power has been conceptualized as "control over valued resources" (Cha et al., 2019: 653), and Cha and Roberts (2019: 735) show how individuals may "draw on or 'mobilize' their minority identity as a resource to further work-related goals." My investigation revealed how the identity network of core members resulted in them having power over the system. However, are there other identity networks that result in one member having power over

another? Alternatively, because identities are resources, is it possible for one person to gain power over another by targeting their identities or identity characteristics within their network? For example, by introducing ambiguity and confusion into a situation, it may be possible to reduce the clarity of the system identity, and in turn prevent that person from finding a target of enactment. In doing so, one person may render another, extremely competent person, less able to accomplish a change effort they oppose. Future research is needed to examine these and many other factors that may influence one's process of enactment.

In my investigation, three major types of enactment emerged based on six different identity networks (i.e., core and support Defenders, Benders, and Menders). There may be many more combinations of convergence, centrality, construal breadth, and clarity that lead to different identity enactments. Future research is needed to examine these combinations and their resulting effects on enactment in a variety of contexts. For example, I studied enactment in reaction to an identity-implicating event that encouraged integrating the system identity, but what about situations in which the event involves attempts at separating already converged identities (e.g., Gutierrez, Howard-Grenville, & Scully, 2010)? Will Defenders see that as an identity opportunity as it fits their tendency to prefer silos or a threat as it may remove resources from their area of convergence? Will Menders see it as a threat as it may make interdependent collaboration more difficult or an opportunity to create a silo that only includes other Menders? In other words, how exhaustive are the possibilities of mending, bending, and defending colliding over time?

In a similar vein, my informants' identity networks resulted in three major types of enactment (defending, bending, and mending). As noted, Defenders and Benders often

worked against Menders, and vice versa. This begs the question of whether or not it is better to just have one type of identity network within a system or organization. For example, given their penchant for collaboratively improving the system, would it be better to have all Menders? My sense is that it may be better for organizations to have a variety of different identity networks, and then work to find the best fit between those networks and a particular job. For example, in an entrepreneurial team (e.g., Clarysse & Moray, 2004) it may be desirable to have someone who can bend those around her to do whatever was necessary to gain the necessary funding at a given point in time. In such cases, having several Benders may be desirable. However, as the company grows and no longer needs to go to such extremes, it may be better to have more Menders. Or, perhaps Benders who continually attempt to push the boundaries of what they can force others to do would be effectively counterbalanced by Defenders who are less likely to change or compromise for a Bender. Indeed, in certain highly-regulated industries, or in positions that require strict adherence to a set of rules (e.g., safety officer for an airline), Defenders may be more desirable than Menders. In short, I suggest that, for large organizations, having a mix of Defenders, Benders, and Menders is beneficial as having all three types may address a larger variety of organizational needs. In such cases, proper network-job fit is important, as is teaching leaders how to manage conflict between identity networks (instead of between two separate identities). However, future research is needed to better understand how different identity networks impact each other in various organizational contexts.

Finally, although my context included a functionally diverse team implementing a change, the focus of my investigation was on why individuals worked against each other

when enacting a common higher-order identity. Future research should investigate how different identity networks influenced the formation of a team's social identity. For example, do members with certain networks primarily represent the functionally diverse team to their functional area, their function to the functionally diverse team, or some combination of both? How does such representation change over time, and what effect does this have on the success or failure of the change initiative? Given that functionally diverse teams are prevalent in organizations (e.g., Aime, Humphrey, DeRue, & Paul, 2014) and also have difficulty in completing their objectives (Majchrzak, More, & Faraj, 2012), such research could go far in advancing theory while also being practically relevant – a combination that is becoming increasingly important in our field (Sharma & Bansal, 2020).

Practical Implications

My theory has several implications for practitioners as well. The first is that organizations and leaders need to expand their focus beyond getting employees to buy-in to a common higher-order identity. This is true across industries, but especially true in healthcare. Since the turn of the century the extent of errors and efficiencies in the United States healthcare system have become a part of the public consciousness. In 1999, the Institute of Medicine (IOM) published its landmark report, "To Err is Human," revealing that preventable medical errors lead to over 100,000 deaths annually in the US. A problem that they promptly provided a solution for in their 2001 report, "Crossing the Quality Chasm," highlighted the importance of patient-centered care as essential for improving healthcare delivery. Although the rallying cry for patient-centered care has continued to grow (e.g., US National Cancer Institute's Strategic Plan for Leading the

Nation, 2006), so too has the quantity of errors and cost of care. Evidence has been starting to emerge that patient-centered care may not improve clinical outcomes, without an explanation of why (e.g., Rathert, Wyrwich, & Boren, 2013). Traditional explanations for organizational change would suggest that the shared higher-order identity linked to patient-centered care would promote value alignment and set the change up for success. However, this is clearly not enough, and this dissertation explains how and why individuals with the same higher-order identity work against each other in their efforts to provide patient-centered care – ultimately to the detriment of all patients.

For both healthcare and other organizations, while buying into a common higher-order identity is an important initial step, organizations need to follow it up with attempts to align an employee's identity network with the most desired behavior from that employee. Clearly this is not a one-size-fits-all approach in that some positions may benefit from one identity network while others benefit from another. Those in highly structured and independent positions (e.g., accountant) may benefit from a Defender network that helps them increase the efficient use of resources within their specific area while those in more creative positions (e.g., toy designer) may benefit from a Bender network so that they can uniquely employ multiple resources throughout the system (cf. Elsbach, 2009), and those in positions requiring collaboration (e.g., military units, Weick & Roberts, 1993) may benefit from a Mender network as they recognize the need for such collaboration to interdependently employ system resources.

Alternatively, if a leader finds that her employees have already enacted a particular identity network, it may be preferable to use my theory for targeted management of conflict between the networks. While identity conflict (Fiol et al., 2009),

task conflict, and relational conflict (Jehn, 1997) have all been shown to reduce important outcomes (e.g., performance, see Hirsh & Kang, 2016; Korsgaard, Jeong, Mahony, & Pitariu, 2008), the literature has offered few specific targets for leaders to manage such conflicts. Using what my findings have revealed about enactment of identity networks, leaders may be able to better manage identity conflicts in order to prevent relational and task conflicts. For example, to manage conflict between Menders and Benders, it may be helpful to implement standardized processes but leave it to the discretion of employees to deviate from those processes when they have a good reason for doing so. Leaders can explain to Menders that requiring documentation of such deviations helps improve standardization efforts in the future, thus tapping into their desire for continued integration of non-convergent system elements. For Benders, leaders can point out that documented deviations from a standard helps system members become more familiar with their preferences, and therefore reduce the effort required to tailor the system as needed. In this way, leaders may be able to create a system of "structured flexibility" (e.g., Smith & Besharov, 2019) that maximizes system performance and buy-in from system members with different identity networks. Finally, organizations and leaders may influence the enactment process itself. For example, by connecting a given system element to a Defender's area of convergence, it may be possible to get them to reconstrue (Carton, 2018) the element as potentially helping their higher-order identity, and thus work to integrate that part of the system identity.

The second practical implication is that my theory provides a path of progression for leaders in developing their employees. In general, I suggest that encouraging a progression from defending to bending to mending makes sense given that, as noted,

mending involves a desire to proactively integrate multiple system elements and both proactivity and identity integration have been shown to help organizations and individuals (Caza et al., 2018; Grant, Gino, & Hofmann, 2011; Parker, Bindl, & Strauss, 2010; Ramarajan & Reid, 2013; Ruderman, Ohlott, Panzer, & King, 2002). However, under certain conditions (e.g., high need for organizational flexibility, need for strict adherence to regulations), other orders of progression may make more sense. For example, in certain positions within the military it may be preferable to have a Bender rather than a Mender as the latter may wait for help to accomplish the mission if it requires actions outside their role construal while the former may find a way to bend whatever resources are necessary for mission accomplishment. Similarly, Defenders may perform better in competitive jobs that involve representing others (e.g., talent agents) or jobs that require resisting the temptation to bow to pressure by others (e.g., safety officer, equal opportunity officer). Therefore, on occasion it may be beneficial for leaders and organizations to orchestrate progression toward other types of enactment.

Returning to the more common pathway of defending to bending to mending, leaders may shift enactment by targeting efforts toward specific parts of their employees' identity networks. For example, to help an employee move from defending to bending a leader can encourage them to engage in job crafting (Weller, Hymer, Nyberg, & Ebert, 2019; Wrzesniewski & Dutton, 2001) to expand that employee's construal of their role identity (i.e., they are responsible for, and can do, a lot more than they are currently doing). Over time, it may be possible to grow the Defender's silo to the point that it includes a large portion of the system, and thus shift them from defending a relatively narrow area to defending the whole system. Alternatively, a leader may help an employee

move from defending to mending by emphasizing dependencies on areas of the system the Defender cannot control (i.e., multifaceted construal of their role identity) and also emphasizing a joint responsibility for the overall performance of the system (i.e., a multifaceted higher-order identity). Such joint responsibility may be encouraged through ongoing membership in functionally diverse teams (see Haslam & Ellemers, 2005). Similarly, to encourage progression from bending to mending, it is important to provide some clarity to the employee's role identity by setting boundaries on their domain of influence. While doing so, it may be particularly important to emphasize the Bender's autonomy within a clearly defined area.

My theory also provides a path for leaders to progress toward bending or defending as well. In addition to the paths provided above, to shift from mending to bending, a leader can ensure that they designate authority along with responsibility. In doing so, they may be able to shift the Mender's construal of their role identity from multifaceted (i.e., they are responsible for more aspects of patient care than they can control) to broad (i.e., they can control all aspects of patient care for which they are responsible). Additionally, the leader may present short-term bending of system elements as a viable work-around in systems that are difficult to change due to large amounts of bureaucracy (Hannan & Freeman, 1984), and thus take advantage of the frustration Menders feel regarding their inability to change systems. Additionally, progressing from mending to defending may involve emphasizing the ambiguous nature of the higher-order identity while providing clarity regarding their area of convergence. Shifting the employee's cognitive focus and corresponding sensemaking regarding their identities may indeed shift the very nature of those identities (Weick, 1995) and thus their identity

network. Finally, shifting from bending to defending may involve expanding the construal breadth of Bender's system identity while, at the same time, standardizing procedures outside of their specific work area. This may lead Benders to the realization that they no longer have the ability to bend the entire system but can still bend everything within their area of the system, and thus shift their identity referent to that area (i.e., become Defenders). Importantly, I am by no means implying that progressing toward one type of enactment or another is the universally "right" form of progression as certain types of enactment may fit better in some groups than others. I am simply showing how leaders can manage employee progression by focusing on their identity networks and the process by which they enact those networks.

The third practical implication of my findings is that leaders and organizations may manage change by focusing on specific parts of the enactment process. For example, a leader may force the system exploration of Defenders, but only in areas that will directly and positively impact a Defender's area of convergence. In doing so, the leader may connect non-convergent system elements with highly central identities in order to increase the Defender's desire to enact change while also limiting their desire to guard against change. For example, in my data, Defenders guarded against having patients consume a carbohydrate drink prior to surgery because it didn't help them recover faster in the hospital, and thus did not affect their area of convergence. However, if change leaders would have explained that the drink does speed patients' progress to full functionality after they go home, this may have connected the use of the drink with patient care within the Defender's specific area and increased their desire to integrate the change. Similarly, for Benders, a leader may frame change as a means of increased

flexibility of the system so that it may bend easier. More specifically, a leader may help Benders expand the construal breadth of their system identity and their role identity to include the ability to bend system processes instead of just the behavior of specific system members. The leader can explain that the added flexibility in processes will result in a system that more easily bends to their will, and in turn the needs of the customer, thus supporting their narrowly construed higher-order identity. Finally, leaders may focus on increasing the clarity of Menders' system identities in the order in which they would like change to occur. Such focused increases in clarity will limit the number of changes a Mender tries to implement at any one time and dictate the speed and sequence of change that is most optimal for system performance.

Conclusion

My dissertation sought to understand why individuals seem to work against each other when enacting a common higher-order identity. Through a longitudinal qualitative study of a surgical system in a cancer center, I identified a process by which individuals enact their identity networks, which include a set of identities and the convergence, centrality, construal breadth, and clarity of those identities. I also identified three different types of enactment that emerged from this process and explained how and why each type was viewed as either a threat or opportunity to the common higher-order identity, depending on each member's identity network. My emergent theory suggests that individuals enact multiple identities as a gestalt of both the identities and their characteristics instead of enacting identities in a hierarchical or sequential order. Additionally, identity characteristics matter when it comes to enacting multiple identities as the convergence, centrality, construal breadth, and clarity of different identities affect

the enactment of them all. It is my hope that this dissertation helps us better understand how and why individuals' identity networks are enacted and inspires future research that discovers how organizations and leaders can manage that process for the benefit of everyone.

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APPENDIX A

PROOF OF IRB APPROVAL

APPROVAL: MODIFICATION

Margaret Luciano
Management and Entreprenuership
480/727-4006
Margaret.Luciano@asu.edu

Dear Margaret Luciano:

On 3/6/2019 the ASU IRB reviewed the following protocol:

Type of Review:	Modification
Title:	Diffusion of Best Practices – Part 1 Determining Project Scope and Required Customizations
Investigator:	Margaret Luciano
IRB ID:	STUDY00008481
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• Protocol Feb 2019, Category: IRB Protocol; • Consent - Surveys & Observations Online v3.pdf, Category: Consent Form; • Consent - Interview Online v3.pdf, Category: Consent Form; • Recruitment-Change Leaders.pdf, Category: Recruitment Materials; • Part 1 Observation Protocol.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Recruitment - Surveys & Observations v3.pdf, Category: Recruitment Materials; • External Site Letter of Approval Feb 2019.pdf, Category: Off-site authorizations (school permission, other IRB approvals, Tribal permission etc); • Recruitment - Interview v3.pdf, Category: Recruitment Materials; • Recruitment - External Team Member Bios v3.pdf, Category: Recruitment Materials;

APPENDIX B

INTERVIEW PROTOCOL FOR ORIGINAL STUDY DESIGN

MEMBER: _____ TIME: _____ DATE: _____

CROSS-FUNCTIONAL TEAM INTERVIEW PROTOCOL – FIRST INTERVIEW

Introduction:
Introduce self (initial interview) or greet in some way (follow up interviews)

Thank you for speaking with me today.

Provide brief explanation or reminder of my role and objectives

As you're aware, [Cancercare] is interested in implementing an enhanced recovery program, and I'm part of the team of social scientists that is helping with that process. However, while others are in charge of designing the changes necessary to implement an ERP, my role is to understand the teams that will actually make those changes happen. To do that, I will be conducting a series of interviews, observing team meetings, and probably asking you various other questions as they arise.

There are no right or wrong answers to the questions that I ask. I am just trying to understand how you and your team operate with two goals in mind. First, this study is part of my dissertation which is required to complete my PhD program, and second, we plan on using what I find to distill best practices to improve the experiences of future change implementation teams at other [Cancercare] partner locations.

I'd like to record the interviews if that is okay with you. This will help make sure that I represent what you have to say as accurately as possible. Recordings will NOT be shared with anyone else on your team, the steering committee, or anyone at [Cancercare]. Some specific information may be shared with other ASU researchers, but only after all identifying information has been removed. They are for my personal use only. I will have them professionally transcribed, and both the recordings and transcriptions will be kept on an encrypted drive that is not shared with anyone else. When reporting to others, I will not include any information that can be used to identify a specific person or team.

Do you mind if I start recording now? *(if it is okay, start recorder)*

If at any time you want me to stop the recorder, just let me know.

Interview Questions:

1. To begin with, could you walk me through how you got involved in this project
    a. Why did you choose to participate?
    b. What do you specifically (hope to) get from this experience?
    c. Do you get personal satisfaction from joining this team?

Thinking only about the steering committee…

2. What would you say you bring to this team?
    a. *(if lists roles only)* Are there other things, aside from your expertise as a *(list role—e.g., surgeon)* that you bring to the team?

_____

3. Are there things (talents, skills, abilities, etc.) you could bring to the team, but choose not to or are hesitant to do so for some reason?
    a. If so, how would you describe those things?

4. What is your understanding of the purpose of this team?

5. Would you say that you're on this team primarily to solve a problem or to represent (specialty area)?
    a. What makes you say _____

In our field, there is a lot of research suggesting that people think of themselves as being comprised of different parts. For example, you may think of yourself as a (list major role here), a family person, or in line with a hobby like being a skier.

6. One of my goals is to understand which parts of yourself you engage in the context of your team. To that end, could you provide up to 10 statements that complete the following sentence: "On this team, I am a/the _____. *(write down on Parts Tracking Sheet)*?
    a. Could you explain what you mean by *(list any part listed that is not clear)*

7. On a scale from 1 to 7, one being low relative importance, how important are each of these parts to you *(read each part listed)*?

8. Why do you think you engage these parts of yourself, as opposed to others, when you're with your team?

9. How would you characterize the reactions of others to these different parts of you?
    a. Within your team?
    b. Within your functional area (e.g., PACU)
    c. *(If negative or don't know reactions)* Could you explain the reasons behind engaging that part of yourself?

10. Are there times when you are with this team that you do "teamy" things, but primarily for yourself?
    a. If so, could you describe some of the things you do just for you?
    b. Why do you think you do that while with this team?
    c. Do you associate that with one of the parts of yourself you've already listed or is that associated with some other part?

Another one of my goals is to understand what each person thinks others bring to the team *(get contributions tracking sheet*). To reiterate, nothing you say to me will be shared with any other member of the team.

Repeat 10 – 11 for each team member

11. Could you tell me what you think *(member name*) brings to the team?

12. On a scale of 1 to 7, how important do you think *(list each contribution)* is to the team?

13. It's pretty normal for teams to experience tensions among their members. Would you say there are any tensions between individuals on your team?
    a. Is the tension between two people, the team and one person, etc?
    b. How would you characterize these tensions?
    c. What brought these tensions about?

14. If there are no tensions, why do you think your team is getting along so well?

Shifting from considering individual members of your team, I'd like to talk about the team as a collective…

15. I've been using the word "team" a lot and that may mean different things to different people. Can you describe what you think a team is as compared to a group or other collective?

16. How would you describe this "collective"?
    a. Is it more of a team, group, individuals that sometimes meet?
    b. What makes you say _____?

17. On a scale from 1 to 10, how would you describe the overall intensity of conflict on your team?
    a. What makes you say _____?

18. On a scale from 1 to 10, how would you describe the overall quality of coordination on your team?
    a. What makes you say _____?

19. On a scale from 1 to 10, how would you describe the overall strength of cohesion on your team?
    a. What makes you say _____?

20. Thinking specifically about the steering committee, on a scale from 1 to 10, to what extent would you say:
    a. Your team's successes are your successes
    b. When someone praises your team it feels like a personal compliment
    c. When you talk about your team, you usually say "we" rather than "they"

21. Could you talk to me about anything you're particularly excited about regarding:
    a. How your team is coming together
    b. Other specific team members
    c. How you're personally relating to your team
    d. The tasks ahead of you

22. Could you talk me through any concerns you have regarding:
    a. How your team is coming together
    b. Other specific team members
    c. How you're personally relating to your team
    d. The tasks ahead of you

If you don't mind, I'm going to ask you many of the same questions. However, instead of thinking about this steering committee, I'd like you to consider your team of (specialty area) as you answer.

23. What would you say you bring to this team? *(list on contributions tracking sheet)*
    a. *(if lists roles only)* Are there other things, aside from your expertise as a *(list role—e.g., surgeon)* that you bring to the team?

24. Are there things (talents, skills, abilities, etc.) you could bring to the team, but choose not to or are hesitant to do so for some reason?
    a. If so, how would you describe those things?

25. Again, thinking about your team of (specialty area), could you complete the following sentence: "On this team, I am a/the _____. *(write down on Parts Tracking Sheet)*?
    a. Could you explain what you mean by *(list any part listed that is not clear)*

26. On a scale from 1 to 7, one being low relative importance, how important are each of these parts to you *(read each part listed)*?
    a. Why do you consider _____ so important?

27. How would you characterize the reactions of other (specialty area) to these different parts of you?

28. Thinking specifically about your *(functional area)*, on a scale from 1 to 10, to what extent would you say:
    a. Your team's successes are your successes
    b. When someone praises your team it feels like a personal compliment
    c. When you talk about your team, you usually say "we" rather than "they"

29. Again, it's normal to experience tensions on a team. Would you say there are any tensions between individuals on your team?
    a. Is the tension between two people, the team and one person, etc.?
    b. How would you characterize these tensions?
    c. What brought these tensions about?

30. If there are no tensions, why do you think your team is getting along so well?

For the rest of the questions, please consider both your *(functional area)* team as well as this steering committee.

31. How would you say being a *(functional area)* influences what you do on the steering committee?
    a. Does it influence who you are on the steering committee?
    b. If so, could you describe how it does so?

32. What would representing your *(functional area)* well look like to you?

33. How do you think the work of the steering committee will affect your functional team?

34. How might the work of the steering committee affect your functional team's relationship with other functional areas?

35. Is there anything you add to the steering committee that you don't add to your *(functional area)* team?
    a. What about vice versa? Is there anything you add to your *(functional area)* team that you don't add to the steering committee?

36. How important would you say each of the following are (scale of 1 to 7):
    a. Representing your *(functional area's)* interests well _____
    b. Being a good steering committee team member _____
    c. Being true to yourself _____
    d. Doing whatever is necessary to improve patient care _____

Thank you very much for your time!

37. Though I'll be attending many of your team meetings each month, I'd like to keep informed about how your team is doing between meetings as well. Do you mind if I reach out to you via email on occasion to ask how things are going?

38. Finally, while I'll be speaking with you throughout my time here, I'd like to schedule another interview in about a month. Is there a time that is good for you?

Thank you again, and I look forward to seeing you again soon!

APPENDIX C

INITIAL INTERVIEW PROTOCOL

MEMBER: _____ TIME: _____ DATE: _____

INTERVIEW PROTOCOL – FIRST INTERVIEW

Introduction:

Introduce self or greet in some way

Provide brief explanation or reminder of my role and objectives

Do you mind if I start recording now? *(if it is okay, start recorder)*

If at any time you want me to stop the recorder, just let me know.

Interview Questions:

1. To begin with, could you walk me through how you got involved in this project
    a. Why did you choose to participate?
    b. What do you specifically (hope to) get from this experience?
    c. Do you get personal satisfaction from joining this team?

2. When you think about your work group who is it, if anyone, that comes to mind?
    a. For example, you're a *(functional area)*, do you consider them as your work team or group?
    b. Are there other groups that you would consider "your" work team?

In our field, there is a lot of research suggesting that people think of themselves as being comprised of different parts. For example, you may think of yourself as a (list major role here), a family person, or in line with a hobby like being a skier.

3. Considering that, how would you complete the following sentence: "I am a _____."

4. Do you engage any of those parts of yourself when you're with *(team listed in #2)*?
    a. If so, which ones?
    b. Do you engage any other parts of yourself when with *(team listed in #2)*?
    c. Could you explain what you mean by *(list any part listed that is not clear)*

5. On a scale from 1 to 7, one being low relative importance, how important are each of these parts to you *(read each part listed)*?
    b. Why do you consider _____ so important?

6. How would you characterize the reactions of other *(functional area)* members to these different parts of you?

7. How would you say the people in your *(functional area)* get along?
    d. Are there ever any disagreements or tensions? If so, what do these usually center around?
    e. *[If no tensions]* That's pretty unusual for a group that size. How do you think *(functional area)* has been able to accomplish that?
    f. [If no tensions] I've spoken to several other *(functional area)* and have heard different things from different people. How do you think these different perspectives have developed?

8. Thinking specifically about your *(functional area)*, on a scale from 1 to 7, to what extent would you say:
    d. Your team's successes are your successes
    e. When someone praises your team it feels like a personal compliment
    f. When you talk about your team, you usually say "we" rather than "they"

9. Can you describe the relationship between your (functional area/team/self) and other areas *(conflict, coordination, cohesion)*?
    a. Nurses?
    b. APPs?
    c. Pharmacy?
    d. Anesthesia?
    e. Surgeons
    f. Nutrition
    g. Administrative staff
    h. Data

My understanding is that you are also part of the enhanced recovery Change Team. If you don't mind, I'd like to talk about that a little bit.

10. What is your understanding of the purpose of the Change Team?

11. Would you say that you're on this team primarily to solve a problem or to represent *(functional area)*?
    a. What makes you say _____

12. Similar to before, one of my goals is to understand which parts of yourself you engage when with the change team. Going back to the parts of yourself you listed before, which ones would you say you engage when working with the change team?
    a. Are there any others that you haven't yet listed that you engage on the change team?
    b. Could you explain what you mean by *(list any part listed that is not clear)*

13. *[If new parts listed]* On a scale from 1 to 7, one being low relative importance, how important are each of these parts to you?

14. How would you characterize the reactions of others on the change team to these different parts of you?

15. Are there parts of yourself you could engage for the change team, but choose not to or are hesitant to do so for some reason?
    a. If so, how would you describe those things?

16. Are there times when you're with the change team that you do "teamy" things, but primarily for yourself?
    b. If so, could you describe some of the things you do just for you?
    c. Why do you think you do that while with the change team?
    d. Do you associate that with one of the parts of yourself you've already listed or is that associated with some other part?

17. As you know, teams are a function of multiple members and their relationships with each other while on the team. Therefore, understanding how team members perceive what each person brings to the team is important. When you think of the Change Team, is there anyone that contributes something to the team aside from expertise as a physician, nurse, etc.?
    a. *[If confused]* Are you aware of anyone else that is on the change team?
    b. *[For each person]* What is it that you think they bring to the team aside from expertise as a *(functional area)*?

18. On a scale of 1 to 7, how important do you think *(list each contribution)* is to the team?

19. How would you say the members on the change team are *(will)* getting along?
    a. Have you noticed any disagreements or tensions? If so, what do these usually center around?

20. Would you say the change team is more of a group, a team, or something else?
    a. What makes you say _____?

21. At this point in time, how would you describe the overall quality of coordination on the change team?
    b. What makes you say _____?

22. What about the overall strength of cohesion? How would you describe that for the change team?
    b. What makes you say _____?

23. Thinking specifically about the change team, on a scale from 1 to 7, to what extent would you say:
    d. The change team's successes are your successes
    e. When someone praises the change team it feels like a personal compliment
    f. When you talk about the change team, you usually say "we" rather than "they"

We've been talking about your *(functional area)* as well as the change team sort of separately. I'd like to talk about how they relate to each other for a while.

24. How would you say being a *(functional area)* influences what you do on the change team?
    a. Does it influence who you are on the change team?
    b. If so, could you describe how?

25. What would representing your *(functional area)* well look like to you?

26. How do you think the work of the change team will affect your *(functional area)*?

27. How might the work of the change team affect the relationships between your *(functional area)* and other functional areas?

28. Is there any part of yourself that you bring to the change team that you don't bring to your *(functional area)* team?
    a. What about vice versa? Is there anything you add to your *(functional area)* team that you don't add to the executive team?

29. How important would you say each of the following are (scale of 1 to 7):
    a. Representing your *(functional area's)* interests well _____
    b. Being a good executive team member _____
    c. Being true to yourself _____
    d. Doing whatever is necessary to improve patient care _____

30. Could you talk to me about anything you're particularly excited or concerned about regarding:
    a. How this team is coming together
    b. Other specific team members
    c. How you're personally relating to your team
    d. The tasks ahead of you

Thank you very much for your time!

31. Though I'll be attending many of your team meetings each month, I'd like to keep informed about how your team is doing between meetings as well. Do you mind if I reach out to you via email on occasion to ask how things are going?

32. Finally, while I'll be speaking with you throughout my time here, I'd like to schedule another interview in about a month. Is there a time that is good for you?

Thank you again, and I look forward to seeing you again soon!

APPENDIX D

SUBSEQUENT INTERVIEW PROTOCOL

MEMBER: _____ TIME: _____ DATE: _____

INTERVIEW PROTOCOL

Change team:

1. How have things have been going with the change team since we last spoke?
    a. Have things been progressing the way you thought they would or have there been some surprises?
    b. What makes you say _____ ?

2. While on the change team, have you been able to represent *(functional area)* in the way you've wanted to so far?
    a. What does that representation look like?
    b. What kinds of challenges have you encountered? Can you walk me through what happened?

3. Would you characterize yourself as a good change team member?
    a. What makes you say _____?

4. When speaking with others I've gotten the sense that sometimes they have wanted to push a specific idea but hold back instead. Have you found this to be the case?
    a. If so, can you walk me through what happened?
    b. That's interesting. What made you hold back in that situation?

5. In some of the meetings, I've noticed _____. Can you walk me through what was going on there?
    a. Data driven, but sometimes don't follow it
    b. Resistance to standardization
    c. Everything is for the good of patients, but then disagreement on what's good for patients
    d. Other observations of interest

6. On paper, the change team is a team. To what extent would you say it feels like a team to you?
    a. What makes you say _____?

7. Do you feel more or less connected to the change team now than when we last spoke?
    a. *[If more]* Can you walk me through the process of how that occurred?
    b. *[If not]* Why do you think things have stayed the same even after working on the team for the past (time period)?
    c. What do you think could have happened that would have made you feel connected to the change team?

8. We've talked before about how people bring many parts of themselves to a team. What parts of yourself are you bringing to the change team at this point in time?
    a. One way to consider this is to complete the sentence, on the change team I am a/the _____
    b. *(if lists roles only)* Are there parts aside from your expertise as a *(list role)* that you started engaging?
    c. Can you walk me through how you came to contribute in these other ways?

9. On a scale of 1 to 7, how important to you is being a _____ on the change team?

10. And just to confirm, last time you mentioned that you brought *(read list)*. To what extent do you still engage those parts of yourself on the change team?
    a. *(if changes)* Can you walk me through how you ended up not contributing _____ anymore?
    b. How did you react when you weren't able to contribute in the way you had hoped?

11. How would you describe the current level of _____ in the change team:
    a. Cohesiveness
        a. Is it higher or lower than when we last spoke? Why might that be?
    b. Coordination
        a. Is it higher or lower than when we last spoke? Why might that be?
    c. Tension
        a. Is it higher or lower than when we last spoke? Why might that be?

Influence on Teams and Relationships:

12. *[For Third and Fourth Interviews]* How would you describe the process of explaining *(implementing)* the changes discussed in the various meetings to *(specific group)* so far?
    a. Would you say that, at this point in time, you primarily represent *(functional area)* on the change team, or that you represent the change team to *(functional area)*?
        i. What makes you say _____ ?
    b. How have *(functional area)* reacted to your change team representation?

13. As of now, has being a part of the change team impacted the way you practice in any way? *[If so]* How so?
    a. Could you walk me through how that impact came about?

14. Would you say that the work of the change team has affected your functional team in other ways?
    a. What makes you say _____ ?
    b. Has it changed how the members of your team relate to each other?

15. What about the relationships between *(functional area)* and other areas such as *(examples)*? Would you say the work of the change team has influenced those relationships at all? *[If so]* How so?

Functional Area (and other) Teams

16. We've talked before about how people bring many parts of themselves to a team. What parts of yourself are you bringing to *(functional area)* at this point in time?
    a. One way to consider this is to complete the sentence, when with *(functional area)* I am a/the _____
    b. *(if lists roles only)* Are there parts aside from your expertise as a *(list role)* that you started engaging?
    c. Can you walk me through how you came to contribute in these other ways?

    _____

    _____

    _____

17. On a scale of 1 to 7, how important to you is being a _____ when with *(functional area)*?

18. And just to confirm, last time you mentioned that you brought *(read list)*. To what extent do you still engage those parts of yourself when with *(functional area)*?
    a. *(if changes)* Can you walk me through how you ended up not contributing _____ anymore?
    b. How did you react when you weren't able to contribute in the way you had hoped?

19. How would you describe the current level of _____ in *(functional area)*:
    a. Cohesiveness
        a. Is it higher or lower than when we last spoke? Why might that be?
    b. Coordination
        a. Is it higher or lower than when we last spoke? Why might that be?
    c. Tension
        a. Is it higher or lower than when we last spoke? Why might that be?

Identities:

If you don't mind, I'd like to ask some questions about your personal approach to practicing health care.

20. Throughout my time here I've often heard people describe themselves as Care Providers. Do you think of yourself as a Care Provider as well, or something else?
    a. [If so] What does being a care provider mean for you specifically?
    b. [If not] How would you describe yourself in your patient treatment role?
    c. What does being a _____ mean to you specifically?

21. I've also heard many people say that everything they do is for the patients. To what extent do you agree with that?
    a. *[If yes]* What does doing everything "for the patient" mean to you?
    b. When you think of doing things for the patients, do you most often think of all patients or your patients specifically?
    c. How would you describe your relationship with your patients?

22. What do you see as your responsibilities for patient care?
    a. How much of that would you say you have control over?
    b. *[If difference]* How do you deal with the difference between the two?
    c. Who would you say ultimately directs patient care?

23. To what extent would you say you connect everything you do day-to-day with patient care? Or is it more like you think about being a care provider in conversations like this, but it doesn't come to mind when actually doing your day to day activities?
    a. Are there things you don't connect with patient care on a day-to-day level?
    b. When you think about that connection, is it providing care for all patients or just your patients?

24. At this point in your professional life, are you looking to become a part of more groups, fewer groups, or maintain the number of groups you are a part of now?
    a. What makes you say…?

25. Thinking specifically about the *(change team, functional area, specialty, leadership team)*, on a scale from 1 to 7, to what extent would you say:
    g. The *(appropriate group)*'s successes are your successes
    h. When someone praises the *(appropriate group)* it feels like a personal compliment
    i. When you talk about the *(appropriate group)*, you usually say "we" rather than "they"

26. Has your perception of the importance of any of the following changed since we last spoke? (scale of 1 to 7):
    a. Representing your *(functional area's)* interests well _____
    b. Being a good change team member _____
    c. Being true to yourself _____
    d. Doing whatever is necessary to improve patient care _____

27. Could you talk to me about anything you're particularly excited (concerned) about regarding:
    a. How your team is coming together
    b. Other specific team members
    c. How you're personally relating to your team
    d. The tasks ahead of you

28. Is there anything else we haven't discussed that you would like to mention?

Thank you very much for your time, I'd like to schedule another interview in about two months. Is there a time that is good for you?

Thank you again, and I look forward to seeing you again soon!

APPENDIX E

OBSERVATION LOG

Event	Date	Time Started	Time Ended	Total Time
Change Team Meeting	3-May-19	13:00	16:48	3:48
Change Team Meeting	25-Jun-19	16:22	18:14	1:52
Change Team Meeting	11-Jul-19	16:12	18:28	2:16
Change Team Meeting	24-Jul-19	16:00	18:23	2:23
Change Team Meeting	6-Aug-19	16:14	18:12	1:58
Change Team Meeting	15-Aug-19	16:13	18:14	2:01
Change Team Meeting	5-Sep-19	16:03	17:44	1:41
Change Team Meeting	26-Sep-19	16:17	18:04	1:47
Change Team Meeting	24-Oct-19	16:12	18:50	2:38
Change Team Meeting	21-Nov-19	16:17	17:51	1:34
Change Team Meeting	29-Jan-20	6:55	8:27	1:32
Change Team Meeting	12-Feb-20	6:55	8:11	1:16
Leadership Team Meeting	11-Mar-19	13:02	14:04	1:02
Leadership Team Meeting	12-Mar-19	16:00	16:56	0:56
Leadership Team Meeting	1-Jul-19	15:00	15:34	0:34
Leadership Team Meeting	25-Jul-19	13:00	13:37	0:37
Leadership Team Meeting	5-Aug-19	16:00	16:49	0:49
Leadership Team Meeting	9-Sep-19	16:00	16:58	0:58
Leadership Team Meeting	23-Sep-19	16:04	16:59	0:55
Leadership Team Meeting	1-Oct-19	14:59	16:04	1:05
Leadership Team Meeting	7-Oct-19	16:00	16:46	0:46
Leadership Team Meeting	14-Oct-19	16:01	17:00	0:59
Leadership Team Meeting	21-Oct-19	16:00	16:21	0:21
Leadership Team Meeting	11-Nov-19	16:00	16:51	0:51
Leadership Team Meeting	25-Nov-19	16:00	16:32	0:32
Leadership Team Meeting	6-Jan-20	16:30	17:07	0:37
Leadership Team Meeting	13-Jan-20	16:13	16:49	0:36
Leadership Team Meeting	27-Jan-20	16:14	17:21	1:07
Leadership Team Meeting	10-Feb-20	16:00	16:57	0:57
Leadership Team Meeting	17-Feb-20	16:00	17:04	1:04
Leadership Team Meeting	3-Mar-20	16:00	16:29	0:29
Surgeon and APP Faculty Meeting	14-May-19	16:30	17:42	1:12
Surgeon and APP Faculty Meeting	11-Jun-19	16:30	17:43	1:13
Surgeon and APP Faculty Meeting	10-Sep-19	16:25	18:02	1:37
Surgeon and APP Faculty Meeting	15-Oct-19	16:33	17:42	1:09
Surgeon and APP Faculty Meeting	10-Dec-19	17:23	18:06	0:43
Anesthesia ERP Education	28-Jan-20	6:04	7:14	1:10
Education Materials Meeting	12-Dec-19	8:30	12:15	3:45
Research Committee Meeting	3-Jun-19	15:30	17:08	1:38
TOTAL OBSERVATION TIME				**52:28**

TABLE 1

Examples of Broad and Narrow Construal of Identities

Identity Type	Broad Construal	Narrow Construal
Higher-order	*Does that take money away from my company? Yes it does, but we're here to do what's best for the patients. (202, change team meeting)*	*I think my leadership is not for me… it's for **my patients**. So, I mean…if this isn't about **my patients**, I wouldn't be a part of this thing. (106)*
Role	*I'm a nurse. Which is a lovely catchall to say that I can do many things. And it's logistics, it's equipment, for surgery anyways. It's equipment handling and maintenance. It's being a recordkeeper. It's providing care. Which is something that, you know, I solve. (605)*	*So, [there are] medications that are not necessarily narcotic that we can give for pain and to manage those things, those pieces. [We're also responsible for] getting patients up, getting them started off IV fluids and eating and drinking as soon as possible. (608)*
Relational	A nutritionist explained how she and her team provide preoperative nutrition advice for *all* patients. (502)	*Well, I'll hold anesthesia accountable if they make a mistake. But in the end that's my patient. [Anesthesia] didn't see them preoperatively. They didn't work them up. They didn't get them, meet them, get a rapport and all that kind of stuff. They've got a job. I bring the patient to them and [and] I tell the patient, "Hey, this is a great anesthesiologist." So, in the end if anything goes wrong, even if it's anesthesia's mistake, it's [on] me – it's my patient. (104)*
System	*We're all here for the patients. I mean, there are different cases and different patients. But our ultimate goal is excellent patient care. Which is, in my domain, surgery. So - and they're all surgeons, or anesthesia providers, or pharmacists. So, because we have a common goal, we are a team. (605)*	*There's no scenario where like, [this doctor] and I are working together. He's [a different specialty]. I'm like - we just, we don't work together. Even [these other areas]. We just don't - we all sort of work in our own different silos. (109)*

TABLE 2

Position and Types of Enactment

Role	Defending	Bending	Mending	Total
Surgeon	4	2	4	10
Nurse	2	3	3	8
Physician's Assistant			1	1
Pharmacist	1			1
Nutritionist			1	1
Operations	3		3	6
Data Analysts			2	2
Anesthesiologists			2	2
Total	10	5	16	31

FIGURE 1

Emergent Enactment Model

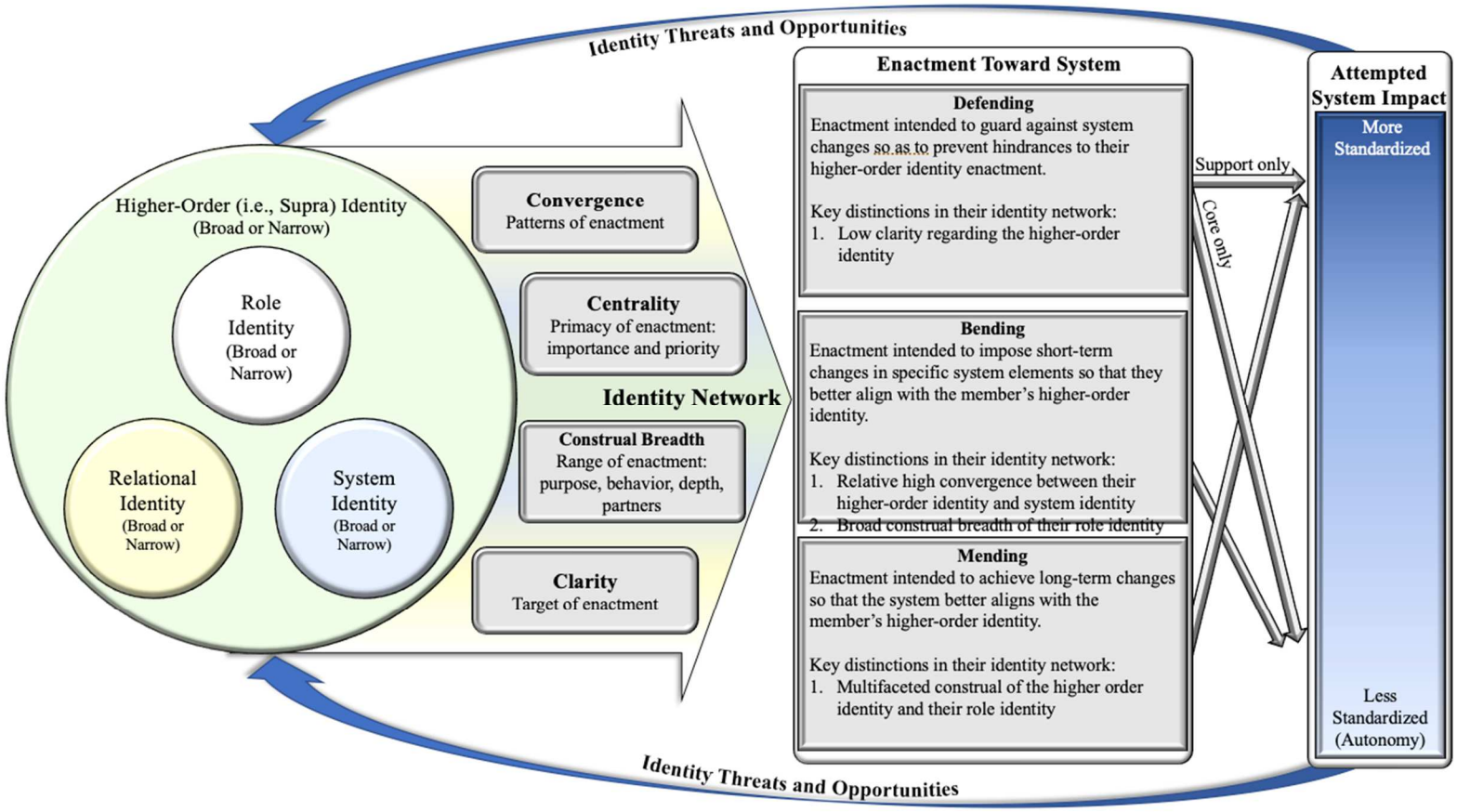

FIGURE 2a

Core Defending Identity Network Enactment

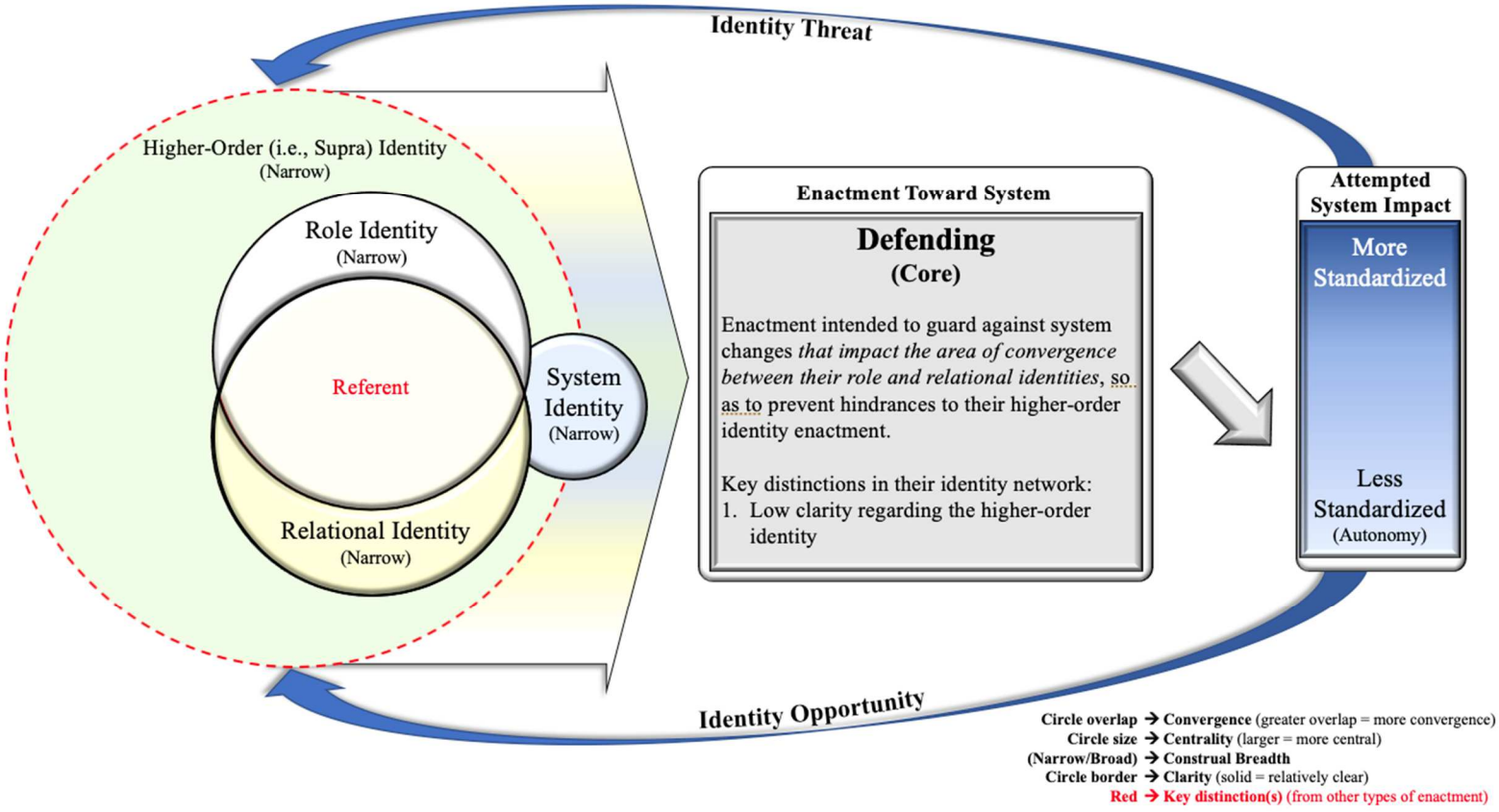

FIGURE 2b

Support Defending Identity Network Enactment

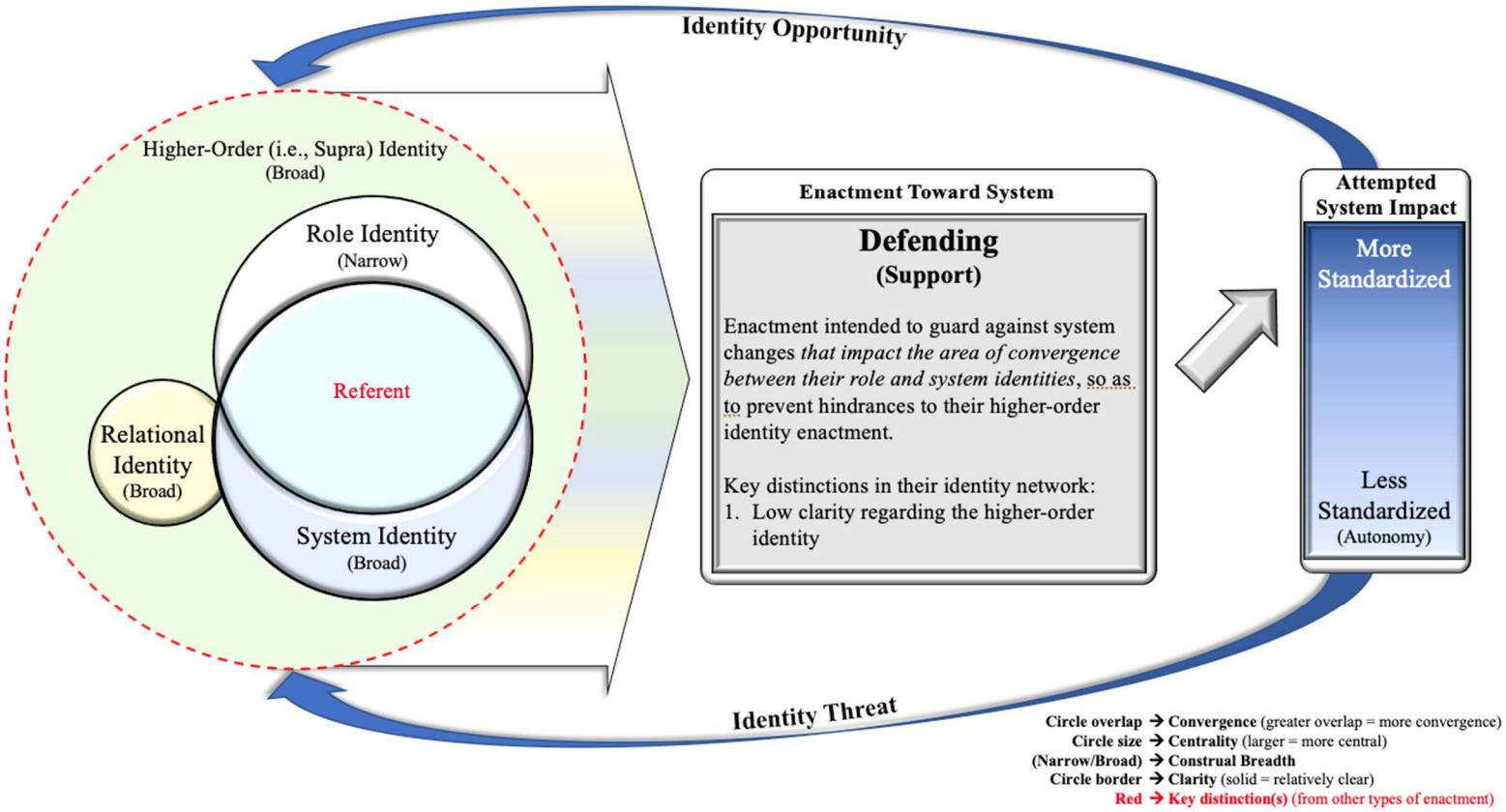

FIGURE 3a

Core Bending Identity Network Enactment

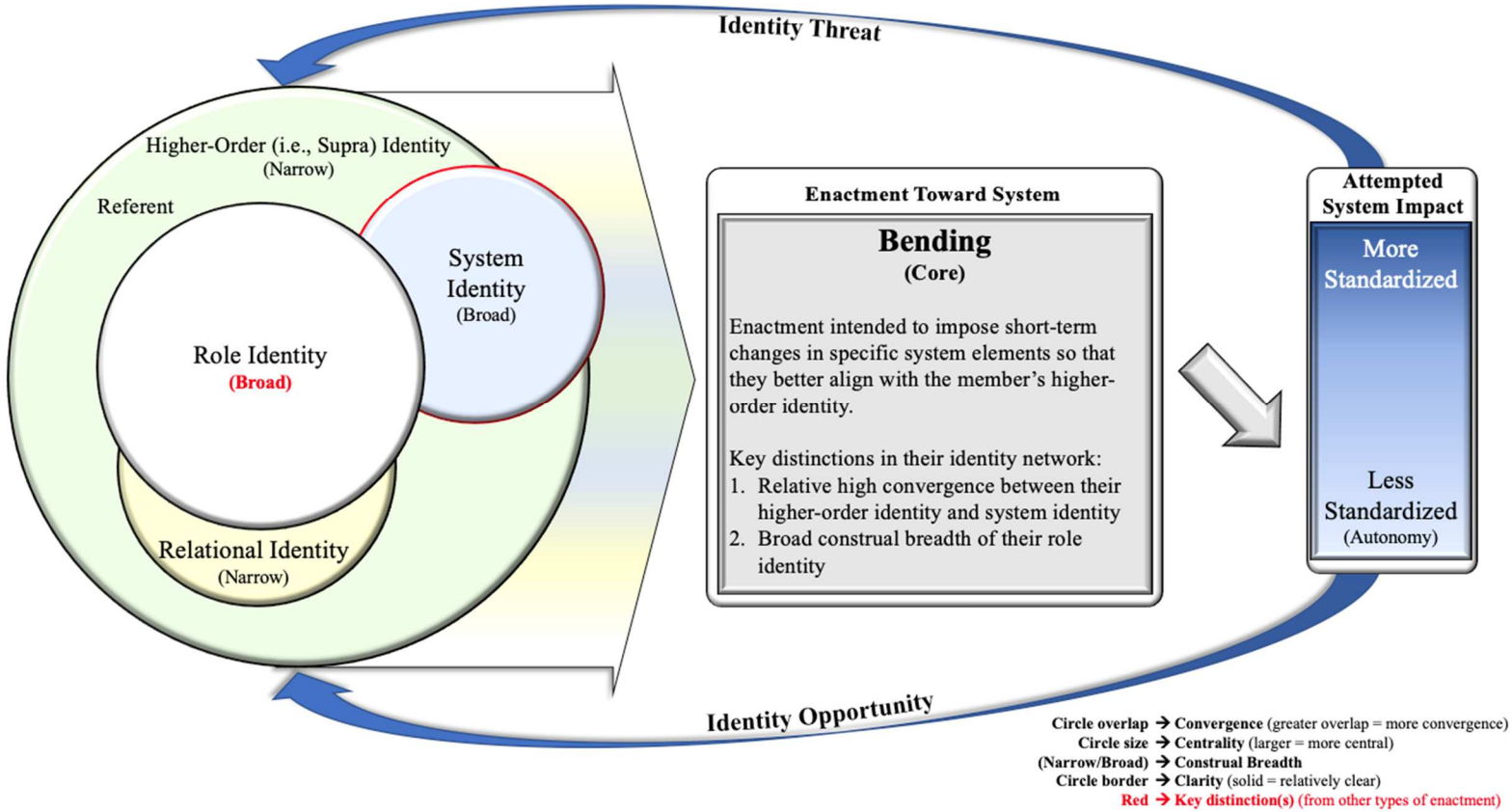

FIGURE 3b

Support Bending Identity Network Enactment

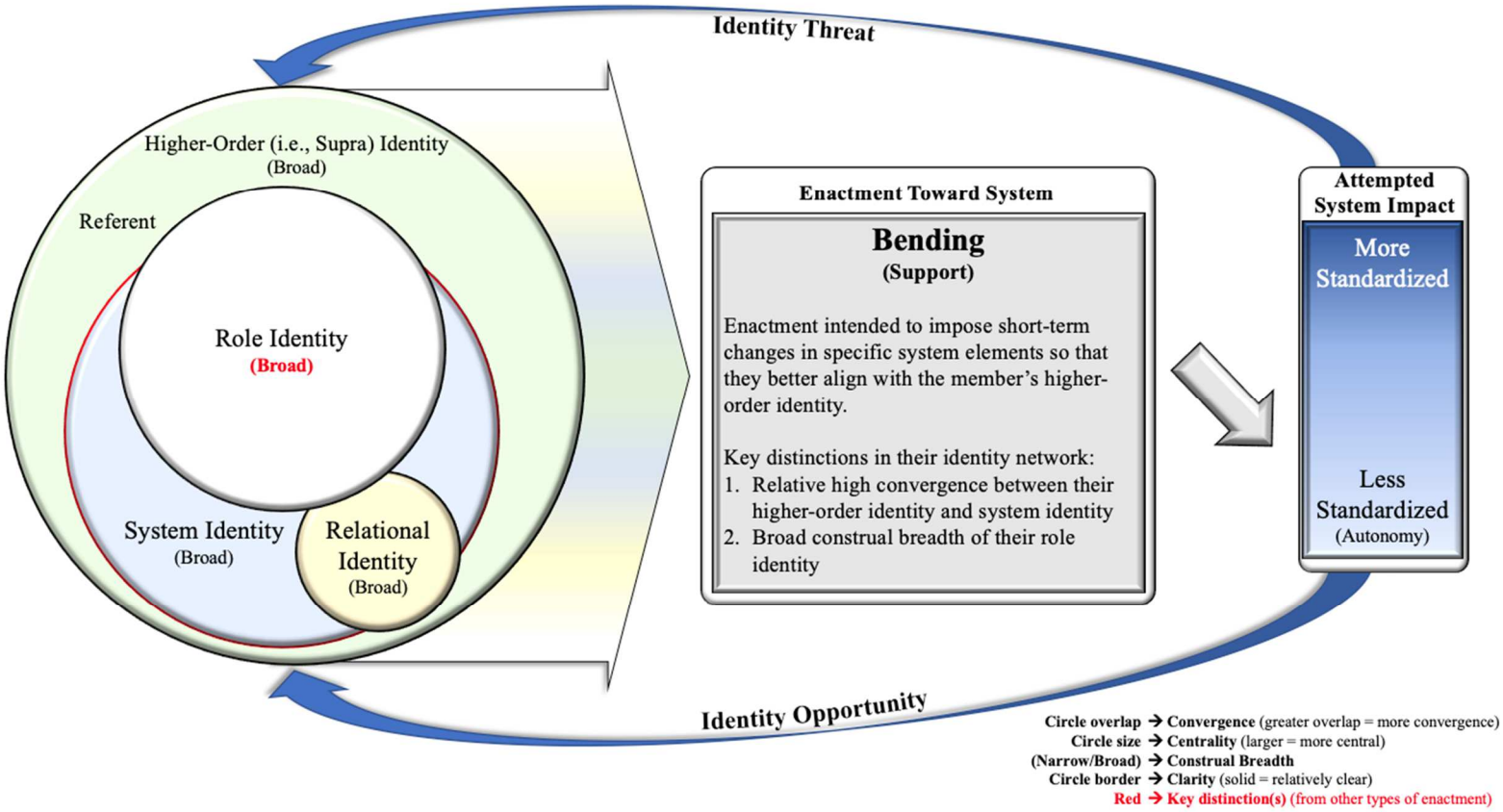

FIGURE 4a

Core Mending Identity Network Enactment

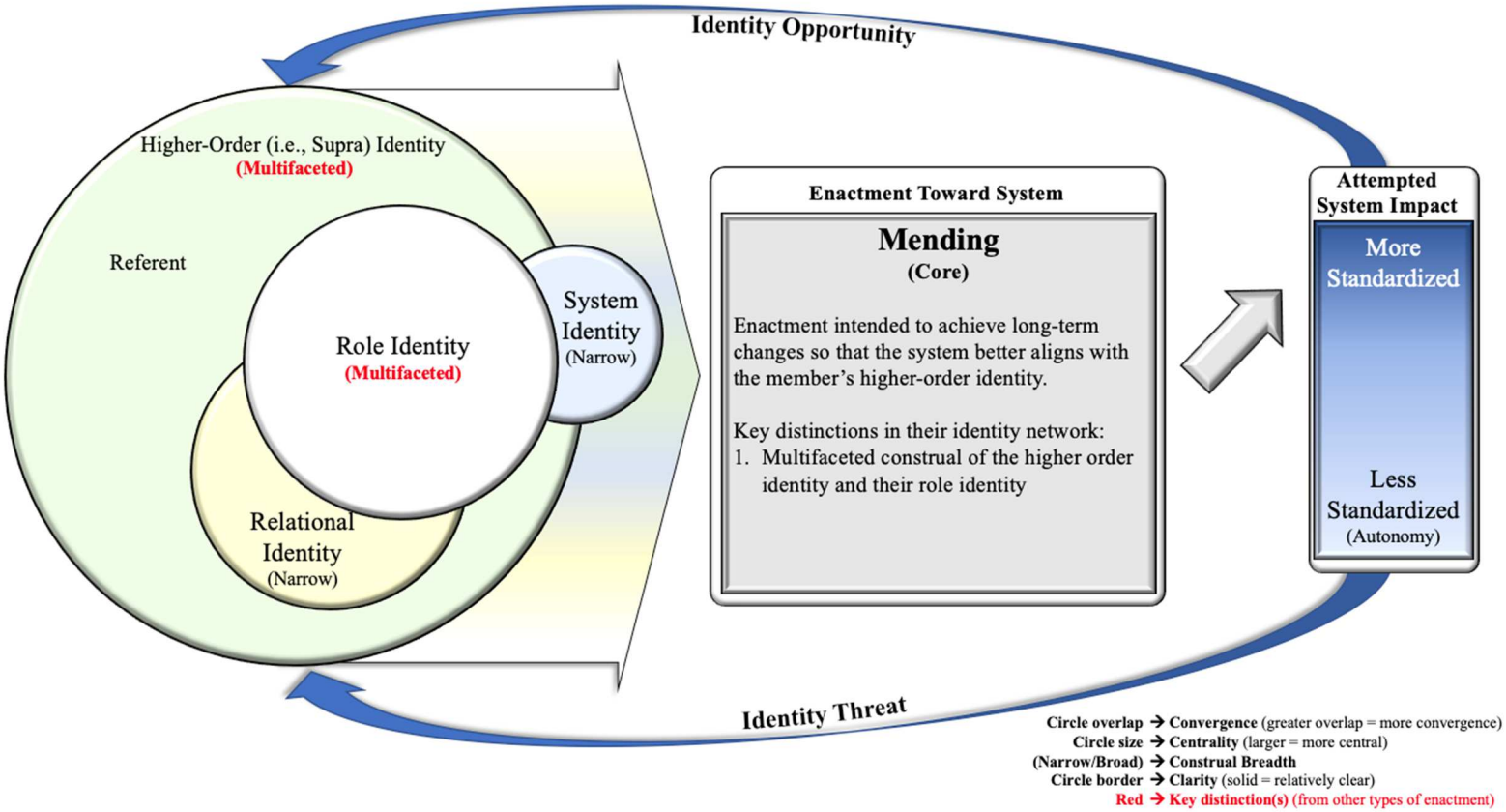

FIGURE 4b

Support Mending Identity Network Enactment

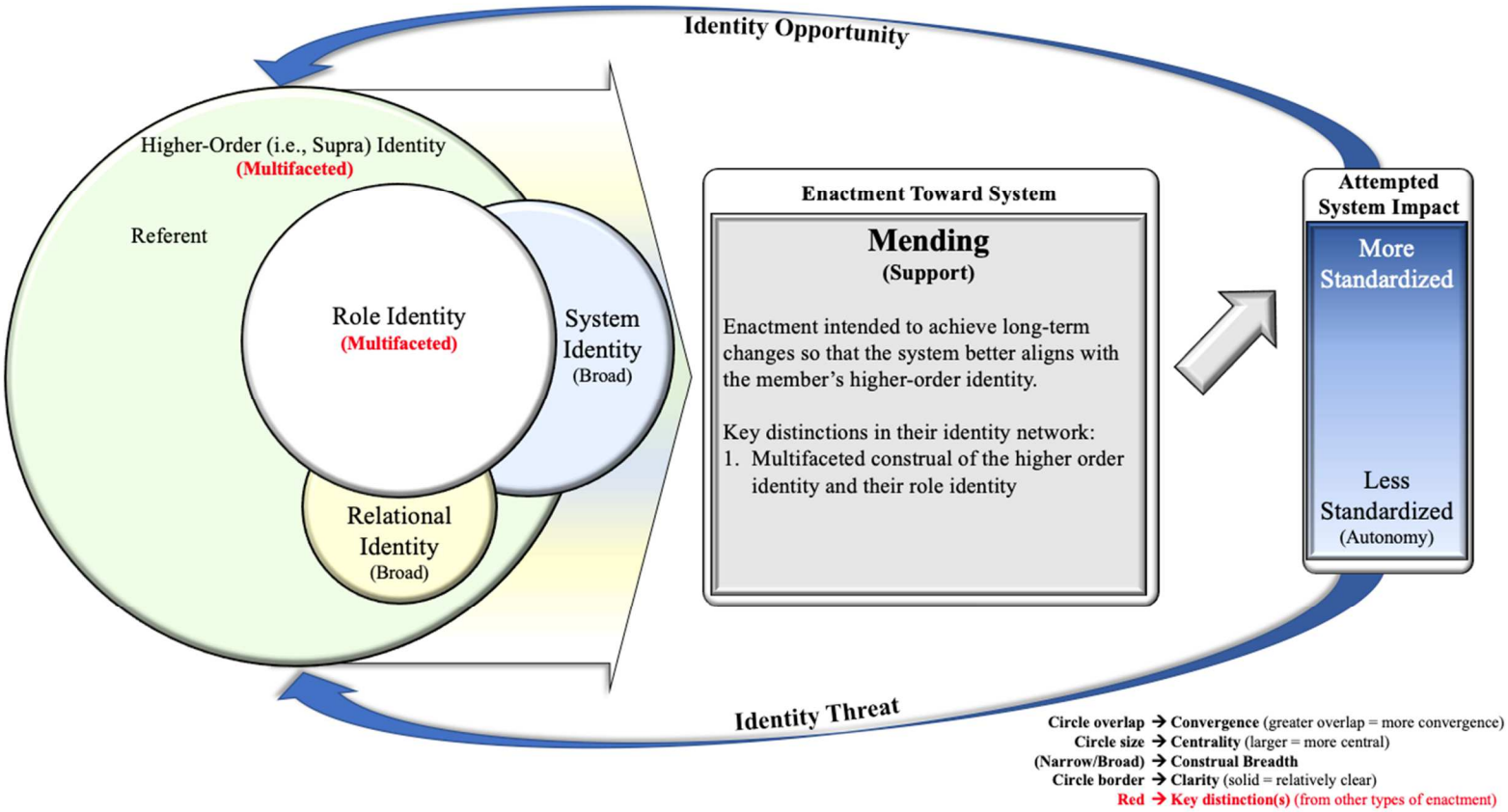

FIGURE 5

Overarching Process of Identity Network Enactment