Alma Mater Studiorum – Università di Bologna

DOTTORATO DI RICERCA IN
PhD in General Management

Ciclo XXVI

Settori Concorsuali di afferenza:
09/B3 - INGEGNERIA ECONOMICO-GESTIONALE;
13/B3 ORGANIZZAZIONE AZIENDALE

Settore Scientifico disciplinare: ING-IND 35; SECS-P/10

TITOLO TESI
Identity dynamics and the emergence of new organizational arrangements:
a multi level study.

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Esame finale anno 2014

Introduction

Thesis argument

Organizational and institutional scholars have advocated the need to examine how processes originating at an individual level can change organizations or even create new organizational arrangements able to affect institutional dynamics (Chreim *et al.*, 2007; Powell & Colyvas, 2008; Smets *et al*., 2012). In spite of the call for an inquiry into the agentic role of individuals, to date most studies on organizational and institutional change have focused primarily on field-level processes, although notable exceptions do exist (cf., Smets *et al*., 2012). Conversely, research on identity work has mainly investigated the different ways individuals can modify the boundaries of their work in actual occupations, thus paying particular attention to 'internal' self-crafting (e.g. Wrzesniewski & Dutton, 2001).

Drawing from literatures on possible and alternative self and on positive organizational scholarship (e.g., Obodaru, 2012; Roberts & Dutton, 2009), my argument is that individuals' identity work can go well beyond the boundaries of internal self-crafting to the creation of new organizational arrangements.

The contribution develops this form of identity work by building a grounded model. I contend that this is a particularly complex form of collective identity work (Leana *et al*., 2009; Mattarelli & Tagliaventi, in press) because it requires, to be successful, concerted actions of several internal, external and institutional actors, and it also requires balanced tensions that – at the same time - reinforce individuals' aspirations and organizational equilibrium. I name this process organizational collective crafting.

In this contribution I analyze, through multiple case studies, healthcare professionals who spontaneously participated in the creation of new organizational arrangements, namely health structures called Community Hospitals. By focusing on individuals' identity work I highlight the role that not only 'who I am', but also the cognitive representations of 'who I could be' or 'who I could have been' (unrealized selves) exert on attitudes and behaviors in the workplace. Moreover I inquire the role of context in supporting the triggering power of those unrealized selves. The loose definition of community hospital at the Regional and National level and the perceived institutional contradictions trigger a high variety of sensemaking processes, so that all the involved actors – despite their different needs - interpreted the new organizational arrangement as the opportunity that could possibly fit their personal needs.

My findings show a strong agential role of identity work that favors the creation of new organizations that enable professionals to flourish at work. I therefore contribute to new and fast growing research streams that focus on the mechanisms through which individuals enact possible and alternative selves at work and become more positive selves, and on their consequences at the organizational and higher-order levels.

Structure of the thesis

   The first chapter settles the theoretical framework of micro dynamics of change presenting two different streams. The first stream deals with the centrality of identity work dynamics, grounding on the dynamic nature of organizational identity (e.g. Pratt). The second stream inquires the micro-foundations of institutional change (Reay *et al*., 2006; Goodrick & Reay, 2010), with a digression on institutional work (Laurence & Suddaby, 2006). The chapter ends with the research questions that the study aims to address.

   The second chapter introduces the research setting, data sources and data analysis. The research setting is related to the new organizational form of Community Hospitals in the

Italian healthcare sector. After 4 preliminary interviews, five case studies have been selected from different Italian Regions. Interviews, organizational archival data and institutional documents are the data sources. The chapter is concluded presenting the final data structure (using Gioia's methodology from Gioia *et al*.; 2013).

Before landing at the final grounded model in chapter 7, chapters 3, 4, 5 and 6 develop the dimensions considered in the grounded model, through field evidences and specific theoretical contributions. Chapter 3 focuses on the individual level and inquires the unrealized selves (alternative selves, possible selves and ideal selves) as triggers of identity work. Literature shows different targets of identity work, such as persona crafting, job crafting or role crafting. My evidence show how, after some independent and unsatisfying job and role crafting trials, family doctors and nurses decided to be involved in the community hospital development in order to enact their unrealized selves, starting a collective effort of job crafting. Chapter 4 inquires the Italian institutional environment to understand which conditions could actually enhance this collective job crafting and the creation of several community hospitals throughout Italy. The environment that results from the analysis is a loosely and non homogeneously regulated setting. The chapter inquires the loose institutionalization as an opportunity for micro dynamics related to the unrealized selves. Chapter 5 addresses the organizational level, deeming into the intra-organizational dynamics that let this collective process of job crafting to be successful. Although archival documents describe processes and procedures that are internal to the organizations, evidence related to identity perceptions and measurement show organizational identity variance among the different actors involved in the community hospital. The emergent pattern at the individual level between organizational identity perceptions and unrealized selves is presented. Chapter 5 shows how those patterns are triggers of organizational identity variance at the organizational level and addresses the mechanisms that at the organizational level mediate

between individual fulfillment and organizational collective agreement. Cognitive and practical tactics that softened potential and real conflicts arising from organizational identity variance are shown. In chapter 6, evidence connects four different kinds of positive identities at the individual and organizational level (Dutton *et al*., 2010) with the structure of the organization. It is shown how those positive identity processes act as mechanisms reinforcing the organizational structure created.

The last chapter (chapter 7) introduces and develops the emerged grounded model. Theoretical contributions are discussed and managerial implications are presented, with a paragraph devoted to the study of limitations and implications for future research directions.

1. Theoretical framework

The purpose of this study was to explore how micro processes can lead to the emergence of a new form of organization (e.g. Greenwood & Suddaby, 2006). This objective was aligned with calls for studying how processes originating at the individual level can change organizations or even create new organizational arrangements able to affect institutional dynamics (Chreim *et al*., 2007; Powell & Colyvas, 2008; Smets *et al*., 2012). Since my interest was to build and enrich theories addressing those calls, I designed a theory-building study. During my data collection, coherently with the iterative structure of explorative research, I had several "back-and-forths" between data analysis and literature review. This process led me to reframe the focus of my inquire, and to identify – on my way - previously unknown theoretical concepts as central dimensions of the emerging grounded model. Although most of the theory should thus logically be presented as paired with the evidence emergence (that is presented in the central chapters of this thesis - chapters 3, 4, 5 and 6), in order to orient the reader towards my final findings, I will anticipate an introduction to the central streams of literature that will be recalled and developed in the next chapters. A significant bunch of literature is still presented in the central chapters and in the final discussion.

1.1. *Micro-foundations of organizational and institutional change*

The research dealing with inter-level influences has shown that higher-order entities, such as institutions and employing organizations, affect individual processes, especially processes related to identity. Among them, some contributions show how the imposed change was revisited and adapted by the involved professionals in a non-passive way.

For example, Chreim, William and Hinings (2007) inquire the re-construction of professional identity through a single case study in a health care unit in Canada after a national health care reform. They consider three levels of analysis: the institutional, the organizational and the individual level. They found that the agentic reconstruction of professional role identity is enabled and constricted by an institutional environment that provides interpretive, legitimating and material resources that professionals adopt and adapt. Institutional forces also impact organizational arrangements that further influence micro-level agency. Doolin (2002) analyzes the impact of a reform in the healthcare public sector in New Zealand. This paper considers how the general intention of government to control and influence the professional autonomy of hospital clinicians was played out in the context of a single New Zealand hospital (Doolin, 2002: 369). With a discursive lens, Doolin tracks in a two-year study how individuals in that hospital negotiate a dominant discourse in the construction of identity and self. In another study in the healthcare sector, which appears to be an interesting setting for exploring social identities' dynamics (Dukerich *et al*., 2002), changes in formal socialization to the nursing profession resulted in changes in the core values of nurses' professional identities (Goodrick & Reay, 2010).

These studies explain how an imposed institutional change is adopted and adapted by the individuals through the reconstruction of identity, but the change eventually follows a top-down direction. Although those studies follow a perspective of evolution of identity through negotiation, the described identity work processes happened under institutional duress. Only Chreim *et al*. (2007) finished their contribution suggesting that their data hint an interesting dynamic that could indicate a connection starting from the individuals' work identity and affecting the macro template at the institutional level.

In line with this suggestion, a few studies have investigated how individual identity-related processes can bring about organizational and higher-level changes. To this regard, Rao *et al*. (2003) found that French chefs' social construction of a positive work-related identity as creative chefs led to the introduction and diffusion of the new nouvelle cuisine movement internationally. Coherently with Laurence & Suddaby (2006) theorization of identity work as a form of institutional work, Lok (2010) argued that institutional logics are reproduced and transformed by individuals' everyday identity work, and showed how British management and institutional investors reworked their practices and identities to simultaneously accommodate, and react against, some of the implications that the new institutional logic of shareholder value imposed. Similarly, Zilber (2002) showed how organizational members of a rape crisis center acted as institutional carriers and instilled new therapeutic meanings into previously established feminist practices. She therefore demonstrated how micro-level dynamics and work can construct, maintain, and change institutions. Finally, Reay *et al*. (2006) investigated the institutionalization of new professional roles showing how seasoned nurse practitioners were able to legitimize their role by enacting three on-going micro-processes: recognizing opportunities for change, fitting new roles into established systems, and proving the new roles' value.

Institutional entrepreneurship and Sensemaking

Lawrence & Suddaby (2006) define institutions as "enduring elements of social life that affect individual and collective thoughts, feelings and behaviors" (:216). Similarly, Scott (2001) defines institutions as consisting of cultural, normative and regulative elements that provide stability and meaning to social life. In the last twenty years a stream of studies inquiring the role of actors in transforming institutions has developed. Those studies build on Jepperson's (1991) definition of institutions as product of purposive (intentional or non-

intentional) action. This stream analyzes the individuals as agents of change, moving from the concept of the institutional entrepreneur. Di Maggio (1988) defines institutional entrepreneur as interested organized actors with sufficient resources: new institutions arise when organized actors with sufficient resources see in them an opportunity to realize interests that they value high (:14). A few years later Oliver (1991) presented a framework showing how organizations strategically behave in response to institutional impact. The theory of institutional work has developed starting from those contributions.

Institutional work represents "the broad category of purposive action aimed at creating, maintaining and disrupting institutions" (Lawrence & Suddaby, 2006). Lawrence & Suddaby (2006) review a vast literature and identify different tactics. Regarding the creation of institutions (as it could be the creation and later attempt to institutionalize the "community hospital"), between the identified tactics, some of them define access to material resources, others reconfigure actors' belief and systems, and others alter the boundaries of the meaning system.

Those institutional entrepreneurship contributions (e.g. Lounsbury & Glynn 2001; Suddaby & Greenwood 2005) mainly analyzed institutional creation and change as bottom-up processes. The same could be said for studies inquiring institutional change with a practice change perspective, that show how modification in local practices were later affirmed at the field level and contributed to change institutions (e.g. Smets *et al.*, 2012; Lounsbury & Crumley, 2007).

In the last decade a big debate emerged in the new institutional literature, trying to address the paradox of embedded agency (e.g. Seo & Creed, 2002). How can embedded agency be explained by a theoretical framework that mainly defines institutions as elements that affect (that is: influence and drive) individuals and collective thoughts, feelings and

behaviors? In this debate, some authors reframe the embedded agency paradox trying to understand the relationship between individuals' sensemaking and the institutions in which individuals are immerged.

Usually sensemaking has been used on local analysis (e.g. intra-organizational level, such as routines) rather than in relationship with macro-context. Despite this, the interrelation between larger contexts and sensemaking has been claimed as needing further theorization (Weick *et al*., 2005; Weber & Glynn, 2006).

The mainstream position in literature theorizing how sensemaking is influenced by institutions assigns to institutions the role of "internalized cognitive constraints on sensemaking ('taken-for-grantedness')" (Weber & Glynn, 2006: 1642). That is, when an institutional element (a logic or a template) is affirmed, individuals take the meanings and expected behaviors carried by that logic for granted: until the institution is disrupted, meanings and behavior expectations will difficultly change (e.g. Lawrence & Suddaby, 2006).

Beyond the notion of internalized cognitive constraint, Weber & Glynn (2006) theorize other mechanisms that could explain the connections between institutions and sensemaking processes. They theorize how the processes of priming, editing and triggering bring institutional context into processes of sensemaking. In their framework institutions trigger sensemaking "posing puzzles for sensemaking through endogenous institutional contradiction and ambivalence" (:1648). The triggering role of institutions delves into two fundamental processes: "first, by providing dynamic foci that demand continued attention, and second, by creating puzzles that require sensemaking due to the contradictions, ambiguities and gaps that are inherent in institutions" (:1654).

Institutional scholars previously supported the view of contradictions and ambivalence as triggers of institutional work, although they did not frame it in a sensemaking perspective.

They consider institutional logics as templates for action and interpretation, and consequently individuals in structural locations that engage multiple logics can catch and craft new opportunities (Powel & Owell-Smith, 2008, Lawrence & Suddaby, 2006). Powell & Owell-Smith (2008) argue that network and institutions co-evolve to shape social and economic arrangements, and a force behind that shaping process is "organizations and individuals who strive to navigate settings where multiple institutional logics either co-exist or collide." (:605). They consequently conjecture that settings where multiple logics overlap are "particularly fertile ground for institutional entrepreneurship" as ambiguous identities and multiple networks offer room to maneuver. Seo & Creed (2002) interpret the presence of institutional contradictions between institutional arrangements as an important precondition for embedded agency. They define an institutional contradiction as inconsistencies and tensions within and between social systems (:223). They state that the "ongoing multilevel processes produce a complex array of interrelated but often mutually incompatible institutional arrangements […that] provide a continuous source of tensions and conflicts within and across institutions" (:225). A micro-level study (Creed *et al.*, 2010) shows how individuals experience and resolve contradictions within and between institutional logics: they analyze how gay and transgender ministers of two Protestant groups address the contradiction of their role and their gay identities. The empirical study finds that the ministers use identity work processes in order to answer to the institutional contradictions they face. The processes they found are processes of identity reconciliation, role claiming and role use.

Changing processes thus find fertile ground around concepts of identity work and sensemaking when related to large-frame literature (as the new institutional literature). In the next paragraph, I will deeper inquire on those concepts following another stream of literature.

That frame is detached from the institutional entrepreneurship literature and more focused on micro dynamics.

1.2. *Identity work as a micro-dynamic of change*

When dealing with shaping of identities, identity work stream should be called into attention. Identity work literature examines the individuals' active construction of identity by considering the social groups' influence. Those studies direct attention to the efforts and practices deployed to create, sustain, or change a particular identity (Roberts & Dutton, 2009) and view the identity construction as more interactive and more problematic than the relatively straightforward adoption of a role or category (Pratt *et al*., 2006). Sveningsson & Alvesson (2003: 1165) define the identity work as "being engaged in forming, repairing, maintain, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness".

Identity work and craftiness: different targets in literature

Identity work can address different targets and consequently can impact on different levels of analysis. Actually, identity work literature has mainly focused on targets at the individual level, with the persona crafting. For example, Pratt *et al*. (2006) analyze professional identity construction through a six year qualitative study of medical residents, and they define work identity integrity as a comparison between who the person is and what she does. They found that, when there is a lack of work identity integrity, identity construction is triggered so that the individual can customize the professional identity on the work.

Beside identity work triggering the "persona crafting", Pratt *et al.* (2006) call for an interesting research direction attempting to move beyond the perception and motivational boundaries. The authors argue that the process of identity construction that they analyzed was tested on professionals-in-training. Consequently, they have stresses the identity construction process, but they could not analyze job crafting or role innovation processes. They suggest that as far as individuals gain experience in their work and as far as the work becomes more discretionary (e.g. gaining autonomy through experience or expertise), the emphasis might shift from identity construction to job crafting and or role innovation processes. This research direction explicitly hints inter-level dynamics (e.g. consequences on activities) related to identity work processes.

Other contributions study the effects that identity work has on the job level: identity work can actually impact and trigger job crafting activities (Wrzesniewski & Dutton, 2001; Leana, Appelbaum, and Shevchuk, 2010; Ghitulescu, 2007; Lyons, 2008; Berg, Wrzesniewski & Dutton, 2010). Wrzesniewski & Dutton, 2001 define job crafting as "the physical and cognitive changes individuals make in the task or relational boundaries of their work". Basically job crafting complement classic top-down views of job design: "whereas job design addresses structural features of jobs that are created and enforced by managers, job crafting focuses on the proactive changes employees make to their own job boundaries." (Berg, Wrzesniewski & Dutton, 2010: 159).

Wrzesniewski & Dutton (2001) propose a theoretical model that explains the mechanisms through which individuals can alter their activities, identifying different ways like changing task, cognitive and relational boundaries. Changing task boundaries means altering the form or number of activities that one engages in while doing the job. Changing cognitive boundaries refers to altering how one sees the job (e.g., as a set of discrete parts or as an

integrated whole). Changing relational boundaries stands for exercising discretion over with whom one interacts while doing the job.

The job crafting is not necessarily an individual process: a few studies inquired it as a collective process. Leana *et al.* (2009) have the merit to theorize that collaborative job crafting and individual job crafting are distinct constructs and that individuals can engage in one of them or in both of them. They define the collective crafting as "not the work of an individual agent as described by Wrzesniewski & Dutton, but instead is the work of a dyad or group of employees who together make [definition of individual job crafting by Wrzesniewski & Dutton] : 2009). Their contribution focuses in defining antecedents and consequences of collective crafting. Another work by Mattarelli & Tagliaventi (in press) builds on Leana *et al.* (2009) and present a model that connects the individual crafting and the collective crafting. The authors find that the crafting process starts individually and unfolds collectively.

Some contributions in the last years focused on processes that drive job crafting. Wrzesniewski & Dutton (2001) consider motivations that drive individuals to enact job crafting activities, such as the need for control over job and work meaning and the need for a positive self image.

In another interesting empirical qualitative study, Berg, Wrzesniewski and Dutton (2010) aim at understanding how employees' structural locations (power and autonomy) shape how they construct and act on their perceptions of the challenges to job crafting that they foresee or encounter along the way. The study show that autonomy and power do not necessarily facilitate job crafting: on the contrary their evidences show that low level employers find it easier to adapt their work environment to craft their job.

Other contributions showed that job crafting has the potential to bring positive outcomes not only to individuals, but also to the entire organization (Lyons, 2008; Tims & Bakker, 2010).

Some recent studies testify to the potential for job crafting to affect organizational processes (Leana *et al*.; 2009; Mattarelli & Tagliaventi, *in press*). Mattarelli & Tagliaventi (in press) addresse collective job crafting through changes at the organizational level, such as changes in the products and services offered and/or in the markets served by the company. The authors investigate the process that leads from job dissatisfaction to new business opportunities in organizations that offshore R&D activities to emerging countries. Their finding indicate that offshore professionals react against the perception of a threat to work-identity integrity through the introduction of new markets, industries, and services, which in turn may change a professional's job design.

At last, other authors considered targets of craftiness on higher levels, through the process of <u>role crafting</u> that affects multiple stakeholders. The role crafting differs from job crafting by the stronger impact that it has on social connections. That is, while a job crafting mainly affects the individual pertaining the job, the role crafting concerns all role occupants and other roles connected. For example Reay *et al.* (2006) describe craftiness at the institutional level in order to change role meaning in the nurse professions.

Thus, literature have shown so far that identity work can have a huge impact in crafting individuals and organizational elements (like jobs and roles) at different levels of analysis. Despite this, to my knowledge, no contributions investigated identity work targeting the creation and settlement of new organizations.

Literature on "selves" as connected to the identity work

Within this line of inquiry, recent studies on "selves" can help to appreciate the motivations that prompt individuals to get involved in identity work processes. These

perspectives on selves and identity work share the assumption that individuals can engage in identity work so as to fit their needs and aspirations.

The interesting connection between "selves" and "aspirations and needs" resides in the future selves. The current theories, next to the construct of the actual self or of the past self, consider future selves, such as possible selves (Markus & Nurius, 1986), ideal and ought selves (Higgins, 1987).

Possible self is defined as who the person might become (like, "I aspire to become a dancer"). By ought self, literature indicates who the individual thinks he should be ("I am a general doctor, but I should be a family doctor"). By ideal self we mean who the person would ideally like to be ("I would like to a be a great doctor"). Possible selves thus 'provide the cognitive category that comprises idealized or aspirational identities toward which one is striving' (Kreiner & Sheep, 2009: 35).

Obodaru (2012) systematizes the literature on selves and introduces the construct of alternative self. She denies the perspective where the choice is at the core of developing a mature self concept: on the contrary she develops a theory where not all forgone alternatives are suppressed, rather they can continue to influence the professional lives of individuals, both in positive or negative ways. Drawing on self comparison and counterfactual literatures, the author introduces the construct of *alternative self*, defined as "who the person could have been if something in the past happened differently" (Obodaru 2012).

Alternative selves become important in the comparison with the real self, because of the individual need of self-enhancement and self-improvement. Alternative selves, or the 'selves not taken', are self-redefining counterfactuals that are part of the self-concept and can provide an evaluative context for the current self, thus influencing, in case of upward or downward comparisons, affective, cognitive, and motivational states (Obodaru, 2012). Particularly

insightful is the idea that better alternative selves may strengthen individuals' understanding of a desired future and enhance their motivations to change the current reality to progress toward it, for instance, through job crafting activities (Obodaru, 2012).

Close to the concept of 'selves not taken' that may act as a reference for individuals' actions, are unanswered callings. A calling is an occupation that an individual did not choose but she feels drawn to pursue since she expects it to be meaningful and enjoyable and sees it as a central part of her identity (Berg *et al*., 2010). Berg *et al.* define an unanswered calling "as an occupation that an individual (1) feels drawn to pursue, (2) expects to be intrinsically enjoyable and meaningful, and (3) sees as a central part of his or her identity, but (4) is not formally experiencing in a work role." (:974). From a survey, the authors distinguished between two types of unanswered callings: missed callings and additional callings. "Participants with missed callings are those who do not view their current occupation as a calling but have one or more unanswered callings, and participants with additional callings are those who view their current occupation as a calling and have one or more unanswered callings." (:984,985).

In their study, Berg et al. (2010) find that individuals pursued their unanswered callings by crafting their job and leisure time with different techniques (task emphasizing, job expanding, role reframing, and vicarious experiencing, hobby participating). This study is quite interesting since it explicitly links the craftiness activities to unanswered calls as my field evidence shows with unrealized selves.

At last, a confirmation of imaginary selves as triggers leveraging individual identity shaping comes from the positive identity framework (a framework developed after 2010 by Dutton & Roberts). Kreiner & Sheep (2009) define two kinds of identity issues: the ones

aiming at "closing the gap between the real and ideal" (both as perceived by the self) and the ones aiming at "closing the gap between self-perception and other-perception" (:25).

Positive identity work

To orient the reader towards my final findings, it is worth to introduce one last concept that will later emerge as related to crafting processes: the positive identity. The positive identity framework has developed in the last years. Dutton, one of its main scholars, characterizes this frame from its "view of identity work that is inspired by an entity's desire to grow and evolve rather than a need to maintain social status or self-worth in the face of threat" (Roberts & Dutton, 2009). Positive identity development is a theoretical mechanism that affects both the micro and the macro organizational fields. Dutton defines positive work-related identity as "work-based self-definition that is beneficial".

Wrzesniewski *et al*. (2013) call for understanding how, over time, positive work identities are outcomes or drivers of crafting processes. The authors propose a theoretical framework connecting job crafting and positive work identities, concluding that "positive work identities can be motivational drivers of job crafting, outcomes of it, or both" (:296).

In the seminal article of this framework, Dutton, Roberts and Bednar (2010) answer to the question "What makes a work-related identity positive?". They review the organizational literature and identify four distinct theoretical perspectives capturing the positive aspects of identity construction processes: the virtue, the evaluative, the developmental and the structural perspective. The <u>virtue perspective</u> states that an identity becomes more positive when it is imbued with virtuous attributes; <u>the</u>

evaluative perspective shows positivity when the identity content is favorably regarded by others and oneself. The other two perspectives move the focus from the static content of the identity to the dynamic nature of identity. The development perspective assumes that an identity becomes more positive if it is capable of progress and adaptation overtime and thus if its content changes in the direction of what can be considered an ideal state /improved state (progressive development) or in the direction that settle the identity in a better fit with internal/external standards (adaptive identity). At last, the structural positive perspective aims at relating the different facets of identity in harmonious and complementary ways (Dutton, Roberts and Bednar, 2010). Focusing on positive identity therefore implies to focus on the generative and elevating states and dynamics that unfold at the individual level or within organizations.

This research thus moved from my intention to embrace the perspective of the micro-foundations of organizations and institutions to explore the issue of how individuals' identity work influences groups, organizations, and/or crosses organizational boundaries.
When data analysis helped me to reframe the focus of my inquire, I became interested in understanding if and how the selves not (yet) taken may be a powerful drive able not only to affect individual cognitive processes and actions, but also to generate organizational outcomes that go beyond single initiatives of job crafting. In particular, this study also explores under what circumstances the motivation to act out possible selves may lead individuals to be active agents who try to modify the organizational context in which their work is performed or to create new organizational arrangements.
In the next chapters I will introduce and develop the research design.

2. Research context and methods

Given the paucity of theoretical literature explicitly connecting the creation of the new organizations and the micro-dynamics of identity, an explorative approach is the best suggested methodological approach (Eisenhardt, 1989). Actually, despite the numerous calls, the empirical evidence connecting identity and change is still underdeveloped in the literature and this reinforces the need for an inductive approach.

In particular, to inquire into the relationship between identity work and the creation of higher-order arrangements, I designed a multi-level research. Multilevel theories bridge the macro-micro gaps connecting the dots and making explicitly the links between constructs previously unlinked. Actually most relevant real-world problems involve multilevel phenomena, yet most management research uses a single level of analysis (Hitt *et al*., 2007: 1385). For example, organizational change and innovation are among the management problems that require a particular attention to multilevel studies, considering individual behaviors and perceptions, occupational sub-groupings, and whole organizations at the same time (Klein, Tosi and Cannella, 1999: 247).

The fact that a research design mixes constructs at different levels does not necessarily implies that the research design is a multi level model. Klein, Dansereau and Hall (1994) describe different research designs: cross-levels models describe relationships among independent and dependent variables at different levels of analysis; composition models (mixed effects models and mixed determinants models) explain the nature of a variable at multiple levels of analysis (mixed effects models deal with the effects of that variable at multiple levels, and mixed determinants models deal with the predictors from different levels of analysis on that variable); multi-level models explicate the relationships among variables

generalizing across levels. Since I am trying to "specify patterns of relationships replicated across levels of analysis" (definition of multi-level studies from Rousseau, 1985) I designed a multi-level study.

Given the multi level design choice, it is worth to consider also limitations of this kind of structure, since I had to keep them in mind throughout the different steps of the analysis. The main limitations of multilevel models are: a) the need to integrate diverse theoretical approaches (e.g. identity work and institutional work); b) the risk of over-simplify the reality when translating phenomena occurring at one level into another (for example, to affirm that if in team as a result of x happens y, then even in organizations as a result of x happens y); c) excessive complexity of models resulting from the effort of putting together too many aspects of organizational reality (Klein *et al.*, 1999).

The explorative study aims at building a grounded model and consequently I will follow the grounded theory approach of Strauss & Corbin (1998): from evidence gathering (Lofland & Lofland, 1995) to the coding phase and the recognition of recurrent themes and patterns of relationships, towards theory-building. I carried out the study based on multiple case studies (Yin, 2003).

2.1. *The research setting and the selection of case studies*

The healthcare sector and the hospital context are situations where identity creation processes and institutional debates are considerably salient. Most of the studies dealing with the imposed changes and the consequent individuals' identity work has been developed in the healthcare sector (e.g. Chreim *et al.*, 2007; Doolin, 2002). Most of the empirical studies considering the identity integrity search (Pratt *et al.*, 2006) and the "institutionalization phase" with the role-legitimation (Reay *et al*., 2006; Goodrick & Reay, 2010) are settled in the

healthcare sector. The richness of empirical studies support the idea that the healthcare sector is an extreme context (Eisenhardt, 1989) where I could observe micro identity process and inter-level connections. Extreme cases facilitate theory building because the dynamics being examined tend to be more visible then they might be in other contexts. For those reasons, the context I have chosen is the healthcare sector.

In that context, the new organizational form that I decided to investigate is the Italian community hospital.

Community hospitals were first born in the UK in the 20s, and were later imported in Italy by Italian physicians. While in Italy an ambiguous regulation and a somewhat controversial use of different labels for healthcare structures makes it still difficult to obtain a complete list of the currently operating community hospitals, in the UK community hospitals are largely regulated by national laws. For example, the National UK government runs an updated register of all the structures that are recognized as Community Hospitals[1], and there are also non-profit associations of Community Hospitals whose goal is to "promote networking and encourage research and audit with other Community Hospitals as well as promoting innovation and best practice within and across Community Hospital services".[2]

The preliminary interviews in the Italian context and later interviews indicate that actors involved in the community hospitals knew that similar structures existed in the UK, but they did not collect sufficient information in order to use them as a model. Some interviewees state: "*we knew that there were Country hospitals in the UK and that there are more than 500 hospitals managed by family doctors there*"; "*For us that name [country hospital] meant nothing, it was just a label.*"; "*Someone told me that this form was inspired by a UK hospital, but we did not visit them*"[interviewed doctors].

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[1] See for example the web site: http://www.sompar.nhs.uk/our_services/adult_services/hospitals/
[2] http://www.communityhospitals.org.uk/

Thus, the emergence of the Italian community hospital and its enactment in different arrangements can indeed be defined a unique case. In fact archival documents define it as emerged from the bottom, and they show how this form gradually spread throughout the different Italian Regions, although Italy was missing a clear official regulatory direction claiming for the implementation of those structures. Moreover, preliminary interviews in two case studies, framed the emergence of the first community hospitals as driven by the purposefulness and resolution of involved doctors and nurses.

The first community hospital, that I fictitiously name CARE, was created in Northern Italy in 1996 with the aim to address local patients' chronic or terminal diseases and was managed by family doctors and nurses. After its inception it has served as a benchmark for the establishment of similar organizations all over Italy. Over the past 15 years, 65 community hospitals have been opened in Italy following CARE example. It is worth underlining that family doctors' participation in the community hospital experience is on a voluntary basis, and that all of them still practice the 'traditional family medicine' in their own offices, while simultaneously working part-time in the community hospital.

When selecting my case studies, I first opted to investigate CARE, the first Italian community hospital, since it can be deemed as an extreme case that facilitates theory building, because its dynamics tend to be particularly meaningful (Eisenhardt, 1989). As my informants state:

> *We have been the first CH in Italy and we can say to have affected public ruling on this topic. Territorial medicine was born here, I mean. It was me who created such expressions as being a broker between the territory and home, being an intermediate structure. Italian CHs built on our experience. And then in 2006 the former Health Minister came up with Health Houses, but Health Houses are just this: the vice-minister came here, watched everything, wrote down what we were doing, went back to Rome, and turned it into an idea of their own.*

CARE is still managed by the five family doctors and the head nurse who started the organization, and by four nurses.

Concerning the additional cases, I looked for organizations located in different Italian Regions to eventually account for variations traceable to differences in regional contexts and healthcare regulations.

I first collected information about the open community hospitals in Italy, dividing them by Region. To obtain such a list, I mainly built on my online researches and on sectorial documents (some lists already existed). Among my list of community hospitals, I made a short list to highlight the hospitals that could be considered relevant as a case study (some of them were for example very small – e.g. 3 beds, and included a very limited number of involved professionals – e.g. 2 or 3). From the updated list, I phoned to the head nurses or to the directors in order to ask for the possibility to have access to the hospitals.

In addition to that, I was inspired by Leonard-Barton's (1990) dual methodology in the selection of case studies among retrospective and longitudinal case studies, and I selected hospitals opened in different years (from fifteen years ago, to four years ago).

As I will explain more deeply in the following paragraphs, I reached theoretical saturation (Strauss & Corbin 1998) after data collection in 5 different case studies located in 5 different Italian Regions.

As a result, beside CARE, I picked up: ARCMED, located in central Italy and born in 1999 with the participation of five doctors and six nurses; MEDITEAM, located in the North-East Italian region, which started in 2000 and is managed by one head nurse, one nurse, two nurse aids, and four doctors; and WEALTH, which opened in 2003 and occupies two doctors, one head nurse, a social assistant and rotating nurses and nurse aids. Finally, HEALTH started in 2009 and is located in central Italy: it is therefore the youngest case. It employs a

coordinator, the head nurse, four nurses and a clinical core team of four permanent family doctors who manage a network of about 100 external family doctors.

2.2. Data Sources

I employed multiple data sources to support my theory building process (Huberman & Miles 1998; Remenyi *et al*. 1998), specifically: archival data, semi-structured interviews, and observations.

As previously stated, my goals was to investigate collective constructs (organizations and organizational forms) as interaction between individuals. Barley & Tolbert (1997) advice how to study changes in collective constructs: they suggest to compile accurate observational records as well as data on actors' interpretations of their behavior at the time it occurs. Since I could not have this possibility, I have studied changes in institutional contexts and on the organizational form of the community hospital resorting to historical and archival data (Goodrick & Reay, 2010). Powell & Colyvas (2008) list methodological ways to capture the processes of "efforts that lead to institutional creation and maintenance" (:292). They advice to consider at first language and vocabulary, considering both the mutual-understanding vocabulary and the aspects of the language that become codified into formal measures of performance. From ethnomethodology, they suggest to pay attention to organizational and individual actions since they represents the efforts of individuals as they engage in the routines of regular operations and confirm how social categories are transposed at the local level: actions shape meanings as well as meanings shape actions. Actually they suggest that studying the formation of categories in organization is an excellent way to connect micro-level processes with the larger social order. To them, metaphors and stories are also significant since they provide a mean to shape the understanding of an experience.

Archival data from the institutional level, interviews, and eventual field notes thus compose the data source.

Archival data. I reviewed national documents related to the emergence of community hospitals and, when available, the single community hospital's internal documents detailing some guidelines for their functioning. It is worth noting, however, that only some of the community hospitals that I studied had quality manuals, job descriptions or organizational charts in place, even though some doctors told us that they were in the process of creating a more formal documentation. I also reviewed specialized publications and proceedings of national conferences, professional associations' statements of policy, newspapers' and medical journals' articles regarding community hospitals.

Table I. Types of analyzed documents[3]

Level	Sources of Data
Organizational level	Internal documents, templates, presentations, reports and rules. Other external documents related to the community hospital, such as local newspapers, local tv news, local meetings and territorial reports.
Regional level	Regulatory Regional laws from the 20 different regions, with particular focus on the 5 regions related to the different case studies. Local regional healthcare reports.
National institutional level	Statements of policy changes by Medical professional association Statements of policy changes by professional Unions Summary of government reports Reports of national healthcare biannual plans.

Semi-structured interviews. Before entering the field, I run four preliminary interviews with healthcare providers and general managers. Those interviews highlighted how Italian community hospitals still lack a common specific regulation and differ dramatically from case to case, thus leaving room for individual agency and institutional negotiation.

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[3] See chapter 4 and 5 for a detailed list of analyzed documents. A synthesis is also reported in the appendix.

Details about the number of interviews that I conducted from July 2012 up to June 2013 for each case and the interviewees' main characteristics are reported in table II.

Table II. Details of the interviews conducted
(2 preliminary interviews excluded)

	CARE (1996)	ARCMED (1999)	MEDITEAM (2000)	WEALTH (2003)	HEALTH (2009)
Number of intervieewes	11	10	5	9	5
Roles	1 general manager, 5 doctors, 1 head nurse, 2 nurses, 2 OSS	3 doctors, 1 head nurse, 1 night doctor, 3 nurses, 1 physioterapist, 1 home nurse	1 coordinator, 1 heard nurse, 1 nurse, 2 doctors	2 head nurse, 1 external doctor, 1 social assistant, 2 nurses, 2 OSS, 1 general manager & director	1 coordinator, 1 head nurse, 1 nurse, 2 doctors of the core group

Chreim and colleagues (2007) inspired my research protocol. During interviews, I asked my informants what the core features of their profession are, whether and how these have changed over time, what expectations they had when joining the community hospital and why they decided to participate in it, what the core features of their community hospital are, how their community hospital works, how they contribute to community hospital daily activities, what they like and what they do not like about community hospital (questions and structures of the protocol are also supported by Creed *et al*., 2010 and Berg *et al*., 2010).[4] Since the very first interviews, I realized that my informants—when narrating their life before the community hospital experience—spontaneously discussed about the professional choices that they had to make in the past (for instance, abandoning after high school the idea of pursuing a career as a psychiatrist and becoming a nurse), and how they kept thinking about such missed opportunities. Some suggested how they often thought about new cognitive representations of self that were dramatically different from those to which they had been

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[4] See appendix to check the Italian protocol and other authors that inspired it.

socialized and which fitted their current roles. I thus adjusted overtime the interview questions to explore deeply such issues in subsequent interviews and be able to grasp the relationship between self-comparison processes and the active participation in community hospitals. Interviews lasted between one hour and one hour and a half. All interviews were conducted face-to-face and were tape recorded and transcribed verbatim.

Observation. I was allowed to observe a few meetings between community hospital members in two sites. I took field notes while observing meetings and transcribed them into extended files. ARCMED let me observe some moments of interactions between doctors and nurses regarding therapy discussions.

2.3. ***Data Analysis***

In analyzing my qualitative data, I availed myself of the guidelines provided by Strauss & Corbin (1998) to build a grounded model and I adopt an iterative approach of constant comparison, where data collection, coding and analysis are intertwined. I continuously move back and forth between my field notes, the theoretical model that I was building and new batches of data, to find support or to detect inconsistencies between new ideas and data. This means that the theory emerging from the analysis of my initial fieldnotes guided further data collection (theoretical sampling, Glazer & Strauss 1967). For instance, as above underlined, when I started coding the first interviews, I came to recognize that my informants engaged in self-comparison processes. Therefore, in subsequent interviews I asked my informants to comment more on that aspect and related processes to understand whether the provisional category that I was building would fit new instances of data or whether it would need reconsideration, new elaborations or clarification.

During the coding process I read the field notes collected up to that moment several times to get a thorough view of the data. I identified recurrent themes and concepts in my data and grouped them to form categories (open coding) with the help of the software for qualitative data analysis MAXQDA, and I subsequently selected the most important categories and relations among them building on Gioia's methodology (Gioia *et al.*, 2013).

Data structure

My data structure builds on Gioia *et al.* (2013) methodology. This methodology is a "systematic presentation of both a ''1st-order''analysis (i.e., an analysis using informant-centric terms and codes) and a ''2nd-order'' analysis (i.e., one using researcher-centric concepts, themes, and dimensions" (:18).

Forming categories. Strauss & Corbin (1998) suggest to start the data analysis by open coding, that is by attaching labels to data evidences in order to group evidences that seem to pertain to the same phenomena (Strauss & Corbin, 1998). Gioia *et al.* (2013) 1st order analysis is quite near to the open coding activity, although it includes a first filtered analysis. This analysis forces the researcher "to adhere faithfully to informants terms". Thus, in this phase, no attention is given in distilling categories, that is why the number of categories usually explode up to 50-100 codes. After this activity I obtained several codes, referring to different levels of analysis and to different subjects. Levels were both the individual, the organizational and the field level, while subjects could refer to the organizational identity characteristics, to the desires and expectations of professionals involved, to the actions they enacted and enact every day in the community hospitals, to the community hospital's image as seen from external professionals and institutions. After a rough filter activity, I used those codes as 1st level data. For example I recognized that informants were addressing topics such as "who I might become, who I would ideally like to be, who I could have been if something in the past

happened differently", evocating concepts that literature labels as 'possible selves', 'ideal selves' or 'alternative selves'.

Aggregating data in theoretical concepts, I obtained the 2nd order data. For example at the individual level, I aggregated the instances where my informants were commenting traded-off professional choices or desired professional selves lurking in their mind, into the category "unrealized selves". Another emergent category at the individual level refers to the types of 'positive identity' and reflects instances in which my informants underlined how the active involvement in the community hospital allowed them to experience feelings of virtue, development, harmoniousness and positive evaluation.

Below I list the main categories, and their properties in order to show the first round of coding results. Category presented below are just the main categories, cleaned from the "immaterial categories"[5] .

Main categories identified	Example
• **Identity** *Name source: disciplinary reading.*	*"Our structure is an intermediate structure, between hospitals and home care"* [Doctor, CARE].
• **Image** *Name source:* **disciplinary reading.**	*"Actually even today, after two years and all that public relation,it's not that hospital doctors have properly understood what a Community hospital is"* [head nurse, HEALTH]
• **Actions/decisions** *Name source:* **me.**	*"We decided how to create the patient case history. […] We took something from case history templates of other wards [...]. Basically we decided that our doctors had to fill and work as well as doctors in other hospital wards."* [nurse, HEALTH]
• **Alternative selves** *Name source*: **disciplinary reading (Obodaru 2012).** *Definition*: **who the person could have been if something in the past happened differently.** • **Possible selves**	E.g. Unrealized self / Alternative self. *"I wanted to be a lawyer so I attended in Romania the first year at the International Law school. But then we had communism and it became difficult to attend university for me,*

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[5] "Immaterial categories" are identified toward the end of the analysis, as non constituent of the grounded theory and thus excluded from the model. E.g. One dropped category is "Identification".

Name source: **disciplinary reading (Markus & Nurius, 1986; Kreiner & Sheep; 2009).** *Definition*: **who the person might become** • **Ideal selves** *Name source:* **disciplinary reading (Higgins, 1987).** *Definition*: **who the person would ideally like to be** → **Unrealized selves** *Definition source:* **Suggestion from Caroline Bartel, during Symposium discussion (Symposium ID # 14447, Academy of Managemet 2013).**	*so I had to drop the Law school. I thought "what is my second job choice?" and nurse was the only answer, so I did it. I would have loved to be a lawyer but you know, when money is missing and you don't have any person who financially supports you and advices you, you can't grow."* [Nurse, WEALTH]
• **Positive virtue (the attributes used to define the self include virtue and strength features);** • **Positive development (the perception that identity is capable of progress and adaptation overtime);** • **Positive evaluation (the identity is considered favorably by others and herself);** • **Positive structure (the different facets of identity are harmonious and related to each other in complementary ways).** → **Positive selves** *Name source: disciplinary reading (Dutton et al. 2010)*	E.g. Positive self / Positive development. *"[Being a doctor here] gives satisfaction because you can see a lot of different pathologies in their whole development. I would have seen them in my personal studio or in a patient's house, but just at the beginning of the disease when I can make a diagnosis, or at the end when the patient leaves the hospital. In the middle, if my patient is hospitalized, I can't follow the disease development. [… Being a doctor in the CH let me] see the whole disease development, you can understand it, recover from it, nursing it "* [Doctor, ARCMED]
Other constructs: Procedures, Tools &technology, Recognized changes, … *Name source: informants words*	E.g. tools & technology *"But the greatest thing above all we've done has been this: […] with local donations from production premium of workers, […] municipality and regional support […] in three years we managed to buy a digital radiography machine for our structure"* [Doctor, ARCMED]

Properties and dimensions of categories. Following Strauss & Corbin (1998) categories'

properties and properties' dimensions have been attached to the identified categories[6].

The protocol was built in order to let informants recall and narrate the story of their

community hospital through time. The protocol also drove informants to dedicate attention to

different levels of analysis (e.g. how is your work in the community hospital seen from other

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[6] A Property is defined as an attribute of a category, while a Dimension is the location of a property along a continuum (Strauss & Corbin, 1998).

external collegues? How is the community hospital perceived from the outside?).
Consequently, most of the topics (categories) referred to different moments in time and to different levels of analysis. I decided to track those information at least for the main categories (such as, for example, identity, identity work or decisions). I thus attached appropriate properties to the categories.

The table below lists as example categories' properties and properties' dimensions that I used for the main categories (e.g. identity).

Categories' properties	Properties' Dimensions
Time	*in the past, *before community hospital opening, *just after community hospital opening, *now, *in the future
Levels of analysis [➔*see methodological clarification below]*	*Person, *organizational role in the CH, *organizational level as CH, *proto-typical
Other actors involved	*Intra-organization: doctors, nurses, aid nurses, head nurse. *Inter-organizational relationships: Universities, hospital doctors, hospital nurses, Institutions (municipality, regions, unions, local healthcare agency…), local population
Types **Types represent:** **Attributes, if attached to Identity or Image categories** **Types of actions, if attached to Action category**	Types turn into central element of the analysis, since they represent: - Attributes E.g. intermediate structure, innovation, territoriality, … - Types of actions E.g. Aim of action (resource finding, sense giving, decision taking, …) & Way of acting (through imitation, through collaboration, through Organizational Citizenship Behaviors, …)

Since one of the contributions inquired in this dissertation deals with the relationships between perceptions of organizational identities and unrealized selves (through coherence

between significant attributes and enacted organizational roles), it is worth to specify the definition of level of analysis as a significant step that is part of the coding activity.

Definition of Level of analysis. During the coding, one tricky activity was to distinguish between quotes that addressed the organizational-level or the roles-level characteristics. Although for some quotes this could be easily achieved, for some others a discussion was needed. Four quotes from the same interviewee (Nurse 1, from Case 1) are reported to help clarifying this passage. The following 2 quotes represent an example of role and organizational level dimension definition:

1) E.g. role– level quote *" […] Same story for medications: procedures have changed but we are still very independent: doctors order antibiotic and we give it to the patient following the procedures, and then there are also rules for medications, and this responsibility it's rather ours than the doctors'. In a sense, regarding medications, we [nurses] are much more experts than doctors, […] and less followed than in other structures."*

2) E.g. organizational – level quote. *"Before my arrival I had not so many ideas about what I would have found. I expected the Community hospital as a geriatric department, but then… it's not like that. We had several moments where we had different kinds of inpatients. Afterall, we've always had a little bit of everything."*

Beside those quotes that clearly address the organizational level or the role level, other quotes from the interviews were rather tricky. Sometimes it can happen that it's not clear whether professionals perceive certain characteristics as attributes of the whole organization or attributes of their own specific role in the organization. If this was not extremely clear from the interviews, I asked to other 2 independent coders to find an agreement on those quotes. Below an example from the same interviewed nurse.

3) *"Well there are a lot of differences between here and a hospital. Working in a hospital let you much more up-to-date, because there it's a continuous seeing new things, both considering therapies and procedures. Here, it's different: things are slower. It's not that you can't learn new things, I've learned a lot here, but here the introduction of therapy changes is slower and it's not easy to see new things"*

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4) Working here I've discovered that there is a lot of psychological work with inpatients and their relatives. This angle is not present in big hospitals, I can tell you this. Probably it's the fact that here we are a small hospital that let us dedicate time to those kind of things. In hospitals professionals don't even remember the inpatients' names. I think this characteristic is a beautiful thing, at least a positive thing.

Both the 3rd and the 4th quote have been marked as organizational-level quotes.

Below I report the resulting data structure

Figure I. Data strucuture

First order (informant) concepts   *Second order themes*   *Aggregate analytical dimensions*

- Who the person might become
- Who the individual thinks he should be
- Who the person would ideally like to be
- Who the person could have been if something in the past happened differently

Unrealized selves

Triggers of new organizational arrangement creation

- Individuals were previously active in crafting their jobs and their roles
- The individual enactment was not enough satisfying

Dissatisfaction with job crafting

- Shared organizational identity attributes
- Regular opportunities for discussion among involved professionals
- Share and standardize procedures

Converging

Collective organizational crafting

- Wanted meanings injected into the shared organizational attributes
- Professionals buffer their different interpretations of community hospital with role differentiation
- Work-around strategies that address eventual disagreement, leveraging on grey areas of internal agreements.

Distancing

- Virtuous characteristic of the organization
- "I work for a virtuous organization"

Virtue

- New roles in the hospital include values perceived as "improvements"
- Relational boundaries enhance growth
- Tools in the community hospital enhance growth

Development

Positive identity as a reinforcement mechanism

- The organizational structure lets its participants enact different work-related identities
- The organization gives opportunities to enact also "other passions" (e.g. informatics engineer, journalist, ..) in a complementary way
- Work-family balance

Structure

- The organizational is positively evaluated by patients, families, territory in general and other healthcare professionals

Evaluation

- No clear guidelines to follow / no reference to look up
- Late official acceptance of *community hospital*
- Proto-characteristics still need to clearly emerge
- Variance between different regulations

Loosely regulated context

Contextual triggers of different sensemaking processes

- Contradictions existing among different institutions
- Contradictions among the same institution through time
- Contradictions among Values and Logics

Ambivalence and *contradictions at the* institutional level

From Data Structure to Grounded theory

Data structure gives a static view of the concepts and constructs that have emerged, and it does not capture the dynamic explanation of events, since it cannot show the connections between the constructs. Consequently, the next necessary step aims at connecting categories and concepts.

This view is eventually accomplished by the grounded model, that "shows the dynamic relationships among the emergent concepts that describe or explain the phenomenon of interest and one that makes clear all relevant data-to-theory connections" (Gioia *et al*., 2013: 22).

While the grounded model was shaping, the relationships between categories were showing a connection between the characteristics of the unrealized selves (individual level), the enacted roles (intra-organizational level), the perception of importance of perceived identity attributes at the organizational level, and the positive selves (individual level). In the next paragraph I explain how I identified recurrent patterns that connect those recurrent themes.

Several authors wrote about methodological procedures aimed at showing – dynamically- how the constructs are connected. The Gioia *et al*. (2013) methodology leaves the grounded model generation step to a free inductive activity. Their grounded theory articulation distinguishes three main steps: formulate dynamic relationships among the 2nd-order concepts in data structure; transform static data structure into dynamic grounded theory model; conduct additional consultations with the literature to refine articulation of emergent concepts and relationships.

At last, once the emergent relationships were clear, I went through the data to look for evidence supporting or neglecting these relationships, by looking for quotes from the interviews that explicitly stated the link between the concepts of interest, such as, for example, an explicit link connecting the unrealized self characteristics and the perception

organizational identity attributes, or the unrealized self characteristics and enacted roles in the organization.

In the following chapters, I present the different aggregate constructs that emerged from my data, showing relationships among them through extensive field evidence. Field evidence are presented by level of analysis: chapter 3, 4 and 5 show the identity dynamics that brought to the creation of the community hospital, from the point of view of the individual (ch. 3), the institutional context (ch. 4) and the intra-organizational dynamics (ch. 5). Before introducing the final grounded model in chapter 7, chapter 6 presents mechanisms of reinforcement of those dynamics.

3. Evidence from the field. Community hospital as a new arrangement where to enact unrealized selves

3.1. Self as a network of identities. Unrealized selves as triggers.

During interviews, I asked my informants what expectations they had when joining the community hospital and to describe the story of the community hospital where they work. Most of the interviewees described community hospital's story spontaneously relating it to their personal non-satisfaction at the time of their involvement and explicitly stated how -at the moment of the interview - their involvement in the community hospital recovered that dissatisfaction.

The next quotes are example in which informants clearly and explicitly connect - in the same passage - the initial dissatisfaction at the moment of their involvement and the actual description of the organizational arrangement as a solution addressing the previous dissatisfaction. Doctor Cerif from MEDITEAM says:

> *We could not be more just prescribers of drugs anymore, we needed to be doctors. Here we can be doctors! We refresh our clinical practice, we deal with hospital doctors , we can ask advice to them .. That is another way of working and , another way of being a doctor. This is much more fulfilling! If I can speak frankly, it gives greater satisfaction to me.* [MEDITEAM, doctor]

A nurse from ARCMED explains:

> *During my career, it often happened to me to be front of hospital doctors who just told me "do your therapy". And after I did it, I realized it was not even tracked by the medical records. Those doctors look a bit down on you, you understand? But here it is different, here I can say that there is a real collaboration with physicians.* [ARCMED, nurse]

Similarly, the head nurse from HEALTH explains

> *Working here in the community hospital, for a nurse, it means working in an place where you can interact with the doctor as a peer, where you can make your choice about the type of intervention - clearly respecting the boundaries ... [...] Here is the triumph of autonomy, because it is run 24/7 by nurses, and the doctor is a general practitioner who is usally here only on demand or a couple of times a week.* [HEALTH, head nurse]

Since the beginning, what seemed to emerge from the interviews and documents is a recurrent theme about the description of a gap between the real situation (in which the doctor/nurse perceived to be before the entrance) and an imaginary situation that the community hospital could somehow allow to enact. In other words, professionals' descriptions start from a gap between the actual identity and the wanted identity. Identity literature has recently shown different constructs that could explain the processes of individual identity shaping as a consequence of real/ideal gap between identities. As Obodaru (2012: 35) states, imaginary selves "are real in their consequences", and considering them could help understanding the behaviors and choices of individuals. Literature suggests different constructs connected to the concept of imaginary selves. For example possible selves (who the person might become - Markus & Nurius, 1986) and ideal selves (who the person would ideally like to be - Higgins, 1987) represent future states of the selves; while alternative selves (who I could have been if something in the past happened differently – Obodaru, 2012) still influence the desired future selves of the individuals.

Collected data (especially from the interviewees) present an impressive amount and variance of imaginary selves. At HEALTH, for example, Doctor Beagle said that before joining it, he used to feel dissatisfied with a profession that was increasingly more about compliance with administrative requirements and less about caring for the patient:

> *We were strangled by bureaucratic practices and taking care of patients was almost an accident in our everyday work. […] I graduated in medicine, not in writing prescriptions for adult diapers, if you know what I mean. It used to be just bureaucracy and that's it; you'd write prescriptions all day long. What was missing was a true relationship with patients.* [HEALTH, doctor]

Similarly, doctor Jordan at CARE strove for a possible self (Kreiner & Sheep; 2009) as 'all-round' doctor, taking care of his patients in each stage of their life and sickness, from diagnosis phase to acute crisis management (e.g. by contacting specialists), to post-hospital

treatments in the place where patients and their families live. He declares how all-round care should become part of a family doctor's practice:

> *We should feel the pride to manage all the aspects of medicine: not only treatments, but also the diagnosis of a new disease by ourselves, without always knocking on hospitals' doors. We should roll up our sleeves, exercise our mind, get insightful.* [CARE, doctor]

Conversely, other doctors who had previously had an experience in hospitals underlined the necessity for family doctors to be like hospital doctors who are able to offer post-acute treatments in specific arrangements. For them, the career as hospital physicians that they had to give up represents an answered call (Berg *et al.*, 2010) and a continuous reference as an alternative self (Obodaru, 2012). Doctor Mats from CARE for example deems the inability to proceed with a hospital career as being a major event of his life and quite frankly recognizes that he has not ever fully recovered from that loss:

> *A salient event in my life…After I graduated in Medicine, I had to join the Army for a 18-month compulsory service and so I burnt every chance of getting a position in the hospital. When I came back, I asked my thesis advisor if I could somehow work at the hospital and she said. 'Can your family help you out financially for the next 10-12 years? Because you wouldn't get a single euro [as a wage] if you stayed here.' I replied that they couldn't and she suggested that I search for a position somewhere in the suburbs. I then tried in a small hospital in a town nearby. I practiced there for five years and then I stopped. Once again, there weren't any opportunities ahead. That's how I started my career as a family doctor. Basically, because there was no opportunity for me in a hospital.* [CARE, doctor]

Similarly doctor Traffle at ARCMED states "*As soon as I graduated, I shot all the various hospitals that were there, and saw that there was the possibility of being hired, I applied on the territory*". And now he states:

> *So, I'm here is since the year 1975, just after my degree, so it has been 38 years now. Now I consider the majority of my patients as friends rather than patients. They knock at my office and come in to tell me, "Oh ! I do this", "Oh I need that," like this, saying "OH". Then in the morning, when I'm the attending physician on the hospital community, I wear my white coat - I have always hated wearing it! -*

and the same patient who told me "Oh", now says "Excuse me doctor, can I ask if ..". Get it? And this is funny! Do you now understand what is the difference between a family doctor and a hospital doctor? It's still me, mind you! This is amazing! So you are looked as a hospital doctor when you're in the community hospital, and it seems like you should have more respect ...[ARCMED, doctor]

Eventually, other doctors started immediately their practices as family doctors without any previous experience or after trying an unsatisfying experience in a hospital. For instance, Doctor Val from CARE recalls how her previous experience in an emergency room did not fit her at all, although it has provided her with useful contacts in the country hospital. Similarly doctor Zux from HEALTH states *"I've been a family doctor in the last 20 years: I have two studios and this is it. I love my profession",* as well as Doctor Rox from CARE who declares to "*have a specialty in physiatry, that was never useful in my life since I've always been a family doctor".* These doctors, have a clear "ought self " (Higgins, 1987) as doctors that believed in old-style practice, in which a doctor knows not only her patients' health problems, but also their lives and their family histories. They believed that these features of their ought self were overlooked in their current work as family doctors in which contacts with patients were time-limited, interactions with families occurred rarely, and most of the time those constraints affect the quality of their profession.

Also MEDITEAM professionals commented that they often thought about the career choices they had made and the associated paths they had decided not to take or about possible professional selves characterized by different attributes and values. For instance, nurse Lory after high school decided not to undertake a medical degree but to pursue a career in nursing. However, she perceives that a career in medicine, and in particular as a psychiatrist, would have been even more oriented toward helping others than the nurse profession. She admits that she frequently talks and thinks about it with the following words:

> *I always believe that I could give even more to others and many times I say to myself: if I had kept studying, if I had become a doctor, I could have helped others in a more complete way.* [MEDITEAM, nurse]

"Being a psychologist" represents an alternative self for Lory and an evaluative referent for the current self.

MEDITEAM's actual head nurse Francis disclosed that she had been nourishing an alternative self that had led her to quit at the age of 30 her career as head nurse to go back to college and graduate in political science. She concisely admitted to *'Have a double soul: political and sanitary'* and continued: *'That it has been a very difficult choice because at that time I could have studied something coherent with nursing […] I don't regret it but if I had taken the other road I could have become a nursing manager by now'*.

Family doctor Karl told us that, before joining MEDITEAM, he felt dissatisfied with the way himself as family doctor progressed, as far as evidence-based medicine is concerned, and stated that this latter should become part of the practice of a family doctor. During the interview he expressed his thoughts about the ideal self as family doctor in the following way:

> *Evidence-based medicine is a requisite that is missing in many structures, which are devoted to clinical aspects only. So we are still really stuck to Claude Bernard's nineteenth century medicine. The point is, if you don't show the epidemiological data, the evolution and the improvement of treatments, and the effectiveness of your actions, how can you sustain any new project?*
> [MEDITEAM, doctor]

Hence field evidence show a strong dimension of <u>self-actualization need</u> that goes well beyond a one way path identity shaping: actors don't seem to be driven by needs of reinforcing professional identities that they already enacted. They don't seem to need to enhance the serial choices that one after the other have, in their pasts, defined the specific identity that they enact today. Rather, my data strongly support Obodaru's theory where not

all forgone alternatives are suppressed, where made or unmade choices still lurk in individuals' mind continuing to influence their professional lives, both in positive or negative ways.

As shown from the previous quotes, those selves took several forms: they could be possible selves pending, actual selves interrupted or alternative selves proscribed.

For example Karl doctor from MEDITEAM is a case of <u>possible self pending</u> as family doctor pursuing the evidence-based medicine ("*that's why I have always been and I am so obsessed with data collection!*").

CARE head nurse is a clear case of <u>actual self interrupted</u>: she reported that she always had quite clear ideas about what to do in her life ("*When I was a child and I was in my fifth grade, I said to my mother that I wanted to become a teacher or a nurse (...) I did not want to study though, so - during the middle school years - I decided to become a nurse. You know, we used to watch those movies where there were always some nurses... they were there with the codes, the patients .. those movies like Florence Nightingal, so ... so .. so that was my choice*"). That's why she pursued a career as head nurse and hospital coordinator. When the local hospital was closed, her professional self's was drastically interrupted. She states "*you can imagine how I could feel... […] I just wanted to have again the possibility to coordinate long term beds in a structure*" and she adds that, coherently, that was all that she expected and wanted from the new organization she decided to be involved in.

Hospital doctors are the most frequent example of <u>alternative selves proscribed</u> that my data present. Another peculiar example is the story of the social assistant Rix from WEALTH who wanted to be a professional coaching consultant and after 15 years she entered in WEALTH so that she could have a mediation role with stakeholders and inpatients, and – at the same time- could be a private consultant.

The story of need of actualization related to selves that are still unrealized definitely is far from the notion of having a single salient identity or having a single monolithic self, as often considered in literature. Rather, actors' strong desires and needs of self actualization build on the concept of self as a network-self: <u>a self as a "complex network of interrelated identities"</u>. This perspective of a vision of self as a complex network of interrelated identities ensures the activation of multiple selves when the opportunity is given or when the context is appropriate. This perspective is definitely of interest for micro studies that could explain, for example, how the self can comprise different identities (being them interrelated, conflicting or independent identities) or what triggers the activation of those different selves[7].

3.2. *Data evidence: from unsatisfying job and role crafting to the involvement in community hospitals.*

Actually evidence reports that several of the actors now involved in the community hospitals were previously active in crafting their jobs and their roles, following the same unrealized selves they now enact in the community hospital. This is coherent with literature analyzing the role of identity work towards internal self-crafting and towards job and role crafting (Pratt *et al.* 2006; Wrzesniewski & Dutton, 2001; Berg *et al.*, 2010). Below, I report some examples of micro-crafting trials that actors enacted before joining the community hospitals as a place where to enact their previously unrealized selves.

Doctor Zux from HEALTH for example declares that he entered in the community hospital because "*It's fundamental: there is debate, there is information, there is a pooling of experience, there's studying together, we all doggedly try to be more adequate and more*

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[7] Thanks to Caroline Bartel in helping to let this concept emerge during the Academy of Management 2013, Symposium "New Perspectives on Individual Identity Work, Organizational Arrangements, and Institutional Logics. Identity Work and Institutions" Program Session #: 1281 | Submission: 14447 | Sponsor(s): (MOC, OB, OMT).

appropriate; even more updated if we consider that we also talk with associated hospital

doctors". He explained how he actually tried to develop that condition with some role crafting activities in previous experiences, joining a family doctors association where he could share the same spaces with other family doctors. Despite this trial, he considers this experience as non satisfying, since it doesn't fit with his research for professional development. He states:

> "*I'm a member of an association downtown: I am associated with other family doctors. But we are associated meaning that we share our offices, we don't discuss together clinical cases. Associations of family doctors are not so enriching, not so useful... At best you do some refresher courses, but it is not the same thing as sharing clinical practice*" [HEALTH, doctor]

Differently, doctor Traffle from ARCMED had a clear alternative self as a hospital doctor and he pursued its enactment first with crafting of his leisure time initially attending hospitals as an "admitted visitor" ("*At the time, I attended the main hospital during my free time. I used to go there, to speak with the head physician, to observe the other doctors... I was there because that helped me to keep me updated. They knew me, "How are you, how are you doing?*"). This opportunity was abandoned when the hospital doctors started to be worried because of insurance policies. Luckily, he caught the opportunity to be involved into the community hospital as the enactment of his alternative self as a hospital doctor. A similar experience is from doctor Beagle from WEALTH who thinks that being a family doctor is more similar to working in a burocratic organization rather than in the clinical profession. This is why he tried to change the relational boundaries of his role, trying to be the facilitating connection between his patients and hospital doctors, following his recovered inpatients from home to hospitals and to home again:

> "*At a previous time, I used to go – let's say - in the post-surgery ward, and if I met the head physician, he stopped and listen to me. At that time, I could follow my patients in the hospital and I could also mediate the relationship between her family and the other hospital doctors. Today, as a family doctor, if you go to the hospital and you do not know anyone, you can not even manage to enter in the wards, you know? Thus, clearly, you do this work here [in the community*

hospital] so that you can take back your profession, since you put it aside – I hadn't lost it, but I had put it aside." [WEALTH, doctor]

Miss Rix, social assistant of WEALTH, describes how she started from being a social assistant in the public sector and how she kept specializing and changing offices in order to find the proper place where she could counsel the way she wanted. She described her involvement in WEALTH as follows:

> *I worked as a social assistant for so many years in the municipality offices. I cared of so many cases: from handicapped to addicts, from raped minors to psychiatric citizens. […] You don't have time there, you have to care of so many people in a few time, and you are so stressed! I thus moved to the national healthcare sector. I was there for 14 years in the counseling office. In the meanwhile I specialized in arbitration and counseling. Thanks to that specialization, I was appointed to design and run the public family point in my town.*
> *The fact is that I had too many constraint in the public offices … There, I could not care about counseling as much as I wanted. Moreover, I also wanted to work as a private consultant to dedicate as much time as I wanted to the counseling activity. […]I had invested time and money on counseling specialization and no way that I would have given up ! … So I resigned from the public office and I entered in this structure as part time.* [WEALTH, coordinator and social assistant]

Now in WEALTH she cares about the relationships between families, doctors, nurses and inpatients, covering a role that is much more than a simple social assistant, with the job title of "relational coordinator".

Crossing the different case studies and the involved individuals, field evidence shows a stronger agential role of identity work starting from the unrealized selves: from job crafting up to promoting organizational growth. Since there are no chances to enact new self-concepts in existing healthcare services, and the individual enactment opportunities were not enough satisfying, professionals engaged in collective processes to set an organizational arrangement where they could play out their professional identities.

This step from the individual level to the organizational level requires quite a lot of craftiness, both considering the process of mobilizing a collective effort and the efforts of negotiations among participants at the same organization.

Moreover, to succeed it needs to be empowered by a proper context and opportunities. Wrzesniewski & Dutton (2001) clarify that (job) crafting is a matter of adaptive and proactive actions that are continuously carried on. Consequently researchers should keep in mind this, in order to recognize job crafting activities: craftiness is "unrecognized by researchers when they assume job crafting is a discrete event arising from clear or known opportunities to craft" (:160).

Other empirical studies on craftiness considered the perceived opportunities as a moderator variable of the crafting process. For example Lyons (2008), out of a survey of 107 salesmen, creates a model that considers the decision to shape job as moderated by the perceived opportunity to shape job.

When asked why he was so keen on this community hospital project, doctor Beagle from HEALTH says:

> "I don't know .. I've always liked it... I can't say the exact reason to you. [waits and mumbles]. It's something that I believed in. Always believed. Even if it's something that has been kept in a drawer for many years. And as the years passed by, the problems at the local level increased, and I could see that the solution to many problems was still the community hospital. It's clear that you can not do such a project by your own, it's clear that you need to be in tune with the direction and with other people. There was a time when this tune has occurred ... It 's dream that come true, it's one of those things that either do not ever realize or that you make it after 10-12 years" [HEALTH, doctor]

The next chapter inquires those opportunities and the institutional context that enabled the creation of community hospitals, in order to understand which role the context played in enhancing identity work processes.

4. Evidence from the field. Institutional context.

As confirmed from local newspapers and other archival data (e.g. specialized reviews, tv reports, …) for CARE professionals the opportunity to experiment different identities lied in the closure of the local town hospital, which engendered a popular uprising. Nearly half of the local population picketed against the decision to close the local health facility and some of them even chained themselves at the hospital fence. With the support of the district hospital top management, almost all of the doctors proposed to turn the facility into a local hospital where local citizens could be hospitalized for up to 30 days to recover from surgery or other diseases. ARCMED and MEDITEAM cases followed similar situations, although the closure of the local hospital was less disruptive than CARE: while CARE hospital was drastically closed, the two hospitals were gradually dismissed from complete-offer hospitals to small hospitals where just a few wards were still open. In those cases the family doctors had the chance to adjust their positions in a more gradual way. On the contrary WEALTH and HEALTH were born from administrative professionals and doctors' initiatives with no external shocks: they managed to find a space for the "community hospital" in other hospitals' structures that were already present in town.

Each actor involved in the establishment of the community hospital stressed how they had no clear guidelines to follow. Professionals involved in early cases such as CARE, ARCMED and MEDITEAM had no reference to look up to in the Italian health care system. They had to devise any single detail concerning Community hospital functioning, as Doctor Val from CARE says with pride in the following excerpt from the interview:

> *"We didn't have any roadmap to follow: we did it all by ourselves. […] There was really nothing that we could turn to, not a single law, not a single experience. We had to create [this structure] out of thin air"*. [CARE, doctor]

Professionals belonging to more recent CH like HEALTH and WEALTH could visit other community hospitals already established, although – as involved actors said - this was not so helpful since they had to define procedures and organizational settings by their own. For example a nurse from HEALTH states:

> *"We pretty much started to create it by ourselves, because we knew nothing. We had a minimum of training by going into another community hospital nearby, but that was a very different reality. So, we created everything by ourselves - we the nurses, with our coordinators, our nurse head and our aid-nurses"*. [HEALTH, nurse]

4.1. *The emergence of community hospital as a new organizational arrangement.*

Beside external events as helpful opportunities, institutional conditions cannot be ignored while inquiring change at the organizational level, especially in the healthcare sector where both the regulation at the professional level (Doolin 2002; Reay & Hinings, 2005; Greenwood *et al*., 2002) and at the organizational level (Chreim *et al*., 2007) represent strong constraints. From the very first field evidence, I wondered how such an innovation in the healthcare sector could happen out of the regulation process and how professionals could have such a room to build their own organizational solutions and roles.

My data evidence seem to support Chreim *et al*.'s data suggestion (2007), that hypothesized at the end of their study a connection starting from the individuals work identity and affecting the macro template at the institutional level. In fact my evidence presents the creation of new forms of organizations as arrangements where individuals tried to enact their alternative, ideal, and possible selves.

In order to triangulate interviews' evidence, I collected archival documents to analyze data at the institutional level and organizational level. The aim is to rebuild the institutional conditions in which the new organizational arrangements developed. I expected this data to

triangulate the perception of looseness that emerged from the professionals, to shed lights on conditions and processes that let professionals have room enough to interpret the "community hospital" organizational form in different ways and to perceive it as the right opportunity to enact their unrealized selves.

From institutional data analysis, I inquired how the definition of the Italian Community hospital form developed throughout different institutions and through time. I started with the National level perspective: I first went through National official documents and guidelines from Ministries and Agencies, in order to track community hospitals' "official" emergence. Beside structured Agencies, I went through Medical professional association and Unions documents to recall eventual news and development of similar organizations. To finish, since Italian Regions have large room to self-regulate healthcare services beside National deals and guidelines, I checked the timing and content of Community hospital definition processes from the 20 Italian Regions (with the help of other specialized publications[8] from the healthcare sector).

Official documents from National Institutions.

From the analysis of documents related to the national level of the institutional context (see chapter 2 for the table listing data sources), it emerges how the first official mention of *community hospital* in a national legislation came late in the National healthcare plans of the years 2006-09. In this legislation the community hospital is mentioned in the chapter dealing with reorganization of primary cares and it is defined as:

> *"Structure managed by primary care physicians, dedicated to the implementation*
> *of home-caring in a protected environment, or dedicated to the consolidation of*
> *the inpatient's physical conditions or to the continuation of the recovery process*

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8 Among the studies that facilitated my research: "L'OSPEDALE DI COMUNITA' – COUNTRY HOSPITAL IN ITALIA, Studio della normativa nazionale e regionale", Bellentani, 2009.

in a non-hospital environment after the patient's discharge from an acute hospital ward".

"The primary care system should also be connected with the hospital care system, by completing the offer of intermediate healthcare services. The intermediate healthcare services can be implemented by developing, according to the regional conditions, the organizational model named Community Hospital ".
[National healthcare plans of the years 2006-09]

This document highlights also the necessity of a higher involvement of family doctors, and integration of different healthcare territorial professional figures.

Previous healthcare National plans (e.g. 2003-2005) addressed the need to go beyond hospital centrality and to enhance territorial medicine starting from family doctors so that "*an integrated network of healthcare and social services to assist chronic inpatients and old people, and disables can be implemented*". Before 2006, previous legislations intended to help the development of innovative organizational forms related to primary care, although no mention about Community Hospitals was made. This intent can be found in the agreement between Healthcare Ministry and Regions of 2004, where it is suggested to consider "*complex associative experiences forms*" related to primary care. Moreover, the periodical Collective National Agreement[9] (CND) between Family doctors and Healthcare Ministry calls for "*associative experiences or budget experiences*" from family doctors. In those CNDs, since the year 2000, associative forms have been recognized (network medicine, associative medicine, group medicine) and in the CND stipulated on the 23rd of March 2005 other more complex organizational forms are listed in the Agreement Ministry-Regions in 2004. Still, between those forms, community hospital is not mentioned[10]. The 2005 collective agreement mentions that associative forms are part of the functions and tasks in charge to the medical

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[9] Accordo Collettivo Nazionale
[10] The deal mention UTAP – Unità Territoriale Assistenza Primaria (Primary Care Territorial Unit)

doctor since associative forms improve the territorial answer to citizens needs, although they are not compulsory activities.

Therefore, considering all the official documents at the National level, from 2000 to 2005 there are some recalls to concepts that have been proven to be central for Community Hospitals definitions (e.g. associations of family doctors and territorial answers), but above all no explicit mention addresses the *community hospital* concept before 2006.

Documents from professional associations. To have a definition of Community hospital at the National level before 2006, I had to recall documents from Associations and Unions. After the creation of the first community hospitals in 1998, family doctors looked for legitimation through the description of community hospital in national Unions' documents. Since the project was born from the professionals' entrepreneurship, Unions of family Doctors tried to define it in internal documents.

There are two main documents to be kept as a reference, written by 2 different national Unions (SIMET - Sindacato Italiano Medici del Territorio, Italian Union of Territorial doctors, 1998; FIMMG - Federazione Italiana Medici di Famiglia, Italian Federation of Family doctors, 2003). In 1998 the structure was defined as:

> *"A territorial health and social structure that responds to the health needs of those who do not require, in the opinion of the family doctor, the complexity of the 2nd level of care, but -at the same time- have social and health problems that can not be addressed by a classic residential health structure."* [document from SIMET - Sindacato Italiano Medici del Territorio, Italian Union of Territorial doctors, 1998]

They use the following quotes to describe the experience:

> *1. The Community Hospital (CH) is a regional health care facility included in the network of local services (responding also to some social needs) that is directly managed by General Practitioners (GPs) of that area. It supports residents and their relatives, mainly old people not self-sufficient, who do not require hospitalization but who can not be treated at home.*

2. The Community Hospital (CH) is managed by GPs for their patients. It provides a personal assistance and the execution of clinical procedures of medium-low medical level (to care chronic degenerative diseases that are temporarily unbalanced or temporarily worsened) to patients with variable social risk.

3. The CH stands as a link between the hospital and the territory, through the network of the domestic services and the residential facilities for old people (e.g. protected houses and nursing homes). Among the territorial medicine solutions, it represents the solution with the higher healthcare intensity.

4. The CH provides answers to the needs of the vulnerable groups in the population, mostly elderly ones, who have exacerbations of chronic conditions not requiring intensive therapies or diagnosis of high technological commitment, but which cannot be solve at home.

[document from SIMET - Sindacato Italiano Medici del Territorio, Italian Union of Territorial doctors, 1998]

Moreover, the doctors and managers involved in the composition of those documents try to define the Community Hospital *"minimal organizational and structural characteristics"* and they even list the *"requirements and general criteria related to inpatients access in Community Hospitals"* and *"main chronic pathologies that can be treated inside Community Hospitals"*. For example they declare as admitted inpatients those *"who are temporarily without adequate family or social support; patients with chronic and/or re-worsened diseases that require monitoring; [...]; patients suffering from end-stage diseases; patients discharged from hospital wards, they should who require specialized health check (prior definition of clinical pathways); patients in Day Service"*. Regarding the so-called "main pathologies" that could be treated in Community hospitals, the document has a long and general list of pathologies, like *"neoplasias (even in terminal phase), non complicated pneumonias, chronic vascular pathologies (e.g. strokes), cardiac pathologies, degenerative diseases of the central neuro system (e.g. Parkinson)"*.

To conclude, those documents highlight the community hospital experimental characteristic, calling for a desired convergence around proto-characteristics definition (Navis & Glynn, 2010).

Those first organizational experiments have generated a series of models. Now the question arises of how to handle these models. We need to understand which guidelines can help us to implement those models at the organizational level, in order to come out from the trial and to identify some key features able to achieve a wider spread of community hospitals.
[document from FIMMG - Federazione Italiana Medici di Famiglia, Italian Federation of Family doctors, 2003]

Although those two Unions' documents from 1998 and 2003 represent the most precise documents that define Community hospitals, the fact that those definitions have been written by the same medical doctors that were involved in some community hospitals should be considered. Those definitions could be biased by authors' role-driven perceptions and experiences. Moreover, the documents are not the result of a spread negotiation of community hospital proto-characteristics (Navis & Glynn, 2010), rather the authors are the same 6-8 doctors that kicked off the first Italian experiences. Basically those documents represent a bottom-up attempt to define Community hospital as a new organizational form. In fact, those documents are not accepted (nor cited) by National or Regional legislations.

Official documents from Regional institutions. So far it emerged an evident gap between the very detailed definitions from the Unions and the late and superficial definition from the National norms. I inquired whether other structures at Regional levels attempted to define the Community hospital in a more specific way. Since Regions have large room to self-regulate healthcare services, I went through the Community hospital definition of the Italian Regions with a particular focus towards the Regions related to the analyzed case studies.

The situation presents a large variance from Region to Region. Below a table summarizes the main data sources and information emerged from the analysis.

Table III. Regional data regarding community hospital regulation (data sources and content).

Region[11]	Have or had community hospitals?[12]	Regulated? When and where for the first time? (*defined* if characteristics described; *mentioned* if not described)	year
Umbria	yes #	yes. 1997 (ospedale di comunità è previsto dalla L.R. 3.2.1997, n. 34: "Riorganizzazione della rete ospedaliera regionale" + PSR dal 1999). 1999 (deliberazione del Consiglio regionale 1.3.1999, n. 647 stabilisce che l'ospedale di territorio rappresenta l'evoluzione del concetto di ospedale di comunità.). Defined.	1997
Toscana	yes ###	yes. PSR 1999-01 kick off of first experiences of country hospitals mentioned, defined as ospedali di comunita' in PSR 2002-04	1999
Friuli Venezia Giulia	yes #	yes. Piano di intervento a medio termine (PIMT) 2000-2002 ospedale di comunita' mentioned and explained.	2000
Puglia	yes ##	yes. PSR 2002-2004. Ospedale di comunita' o Unità di degenza territoriale defined.	2002
Valle d'Aosta	yes #	yes. 2002 -2004 (PSSR - Country hospital mentioned).	2002
Liguria	yes #	yes. PSSR 2003-2005 "ospedale di comunita'" mentioned as possible solution; D.C.R. 8 agosto 2006, n. 29: "struttura ospedaliera di continuità assistenziale" mentioned. No CH mentioned in the later documents (CH never defined)	2003
Marche	yes #	yes. PSR 2003-2005 (ospedali di comuinta') defined.	2003
Calabria	yes ##	yes. PSR 2004-06, ospedale di comunita' o ospedale di distetto defined (specific chapter)	2004
Veneto	yes ###	yes. DGR n. 2481 del 6 agosto 2004 "strutture sanitarie intermedie" o "ospedali di comunita'". Lancio sperimentazione. L.R. 9-3-2007 n. 5: definizione.	2004
Piemonte	yes #	yes. D.G.R. 7 marzo 2005, n. 75-15004. Ospedale di Comunità mentioned. DGR n. n. 28-2690 del 24-4-2006 definizione Ospedale di Comunita'.	2005
Campania	yes ##	yes. 2006 Ospedale di comunita' just mentioned, not defined.	2006
Lazio	yes ##	yes. DGR n. 424/06 (ospedali di comunita') defined.	2006
Sardegna	yes. #	yes. 2007. Piano regionale dei servizi sanitari 2006-2008 mention money for 2 ospedali di comunita' to be experimented. Ospedale di comunita' defined.	2007
Lombardia	yes #	yes. PSR 2007-2009 mentions Ospedale di comunita' as innovative regional projects. Defined.	2007
Abruzzo	yes # (2013)	yes. Piano Sanitario Regionale 2008-2010	2008
Molise	No	yes. PSR 2008-10 (approved 2009) Contry hospital just mentioned, not defined.	2009
Basilicata	No	L'art. 20 della L.R. 4 agosto 2011 n. 17. parla di Ospedali Distrettuali	2011
Emilia-Romagna	yes #	No	-

What emerges from the data collection is a large variance between Regional regulations.

Some regions activated community hospitals without any norm and some of them still today

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[11] Sicilia and Trentino Alto Adige are missing.

[12] The number of # represent how spread Community hospitals are in the Region. # from 1 to 2; ## from 3 to 4; ### more than 5.

lack a Regional regulation (e.g. Emilia Romagna); other Regions lack both the norms and the organizational experiences (e.g. Molise). Others regulated community hospitals just several years after the first CH was open in the region (e.g. Marche, 5 years later), while others normed the CH as soon as CHs were open (Umbria and Toscana, in the same year). Some regulations consist of a simple mentioning of the structure as a possible healthcare solution without defining it (e.g. Campania, Liguria), others define the structure in its different details and forms (e.g. Sardegna, Veneto).

4.2. *Loose institutionalization as an opportunity for micro dynamics related to the unrealized selves.*

The creation of community hospital is narrated in the national documents from Unions of doctors as a bottom-up process that was later affirmed throughout the different regions. This dynamics immediately recall for a story of institutional creation and change (e.g. Lounsbury & Glynn 2001; Suddaby & Greenwood 2005).

Differently, what field evidence suggest is that the inquired case studies of community hospitals were not born as an attempt to change the whole institutional systems. The involvement of most of the actors into the project was actually driven by local opportunities and personal development needs: the classical tactics that aim at affirming change at the field level (e.g. Reay *et al*., 2006; Lounsbury & Crumley, 2007; Smets *et al*. 2012) were considered only in a later stage. The fact that different individuals interpret the opportunity of Community Hospital in so many different ways, still lacks a theoretical explanation that could support how a loosely institutionalized structure can leave room for different sensemaking processes.

In fact, the classical explanation of internalized cognitive constraints on sensemaking ('taken-for-grantedness') (Weber & Glynn, 2006: 1642) - that is, when an institutional

element (a logic or a template) is affirmed, individuals take the meanings and expected behaviors carried by that logic for granted (e.g. Lawrence & Suddaby, 2006) - cannot hold in this study. Considering the timeline of Italian community hospitals creation and affirmation, it is clear that community hospitals are still not successfully institutionalized in the Italian healthcare sector, and thus internalized cognitive constraint cannot be the theoretical process explaining how the context could actually enhance professionals' sensemaking and how it consequently fostered the growth of community hospitals.

Rather, the Weber & Glynn framework from ambivalence and contradictions at the institutional level seems to fit data evidence, and it could be useful in supporting possible interpretations of the context as a trigger for identity work.

Most of the contradictions were presented by field evidence as existing among different institutions. For example, different doctors from CARE reported that, on one side, they were supported and fostered because their Major saw them as the only possible healthcare answer at the local level, while, on the other side, the Region never supported them nor normed their experience.

Other professionals, along the different case studies, faced strong contradictions between the institutionalized logic of accuracy requested by the profession, and the institutional conditions that forced them to execute a superficial and burocratic job. For example, both doctor, nurses and social assistants commented about this with the following passages: "*Do you think it's fare that I spend my time on those stack of authorizations?*" [ARCMED, doctor]; "*Working like this is not being a doctor!*" [MEDITEAM, doctor]; "*I could not do my job there, always running from a case to the other: I had no time enough to care about different cases!*" [WEALTH, social assistant]; "*I felt that I could not give the needed attention to the inpatients because I was always in a hurry*" [MEDITEAM, nurse].

Another recurrent perceived contradiction is between professional accuracy and the logic of managing costs and expenses. Professionals enact the institutional logic that health issues should not be appraised through the lens of efficiency only, since any person should be given the best treatment possible, regardless of its cost. On the contrary, strong pressures from local unit managers remind them that they had to consider cost constraints. As Nurse Helen says, '*We keep listening to government representatives telling us that we must cut, cut, cut our costs. Are we better health providers if we prescribe 6-euro, old-generation antibiotics rather than 10-euro, new-generation, effective ones to our patients?*'. Most of the doctors proudly report how the community hospitals now help to save a lot of money if compared to other specialized hospitals where inpatients should be otherwise recovered.

Moreover, contradictions can be found even within the same institutional structures. For example a doctor reported how the Region had a "*schizophrenic behavior*" towards them, since the Region behavior fluctuates from using the community hospital as an example to be shown off, till periodically announcing its closure (the closing attempts failed because of popular uprisings).

At last, beside those institutional contradictions, the loose definitions emerging from the norming processes encourage a high variety of possible sensemaking processes and consequent answers.

Those contextual conditions can explain how professionals deemed into the creation of a new organization with different expectations. This is somehow supported by Hargrave & Van de Ven (2009), that reinterpret institutional work as the creative embrace of contradiction. Between the different contradictions analyzed, the authors also consider the contradiction between material and cultural-ideal elements of social structure. The authors describe how institutional actors are motivated by real/ideal disparities: "material/ideal

contradictions inhere not only in institutional arrangements but also inside actors themselves"

(:134). At the individual level they state that actors exploit differences between their stated

values and actual behaviors, since the vast separation between the moral standards and the

actual way of living resolves into inconsistencies and inner conflicts. Building on previous

field evidence, I argue that the perceived institutional contradictions and the loose definition

of community hospital at the Regional and National level triggered sensemaking processes by

the actors involved. The actors embrace the contradictions and the context looseness, taking it

as an opportunity to enhance the realization of their alternative, ideal, and possible selves.

5. Evidence from the field. Organizational identity compatibility with different unrealized selves

5.1. *Organizational identity perceptions and measurement*

When I asked my informants about their perception of who they are as an organization, several attributes defining "who we are" emerged. Most of the interviewees cited, in line with official statements of organizational regulations, that their organizations are a broker between hospitals and homes, territory-bound, and that they give non-acute patients high-level care without separating them from their families.

An impressive number of elements defining "who we are" as an organization emerged from the interviews in different forms.

Some characteristics are related to the elements defining the structure (e.g. which kind of patients, which kind of cares) or its attributes "*This hospital mainly addresses old inpatients, with chronic and multiple diseases* " [MEDITEAM, doctor]; "*Variability of patients ills is high here, you can see a lot of different cases*" [WEALTH, head nurse]; "*To us it's clear that this is the family doctors' hospital*" [HEALTH, coordinator]; "*This is an intermediate structure between territorial services and other hospitals*" [CARE, doctor].

Other informants answered defining what they perceived as the characteristic way of working into the hospital, as representative of central and distinctive characteristics of their community hospital. E.g. "*Our approach to the inpatients and her family is […] a total respect for the person*" [CARE, doctor]; "*The person is not a number here, she has a name and a surname, not like in other hospitals*" [WEALTH, nurse]. Most of the time, throughout all the informants, those description were reported in a distinctive form compared to classical hospitals ("*[…] not like in the big hospitals where[…]*"), to hospital wards ("*differently from*

surgery wards […]") or to residential structures ("*that is not similar to a residential structure!*").

In order to structure all the elements that emerged as central and distinctive characteristics organizational level data were structured into their dimensions as follows.

Below I take CARE as an example and I report two tables showing the 1st and 2nd levels of the data structure regarding organizational characteristics. To analyze those data, I first counted how many times each 1st level data emerged from the interviews, understanding which are the characteristics that represent the organizational identity and which are the central ones for each interviewee.

I assume that if, throughout all the interview, a certain characteristic was never mentioned by the interviewee (nor explicitly answering "who we are", nor implicitly expressing that characteristics when describing "how's the life" in the community hospital), that means that the characteristic is not central to the interviewee. For example, doctor Mats didn't mentioned *empathy and sensitivity* as central characteristics describing the way of working in the community hospital, although those attributes were largely and repeatedly mentioned by the other professionals. Table IV below shows empathy as mentioned 0 times by him and 1 to 2 times by other informants.

Table IV. 1ˢᵗ level data for CARE informants – Organizational identity perceptions

Cell specifies how many times the attribute (rows) was mentioned by the interviewee (column)

	CARE COMMUNITY HOSPITAL	1) Argentine NURSE	2) Tosk AID NURSE	3) Tim NURSE	4) Offel NURSE AID	5) Jordan DOCTOR	6) Rox DOCTOR	7) Mats DOCTOR	8) Val DOCTOR	9) Willman HEAD NURSE	10) All DOCTOR	11) Lucy MANAGER
Inpatients characteristics	Need to have medical check out					2	1					
	Dying							1			1	
	Rehabilitation & protected discharge					1					1	1
	Pathology variance		1		1	1					1	
	Social needs						1				1	1
	Long recovery									3		
	Pathology seriousness						1	2				
	Chronic							1			3	2
	Old people	1	1					1			3	
Way of working	Quality of care											1
	Family-like	1								3	1	
	Quiet			1	1							1
	Hospital of family doctors	1(-)		1		3(+)		2	1(+)	1	4(+)	4
	Resilience										1	
	Availability							1	1			
	Empathy and sensitivity	1(+)				2	1			1	1	
	Flexibilty with relatives					1					1	
	Proactive					1						
	Union					1	1		1		1	
	Competences					1	1	1				
	Responsibility						1					
	Autonomy					2	2			1		
	Debate							1	1	1		1
	Support and back-up						1					1
	Take on responsibility									1		2
	Closeness and respect towards the patient	1(-)				2			1	1	2	
Structure attributes	Renown										1	
	Useful		1			1	2	1				2
	Intermediate structure					2	1	1		2	4	1
	Innovation						1				2	
	Integrated services offer					1	1			1	3	
	Territory-bounded						1	2		1	8	6
	Para-hospital						1	3		1	1	
	Economic convenience					1	1				3	3
	Centrality (importance)		1			2	1		1		1	

In a second moment I aggregated 1st level data in a 2nd order data, so that, for example all the 1st level attributes "empathy and sensitivity", "support and back-up", "take on responsibility of patient" and "confidence and respect towards the patient" are aggregated into "total respect of the person". Table V shows the aggregation structure of organizational identity attributes for CARE as an example.

In order to track 2nd order data values, for each 2nd order code, I enumerated values as follows:

- the 2nd order attribute is 1, if at least one of the correspondent 1st level aggregated attributes is positively mentioned as significant (e.g. "*this structure is convenient because it costs just 100 euros per bed per night, otherwise those patients should stay in the acute hospitals that cost 700-800 euros*" → Economic convenience = 1);

- the 2nd order attribute is -1, if the correspondent 1st level aggregated attributes are negatively mentioned as significant (e.g. "*this structure is not economically convenient for the healthcare system, because without community hospital those patients would stay at home and it's not demonstrated that community hospital decreases the hospitalized people index of the local area* " → Economic convenience = -1);

- the 2nd order attribute is NULL, if none of the 1st order attributes is mentioned.

The table VI below reports the results.

Table V. Organizational identity data structure. From 1st order to 2nd order codes
Darker lables are 2nd order codes.

	Intermediate structure
	Para-hospital
	Hospital of family doctors
	Economic convenience

Territory-bounded		
Integrated services offer		Territoriality

Renown		
Centrality (importance)		Uselful
Quality of care		

	Inpatients characteristics

	Competences
	Innovation

Empathy and sensitivity		
Support and back-up		
Take on responsibility of patient		Total respect of the person
Closeness and respect towards the patient		

Debate		
Union		Collaboration

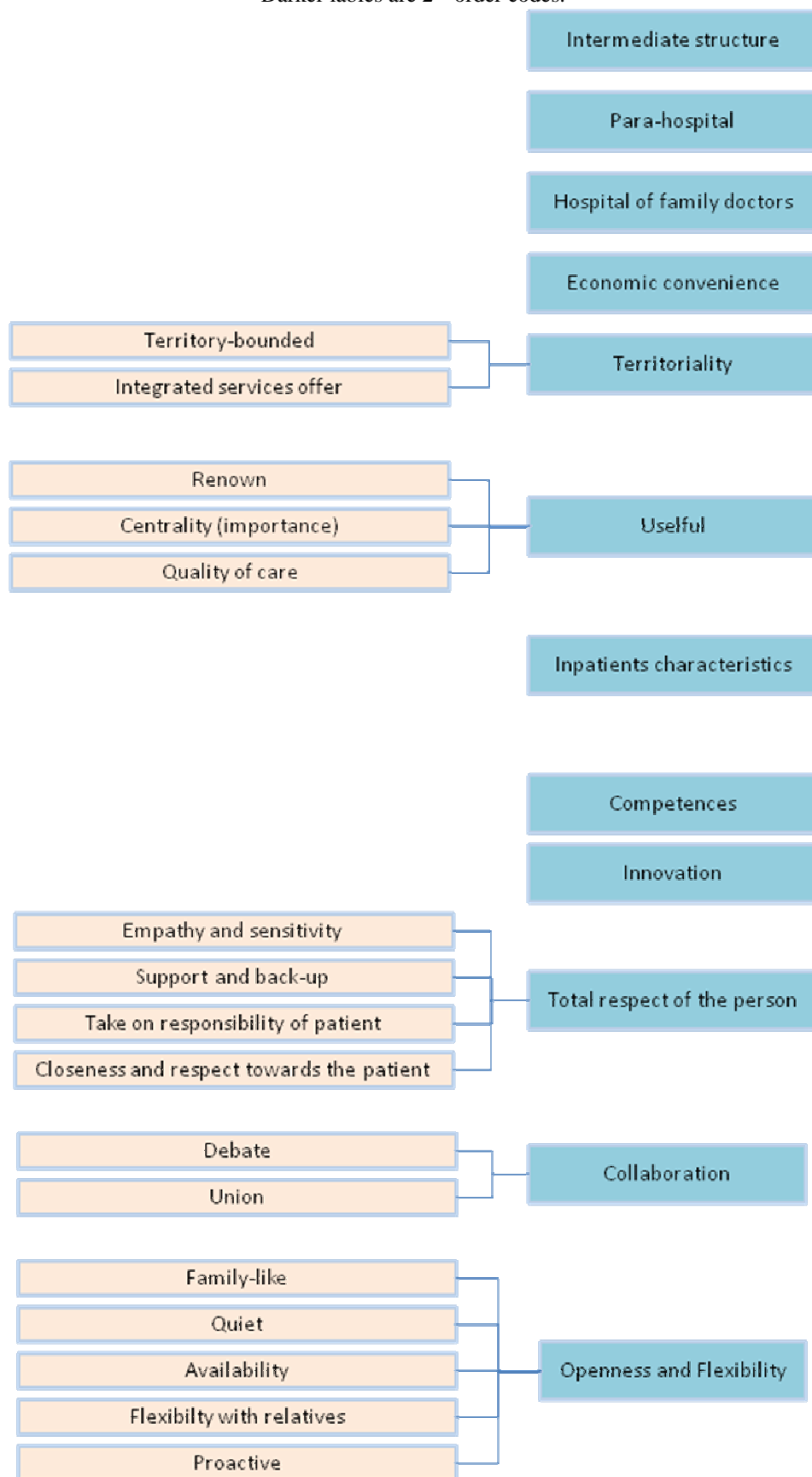| Family-like		
Quiet		
Availability		Openness and Flexibility
Flexibilty with relatives		
Proactive		

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Table VI. 2nd level data for CARE informants – Organizational identity perceptions
Cells specify if the attribute (rows) was mentioned by the interviewee (column).

  1   *if mentioned and the interviewee agrees;*
 -1   *if mentioned and the interviewee disagrees;*
Null *if not mentioned;*
eventual (-) (+)   *if a positive or negative value is attached to the value.*

CARE COMMUNITY HOSPITAL	1) Argentine NURSE	2) Tosk AID NURSE	3) Tim NURSE	5) Jordan DOCTOR	7) Mats DOCTOR	6) Rox DOCTOR	8) Val DOCTOR	9) Willman HEAD NURSE	10) All DOCTOR	11) Lucy MANAGER
Variety of inpatients (from their characteristics)	1	1	-1		1			0	1	
Total respect of the person	1			1			1		1	
Hospital of family doctors	1(-)		1	1(+)		1(-)	1(+)		1(+)	1
Para-hospital					1				1	
Uselful						1	1			1
Economic convenience				1		-1		1		-1
Territoriality						1	1			1
Intermediate structure				1	1	1				1
Innovation			-1			1			1	
Competences	-1		-1	1	1	1				
Openness and Flexibility	1	1	1	1	1	1	1	1	1	
Collaboration				1	1	1	1	1	1	1

Analyzing the tables, what soon emerged as clear throughout the case studies is that, among the same organization's professionals, different perceptions of what are considered as central and distinctive characteristics of the community hospital exist. Professionals perceptions' are not always coherent with the colleagues' perceptions, and as a consequence, a general unsharedness among the organizational identity perceptions exists. Organizational identity variance is not a new phenomenon to the organization literature. Organizational identity variance has been largely studied under the construct of hybrid organizational identity (Golden Bidden & Rao 97; Pratt & Rafaeli 97; Glynn 2000) and of multiple organizational identity (Pratt & Foreman, 2000; Fiol 2001; Glynn *et al*., 2000; Scott, Corman & Cheney, 1998; Hsu & Elsbach, 2012). For example Pratt & Raphaeli (1997) have shown how, in a rehabilitation unit of a large hospital, professionals used dresses to convey the hybrid identities of the unit where they work and their nursing profession.

Similarly, Glynn (2000) wrote about conflicts in an orchestra with hybrid identity as differently perceived by musicians and managers. Beside some shared common attributes, my data confirm a similar status of a multi-faced identity at the organizational level.

That variance has nothing to do with "vagueness" (e.g. identity ambiguity construct by Corley & Gioia, 2004) since internal actors claimed for clear identity statements several times, both in public meetings (e.g. local meeting with stakeholders as hospital doctors, local meeting with non-involved doctors, local television, local and national newspapers releases), in internal documents (internal regulation documents, internal executive presentations), and even during the interviews members never complained about a fuzzy or still-to-be-defined organizational identity.

Consequently, considering as referent articles Pratt & Rafaeli (1997) and Glynn (2000), it's worth inquiring in a deeper way:

1) the organizational identity complexity and variance throughout the internal professionals – e.g. which forms does this unsharedness take?

2) the mechanisms connected with it - which dynamics can explain its existence?

The next paragraphs address the two questions with data evidence. Coherently with the tables so far presented in this chapter, I will first bring evidences from CARE in a more extended way, and I will later present similar dynamics from the other case studies.

5.2. *Coherence between organizational identity perceptions and unrealized selves*

As anticipated, since the very first interviews, the interviewee involvement into the creation of the new organizational form seemed to be coherent with a path of fulfillment of work-related selves. A pattern between organizational identity perception and wanted selves emerged

during the interviews, coherently with recent articles of "unrealized selves" and job crafting (Obodaru 2012; Oyserman *et al*., 2006; Berg *et al*., 2010).

In CARE, for example, doctors Mats who wishes to retrieve an alternative self as hospital doctors underlines the para-hospital nature of his organization, stating:

> *We built this structure like a para-hospital from the beginning: there are beds, a patient enters, we make our case history, we collect all the documents, we do it all ourselves because it's our hospital. Then there's the head nurse, nurses 24/7, professional aid nurses. We had only hospitals to inspire us.* [CARE, doctor Mats]

Coherently with his view, he insisted several times on the hospitalizing characteristics of the structure by noting how patients were not only chronic but also serious inpatients (the previous tables shows how he mentioned twice serious conditions and once dying inpatients). During the interview, he often specified quotes like

> *"At the beginning, and even later on, we admitted hospitals-like patients. Just a few years ago, we have been liken to the towns' peripheral hospitals! Considering the types of patients, we can say that we have the same kind of hospitalization patterns."* [CARE, doctor Mats]

As central and distinctive organizational characteristics he stresses the competences they have as a structure that "can be even better than the previous hospital that was closed"

> *"In practice, here, the community hospital opening was the counterpart of the previous hospital closure. In this local perspective, the community hospital is much better than the wards we had before. Indeed, it responds to citizens' demands that the previous medical wards could not respond to! We now treat chronic and even acute patients, that – despite their serious situations –can not be admitted in the hospitals ..."* [CARE, doctor Mats]

Similarly head nurse Willnal aimed at recovering the self of hospital headnurse that was interrupted with the hospital closure ("*Anyway, to me, the community hospital was a solution to maintain beds that were similar to those of the long-recovery hospitals' beds, so that we*

could keep addressing citizens' needs"). It's quite clear that even the headnurse conceives the structure as a para-hospital structure

> *[...] The fact that you have your own beds, you have a ward back, you have the perception that you have the hospital again... because people lived it as "we go hospitalized" (laughs), you know?* [CARE, head nurse Willnal]

On the contrary, doctor Jordan who has an ideal self as a family doctor points to CARE as a patient-centered structure rather than a para-hospital structure. Doctor Jordan in particular aims at being "*an all-round family doctor*" who takes care of his patients' health with a 360 degrees view, making diagnosis "*without knocking at hospital doors*". To him, the structure is a place where doctors can actually diagnose properly their patients:

> *What we had in mind (although at the beginning, in the first two or three months, we were trembling) was to try out if we could be a bit more independent from hospitals. A chronic and bronchitis patient that we could not treat at home (or that we could not treat because of logistical reasons), but who was still not so acute to be admitted in a hospital ... Well, do we want to test if we can take care of him?* [CARE, doctor Jordan]

All CARE professionals recognize that most of the community hospital recovery cases are related to inpatients recovered from hospitals, usually after surgery or an acute disease. But doctor Jordan repeats that to him this is not the primary aim of the structure ("*I've always thought of the country hospital not as a convalescent hospital: it does not primarily address the old patient who broke his femur, who gets 3-4-5 days of intervention and hospitalization in the orthopedics ward, and then gets here to have his recovery. Yes, community hospital is ALSO like this! But not primarily*") but rather a structure where patients need to recover and have deeper diagnosis: the perfect structure where a family doctor can have a 360 degrees understanding of inpatients problems.

> *"I hope I have helped shape the type of assistance, the type of approach to this particular patient in a particular structure; a structure that is a hospital but not a usual hospital: it's a particular hospital. The hospital held by general practitioners. So doctors with their particular culture, with their own special way*

to stand in front of the patient and in front of the patient's relatives." [CARE, doctor Jordan]

Doctor Jordan, as most of the professionals, agrees around the human-center characteristics of the structure. Those characteristics are also shared by doctors who firmly stick to making up for old-style family doctor practice. Doctor Val for example has a quite traditional and deep attachment to the old-style practice (e.g. *"I always wanted to be a doctor, my father was and my brother is and even if I had sons during my studies, I persist to finish my studies"*) and she highlights the human centered characteristic of the hospital as a central and distinctive characteristics.

> *"I remember in particular patients that have been here, I knew them 'cause they were kind of cards from our town. Maybe they met in the streets. When I remet them as patients , I have learned to know another aspect of time, and sometimes I discovered human aspects that enriched me.*
> *[...] I remember one patient, who was not my patient but the patient of a colleague of mine: his name was [name hidden], said like this: in the local dialect. And he walked back to the times of the war in Russia from Russia till here in Italy. He had escaped from raids and dangers because during them he wrapped himself in a white blanket and he laid down in the snow, so they could never intercepted him. He was a chronic cirrhotic, and -beyond his pathologies- he told me about these experience of life [...]. So through this structure [the community hospital], beyond the fact that I saw them as patients, I could also connect myself to their human aspects. I got to know them from so many different perspectives!"* [CARE, doctor Val]

Doctor Rox, slightly differently, conceives not the structure but her everyday family doctor practice as a *"humanistic profession"* (*"I carry around a bag where I see the person, his being that relates to me, he brings me her woes. I try to solve them, [...] A human relationship. In other words, I give my ability, my knowledge, but I always have to consider that you're not a heart or a leg. If I use a protocol, it's not the protocol that matters, it's you, and I have to apply it to you. Because you are a unique being ... I mean, I have to look at your face, to consider your experience, to try to understand you"*

She considers this "*technical-humanity ability*" as a central and distinctive competence defining the structure itself. In particular she explains how the intermediate-level inpatients need this mixture of competences to be properly cured:

> *The community hospital is useful and it helps the people who have not a family. The so-called sheltered housing or nursing homes <u>do not have the capacity</u> to do what we do as community hospital yet. Our patients are sick, and for them a normal hospital is too much, but a nursing home is not enough. Missing an intermediate structure. Missing an intermediate form. We're not talking about resuscitation or intensive care, nor about nursing homes: we're the middle way.* [CARE, doctor Rox]

Even nurse Argentine, at last, considers the total respect of the person as a characteristic of the structure. She entered into the Community Hospital in order to pursue her work-family balance (Greenhaus & Powell, 2006) after being a highly specialized nurse in a surgery ward for 15 years. Being aware that "*innovation in hospital wards is not like innovation here, 'cause in surgery room everything is faster*", even at the organizational level she pursues the "soft" psychological and human-side approach.

> *I have found that there is a lot of psychological work with patients and their relatives, which in a larger hospital I do not think there is. Due to the fact that we are a fairly small hospital, we can spend more time on certain things than regular hospitals. In regular hospitals sometimes doctors and nurses do not even remember the patients' names. I think [our psychological work] is a good thing, at least a positive thing.* [CARE, nurse Argentine]

Likewise, at MEDITEAM, informants provided different interpretations of the core and distinctive attributes of the organizational identity in ways that were aligned with their self-concepts, which included features of their alternative and/or possible selves. The centrality of family doctors in the management of MEDITEAM is stated by all the informants as a central attribute. In addition, doctor Karl who perceives evidence-based medicine as the "true medicine" that a family doctor should enact, claims that the 21st century medicine will be

concerned with a very aged population, characterized by chronic and degenerative pathologies. Doctor Karl stresses that:

> *To this regard, MEDITEAM's organizational structure is so flexible and easy to use that it should be generalized everywhere […] here we have everything that is needed for territorial medicine, especially for very aged population. By aged I mean over 80. […] We always work with pathologies that go beyond what we have been initially assigned. By beyond I mean more complex.* [MEDITEAM, doctor Karl]

For doctor Mike, the centrality of family doctors is fully enacted not only by admitting patients with more complex pathologies than formally stated, but also by admitting patients that originally would not fall within the responsibility of community hospital's doctors. He explained us that he is more than willing to take charge of patients whose family doctors do not live or practice near MEDITEAM and that in such case:

> *You [CH family doctors] follow a patient and, when you admit her into CH, you become her own doctor until her discharge. During her stay at MEDITEAM, you can talk with her doctor just to inform her about how things evolve, but these patients are considered as yours. In the clinical record you write your own name'.* [MEDITEAM, doctor Mike]

Nurse Lory, whose alternative self is that of being a psychiatrist, interprets the core attribute of CH as being managed by family doctors as a characteristic strictly linked to an enhanced autonomy for other professionals (family doctors operate on a part-time basis) thanks to which nurses can decide autonomously how much time to devote to each patient and what support to offer. As meaningful examples she told us that: *'For instance, this morning I arrived […] close to a patient and I realized that she wanted to let off steam, so I sat down for ten minutes and I talked to her; when I went out, she was smiling, peaceful, and relaxed. I could have never done that in another organization'.* In addition to that, she also explained:

> *Patient by patient, I go to see each of them, I want to know how it goes, I take a look to the type of therapy they have to undergo and if there is something missing. The physiotherapist keeps telling me that it is enough if they are able to walk*

again, but I take walks with them and chat. I dedicate time to them. I try to make sure that they don't have doubts or unsolved issues [...] just see it is a sort of a private visit." [MEDITEAM, nurse Lory]

5.3. *Unrealized selves as forces of organizational identity variance*

Hsu & Elsbach (2012) refer to the organizational identity variance as a condition in which variation in organizational identity perceptions arises among organizational constituents. Scholars showed different forms of organizational identity variance. The most common is the different degrees of saliency attached to different organizational identity attributes. For example, members of the Symphony Orchestra recognized that the organization had different dimensions to its identity, and conflicts arise because musicians choose the art as the most central and salient dimension, while managers chose the business (e.g. Glynn, 2000). Another type is the different valence (positive, negative or neutral) that can be attached to the same categorization of organizational identity (e.g. Hsu & Elsbach, 2012).

Connections between the unrealized self and the organizational identity perception emerged from the organizational constituents' interviews and documents. Although those individual-level forces initially acted as convergent forces grouping the constituents' entrepreneurial activity towards the creation of the community hospitals, now that the organizational identity is formed (Gioia *et al*., 2010), data show that the tensions created by the unrealized selves processes are still evident. The different perceptions of organization identities driven by the enactments of selves act now as divergent forces at the organizational level, leading to non homogenous organizational identity perceptions at the organizational level.

Field evidence show different types of organizational identity variance:

1) Saliency. Among the attributes that are recognized by all the constituents, a certain attribute can be perceived as highly or marginally salient depending on the

organizational constituent. In a limited number of cases, divergent perceptions are related to attributes that are considered salient by some actors and non present by the others.

2) Valence. The same organizational attribute can have a positive or a negative valence depending on the professional involved. That is, when mentioned throughout the data collections, the same attribute happened to be emphasized with a positive or a negative value depending on the actor.

3) Non shared elements. The same attribute creates disagreement within the organization (agree / don't agree).

I'll now go through the different types of variance encountered throughout the case studies.

Saliency. The types of recovered inpatients certainly play a central role in defining "who we are" for a healthcare structure, defining which particular kind of healthcare structure the community hospital is (the so-called *within-form identity categorization* – Kind & Whetten, 2008). Doctors at CARE agree on the fact that they deal with *non acute* inpatients, in general regarding old people and this is coherent with the official statements presented in most of the collected documents. Nonetheless, when specifying the patients characteristics, they stress and empathize in different ways the inpatients descriptions, showing different perspectives of the organization. Doctor All for example is keen on affirming community hospital inpatients as old people.

> *The core, the concept of community hospital is this: a recovery-bed mainly devoted to older people. But not only.* [CARE, doctor All]

He proudly shapes the community hospital on this old target, since "*society needs a structure that really addresses the chronic and multi-pathological old inpatients*" (positive valence). Nurse Tim agrees attaching a negative valence to the low variance of inpatients (and consequently to what he perceives as a under-developed professional specialization):

But here in the community hospital our admitted cases [patients] are more or less always the same, there are no big news. We are closer to a retirement home than a hospital. [CARE, nurse Tim]

On the contrary, Doctor Mats and the head nurse proudly narrate how they have been somehow compared to hospitals given the high variance and complexity of inpatients. Similarly all CARE professionals recognize that a significant percentage of the community hospital recovery cases is related to post-surgery or a post-acute disease inpatients from hospitals (the so called, hospital protected release). Nonetheless, some of them (e.g. doctor Jordan) minimize the phenomenon, infusing a different meaning to the structure.

This variance confirms Hsu & Elsbach (2012) argument stating that "Within-form categorizations are a core element of an organization's identity (Albert & Whetten 1985), and disagreement regarding these could lead to conflict over how decisions should be made and what behaviors different constituents view as most appropriate in a given situation. By studying within-form categorizations, researchers are likely to consider a broader range of differences in perceptions of the same organization's identity among constituents. As a result, they may develop a broader understanding of the drivers of variation in organizational identity perceptions" (:2)

At last, not all the participants agree in recognizing a certain characteristic as present at the organizational level. That is, there are attributes that are simply considered non significant by some professionals of the organization, while some colleagues strongly highlight them when describing the community hospital. For example "*economic convenience*" is a value that is central and distinctive to doctor All, but of no particular interest for the other doctors and nurses. Doctor All repeatedly recall for numbers from external studies showing that the community hospital cost per bed per night is much further convenient than specialized hospitals cost. Dr All takes the role of "stakeholder relationships

referent" and, when speaking with press, politicians and unions, he continuously lists the community hospital characteristics that present positive drawbacks for society. Interestingly his alternative selves are being a professional journalist and a politicians, and with the community hospital he is now addressing both of them by caring about stakeholders relationships, by being the referent for the Italian Community hospitals in a Family doctors' Union and by writing in local newspapers.

<u>Positive or negative valence.</u>

The same organizational attribute can have a positive or a negative value for different professionals. That is, when mentioned throughout the data collections, the same attribute happened to be emphasized with a positive or a negative value depending on the actor. CARE clearest example attains to the fact that "community hospital is the hospital managed by family doctors". Throughout the case studies, this characteristic is considered more or less salient by the involved actors. Considering CARE, this is an extremely salient characteristic to everyone. However not all the interviewee have attached the same valence to the label. While Doctor Jordan, doctor Val and doctor All attach a positive value to it (coherently with their unrealized selves enactments), doctor Rox is not so positively convinced about the family doctor role in the hospital, since - to her - leading the hospital turns into an overwhelming activity:

> *For a family doctor, who has always been a family doctor, who knew that his clinical intervention reached so far [he marks a line on the table], and that from this point forward others address the issues [...]. This community hospital was a big blow: as a mental state, as a habit ... You're used to deal with some patients and not with others, I'm used to deal with cancer patients because I always deal with that […] But in front of a heart failure that rarely happens, I could panic a bit. Acute diseases (acute pulmonary edema, for example) is not part of my routine - thankfully! While I can deal with those kind of diseases and problems such as a cancer. I'm used to it, I deal with it from morning to evening and I can better manage them.*[CARE, doctor Rox]

Similarly nurse Argentine, when describing the fact that in the hospital doctors are family doctors, attaches a negative value to the label. This is because she compares her relationship with the family doctors with the one she had in previous experiences:

> *When I was in the surgery room, there was complicity between me and the doctor, I mean, many times during the surgeries you don't even talk 'cause just looking at him you know what he wants. Here it's different: we often need to interact and clearly communicate what is needed... It's a different way, a different relationship.* [CARE, nurse Argentine]

Another example from MEDITEAM regards the territorial characteristic of the hospital. While family doctors interpret MEDITEAM feature of being a territorial hospital as positive because it helps them to focus on their own patients, the very same attribute is perceived as negative by nurse Lory: denying admission to patients who do not belong to a specific territorial area is inconsistent with her need to help others without any limits or distinctions.

Disagreement. Another form of variance leads to explicit disagreement between actors, since different actors within the same community hospital can agree or not on the same attribute. At CARE there is disagreement about the innovative characteristic of the community hospital. Doctor Rox addresses the organizational innovative characteristics of the structure ("*we are the pioneers who open the way for others*"). Even Dr. All eagerly recalls the pioneering experience "*[Others have] smartly imitated us, because […] we marked a division!*" On the contrary nurses Argentine and Tim recognize that innovation is not really an appropriate distinctive characteristic of the organizational identity "*Who works in a hospital is more up to date because there you can constantly see new things concerning therapies and procedures.*

Here it's different. Here things are much slower [...] In the hospital therapy changes are very fast, while here there's no opportunity to see those things".

Another example concerns the internal debate that is ongoing in CARE. While Doctor Al repeatedly recalls the economic convenience of the structure to the social system "*it costs just 100 euros per bed per night, otherwise those patients should stay in the acute hospitals that cost 700-800 euros per bed per night*", manager Lucy rebuts "*Pay attention: Doctor All keeps saying that that this structure is economically convenient for the healthcare system because the cost per night is lower. But who analyze costs (and I) don't agree. Without community hospital those patients would stay at home and it's not demonstrated that community hospital decreases the hospitalized people index of the local area".*

5.4. *Which tactics for the coexistence of different responses to 'Who are we as an organization?'*

A question that immediately comes to mind is how different interpretations can actually coexist in the same organization without evident contrasts. Studies on the coexistence of different responses to the question 'Who are we as an organization?' have shown how, often after a stormy discussion, organizational members construe a shared response (Pratt & Rafaeli, 1998; Glynn, 2000).

Conversely, in the settings that I have analyzed, different interpretations of community hospitals' organizational identity emerge from insiders more than a decade after the foundation. As reported above, in fact nowadays my informants share some values, disagree on others, and declare that some colleagues do not and the code doesn't show evident contrasts. The coding process allowed me to understand which 'tensions' made this possible as well.

The tensions include forces converging around a shared constructed organizational identity (converging forces) and tactics that individuals used in order to enhance organizational identity coherence with personal selves (distancing forces).

Building on organizational archival data (see chapter 2 for the table listing data sources), Throughout the years, a strong regulation and agreement on procedures was developed among the organizational constituents, that spent a lot of energies in legitimizing their structures towards citizens or other healthcare structures with clear image claims, both on newspapers, televisions and local conferences.

Most of the case studies show that professionals established regular opportunities for discussion among all of them involved. At CARE for example every Friday morning doctors and nurses meet to discuss criteria for patients' admission and discharge, therapies, evolution, and requests for specialists' advice. Doctor Al stresses how the nature of Friday meetings has changed over time to become an influential collective moment where to share and standardize procedures:

> *We meet every Friday morning from 12.30 to 1.30 pm to decide admissions and discharges, and share problems and doubts. These famous Fridays have been going on for 16 years: at the beginning, also county health managers participated, who'd say: 'We have these needs, how can we handle them?'. They ended up writing down more notes than we did. We eventually got free of them five or six years ago. Their involvement was inappropriate: we meet to discuss CARE everyday life, our everyday actions, our patients' diseases.* [CARE, doctor]

Friday meetings are particularly useful to make sure that doctors who do not engage in group practice, nonetheless adopt practices similar to those of their colleagues in dealing with their patients, so that CARE can provide consistent treatments to all of their inpatients.

At MEDITEAM occasions for meeting are sought even more frequently and professionals engage in daily informal dialogues with coworkers regarding every medical topic. Those

dialogues are perceived on one hand as a means to keep competencies updated and access different perspectives on a problem or decision to make, and, on the other hand, as an opportunity to discuss and negotiate criteria for sensitive issues like patients' admission and discharge.

The HEALTH case is slightly different since a wide number of family doctors are and have been involved (up to 90 doctors recovered their inpatients in the last 4 years). As in the other case studies, the clinical responsibility is in charge of the family doctor, but the large number of family doctors involved made, differently from the other case studies, periodical meeting a non sufficient dynamic to keep all aligned: more precise norms had to be decided. As the manager says "*I don't' want the doctors to evanish once we recovered his patient! The clinical responsibility is up to them!*". To force family doctors to carry out their responsibility, a strict procedure was designed to force doctors to be present at least every 5 days to update the medical records. The head nurse explains "*We put in the rules that the therapy that the family doctor orders has a lifetime of 5 days. So that a doctor has to come in at least twice a week, for example on Monday and on Friday*". Beside that, a core medical group was created and it was assigned with tasks of "*organizational and clinical supervision*" (internal document). The core medical group includes 4 doctors, the head nurse and the community hospital manager. Everyday 2 doctors meet the head nurse and the hospital manager from 11 to 12 am. The group need to check that procedures are followed by all the professionals involved and take decisions in case of emergencies.

Although cases present clear procedures, the coding activity let me understand that actors used tactics that let them work, within the procedures, in a way that is coherent with their wanted selves. Tactics are both cognitive and practical.

From the cognitive side, organizational constituents instilled wanted meanings into the shared organizational attributes, so that organizational attributes could reflect their unrealized self. A good example of cognitive distancing relates to the use of the "useful" attribute. Most of the actors repeatedly report the usefulness of the structure. When asked to explain what they meant as "supportive", "useful", "central", … it interestingly happened that actors recalled for they unrealized self enactment. For example, in CARE doctor Mats recalled his alternative self of hospital doctor: he reframed the usefulness of the structure while emphasizing its role of support in relieving congestion in recovery for acute hospitals.

> *The idea of the model was basically trying to reduce hospitalizations and avoiding the chronic patients pilgrimage: often patients with chronic or sub-acute problems need to travel from one structure to the other (first in a hospital, then into a private facility, then it ends up in long-term care, then you do not know where to put her… inconvenience to everyone!). Moreover there is a reduction of the number of beds, so if you're not dying you are not hospitalized. But it is not hospital doctors' fault! Do you know that sometimes on Friday morning at the town hospital there are just two available beds, with a weekend ahead. Any idea what that means?* [CARE, doctor Mats]

Rather Doctor Jordan highlights the usefulness of the structure as a place that supports the doctors in making better diagnosis. Nurses and even inpatients' relatives can support him in the diagnosis process and he can have access to specific medical exams that would otherwise be executed and interpreted only by hospital doctors.

> *The most worthy aspect of all this is precisely that, as a general practitioner, you can make a diagnosis for your patient without cultural hesitation, without feeling inferior, without being hospital doctor-addicted! This was possible in the days when we were compared to other hospital wards of the city, so that patients with our referrals (for example an x-ray referral) had a preferential access to other hospitals machines: on those days we just had to wait a fairly short time to have the referral results, and we could make diagnosis in a few days .*
>
> *[…]That is, if during my visits in the community hospital I enter in a room where there is a relative of my patient next to his bed, not only I don't chase him away (as it usually happens in the hospital), but if the relative leaves the room, I ask him to come in. Also, I usually ask the relative about his impression about the patient: I can spend only a very limited amount of time with my patient, the nurses*

and nurse aids usually provide us [the doctors] precise information, but the patient's affective tone … that thing can be better understood by his relatives. And maybe the relative can detect a issue that we didn't noticed, and in that case we try to fix it. [CARE, doctor Jordan]

Doctor Rox explains the usefulness characteristic of the hospital describing the structure as a human-centric structure where she can continue to have her traditional work

In my opinion community hospitals are useful: useful for us as doctors - because we know that there is a nurse here at night taking care of the patients-, and useful for the family -because otherwise the family is in despair. Don't know if you've ever needed the home care services before: try to have someone in your family that needs 24/7 constant caring, and you'll see how tough it is. [CARE, doctor Rox]

Another example from CARE deals with the intermediate structure claim. CARE members report through different channels that CARE is an "intermediate structure" between hospital and territory. This was reported on national newspaper, local newspaper, local television videos, official documents about CARE case study spread by National Family Doctors' Unions. Every informant agrees on this definition, saying that it is an intermediate structure since it stands between a hospital structure and a territorial cares structure. However, evidence show that different actors interpret this attribute in different ways, settling the community hospital nearer to an extreme or the other (para-hospital vs territorial cares) depending on their unrealized selves. For example Doctor All interprets the community hospital as "*the territorial beds par excellence […]*". He proudly says "*When the ministry wrote the law about the territorial beds, she just came here and translated what she saw into law*". On the contrary doctor Mats and the head nurse settle the community hospital near to the other extreme. The head nurse states "*to me community hospital is having again long recovery beds as a hospital*".

In MEDITEAM different meanings are associated to the label "territorial hospital". The manager of the local unit to which MEDITEAM refers associates to "territorial" the idea that the hospital should serve all the areas under her local unit, and not only the valleys around the town where the hospital is:

> if you saw our Regulation, you saw that it's just written: "for the [name of the area around the town] citizens." I think it is a restrictive way to give answers in the territory, so let's say that this is one of the problems that I want to face.
> [MEDITEAM, manager]

For doctor Mike, conversely, being a territorial hospital means covering the healthcare needs of the all the citizens from the valleys around the community hospital town, no matter if not all the doctors of the valleys want to/can take the responsibility of working in the community hospital. That is, following the internal procedures, an inpatient can be admitted in the Community hospital just if his family doctor takes responsibility for his care. Since not all the doctors from the valleys accepted to be involved in the community hospital, doctor Mike also admits inpatients under his responsibility although they should not be associated with his responsibilities. Differently doctor Karl is always striving to affirm the territorial medicine as a medicine based on data-evidence and involving a multitude of actors and expertise working together, and he aims at an ideal self of family doctor enacting that medicine. Coherently, he explains the territorial nature of the community hospital as a structure that takes part of a network of services:

> We talk about organizational interventions, territorial medicine, .. But what's most exportable of this structure that we have? We have: residential structures, the Community Hospital, general practitioners clinics, pediatric clinics, physiotherapy and rehabilitation, radiology and laboratories. Here we have everything you need for a territorial medicine. [MEDITEAM, doctor Karl]

Some scholars already inquired meaning-based forms of identity change (Corley & Gioia, 2004; Gioia, Schultz and Corley, 2000) and concluded that "the meanings-based form is arguably more subtle and distinctive [than the label-based form of identity change] […] and

therefore has more potential for unique contributions to changing identity" (Corley & Gioia, 2004: 203). That contributions advice leaders and managers to solve internal inconsistencies or divergences connected to meaning-based differences by recurring to sense-giving processes. On the contrary in my case studies meaning divergence helped the organizations to keep ongoing including different desires from the involved actors.

From the practical side, professionals buffer their different interpretations of community hospital with role differentiation. At CARE for example, members have since the beginning differentiated their roles to play out the different attributes that they perceive as characterizing it. Professionals who see CARE as a para-hospital take charge of relationships with hospitals and specialists (cardiologists, oncologists, etc.), and focus on inpatients with severe problems. Their capability to handle difficult situations is attributed to their previous experience in hospitals, as Doctor Val expresses below:

> *I spent a long time working at the hospital [of the city nearby], therefore I was used to coping with hard situations on my own. As a consequence, I'm at ease in treating a patient even with acute disease here. […] So, when we opened CH, it came just naturally to me to deal with the most difficult, borderline cases, and I think this is good for CH.* [CARE, doctor Val]

Professionals who see CARE as a service to the local community have specialized in gatekeeping roles. Doctor Al presents and negotiates CARE with institutions (e.g., local authorities, national health-related associations, press). Doctor Jordan (coherently with his alternative self of informatics engineering) has created and keeps updated the official website for which he has autonomously developed technical expertise. He also coordinates data sharing of inpatients digital and clinical data through the group of doctors. Finally, professionals who see CARE as a third location where to treat their own patients in addition

to their office and patients' home set a tight schedule for their presence at CARE. They fit its activities within their agenda, with little flexibility for adjustments. Doctor Rox explicitly told how she strictly splits her working time between her office, visits at home, and the CH, which is just an addition to her office: where she *'punch[es] in, punch[es] out'*, while having the chance to interact more extensively with patients and their families.

Similarly I witness a role differentiation in other cases. In MEDITEAM for example doctor Karl considers the community hospital as a prototype of 'medicine 2.0' aimed at applying the principles of evidence-based medicine. He has coherently specialized on the role of data analysts. Doctor Karl not only collects data, but also produces regular reports on the types of activities and treatments offered by MEDITEAM and writes publications that he publishes on the Internet, because, as he concisely stated: *'I am obsessed with data'*. Doctor Mike underlines that at MEDITEAM there are no hierarchies because the CH belongs to family doctors—their central attribute in his opinion—but at the same time he stresses that MEDITEAM members soon came to realize that the management of waiting list priorities would benefit from having an internal point of reference that he is more than willing to represent.

At last, not all the procedures are strictly defined and professionals described work-around that address eventual disagreement, leveraging on grey areas of internal agreements. In HEALTH for example the "open-hospital" characteristic creates some disagreements. Some professionals explain that the fact that families and friend can enter in the hospital with flexibility is a positive and central characteristic of the community hospital. Some nurses express how familiars can be helpful, releasing the nurse team from simple tasks as feeding the inpatients. The head nurse reveals that this topic triggers some little conflicts between her

and aid-nurses: *"Sometimes there are still conflicts. For example, since we are an open-hospital, I want aid-nurses to care about inpatients look. I'd like them to cut their nails, to brush their hair. But this is not accepted yet. […] I'm working on a document with those simple rules that I would like to be accepted as normal tasks of aid nurses"*. On the contrary, doctor Zux explains that relatives sometimes are harmful to the relationship between the inpatients and the doctor since they misrepresent the information the doctor requires as they are annoyed by the condition of the sick person. *"Relatives and care givers think they know everything, when they know nothing ... they are so cumbersome. And they tell you that the patient is agitated and that he is annoying, and maybe they don't tell you what would be helpful. There's always this kind of problem at patients' homes."*. Doctor Zux, describes the community hospital as a place where he can be free and decide not to admit relatives in the rooms when he speaks with the inpatients, differently from his colleagues choices.

> *The need of a place where to visit your patients that is not your patients' houses, so that you can be more free… This is what I wanted. Because many times I feel 'closed in the patients' homes, here [in the community hospital] you can be free. You know, sometimes you are the doctor and you should deal with your patient at his house, but there you find also his family members. Here you are free and the relationship with your patient is more head-to-head, it is immediate, it is direct, no more mediation as in patients' homes. Here it's straight. Mediation is sometimes negative, I mean that the patient's family usually makes you look what interests them, and not what is real. Ok? [note: he speaks enunciating every single word as if he is saying something very important]* [HEALTH, doctor Zux]

Another example regards members of CARE and their disagreement about group practice. According to doctors claiming professional identities as hospital doctors and as comprehensive doctors, inpatients at CARE must be cured by every doctor who happen to be around. That means that every doctor can take decisions regarding an inpatient, no matter whether they are her family doctor or not. They explicitly talk about group practice when commenting on CARE core features. Doctor Al says that 'we work according to the principles of group medicine, we all take care of all the patients: when I'm here, I go and visit each

inpatient'. Group practice allows CARE to offer better diagnoses and treatments to patients, since different doctors can see opportunities or alternatives that a long-time doctor may not be able to see, as Doctor Mats told us.

Eventually, doctors who believe in a profession as traditional family doctors deny that group practice be a salient feature of CARE. Doctor Rox clearly states that she takes care only of her own patients, for whom she feels fully responsible, when they are at CARE, and that she does not appreciate that her colleagues interfere with her decisions:

> *We usually say: 'These are my patients, I have these patients'. We have kind of a possessive approach to our patients. I take my own decisions for my patients, be they right or wrong, for which I assume my risks. I expect the others [colleagues] to do the same. We may ask for advice from each other, but in the end we remain independent pinch hitters.* [CARE, doctor Rox]

Doctor Rox, beside recognizing the innovative characteristic of the structure, thinks that still a long way has to come for her organization to learn group working, and call for an external support of "young forces" that could help her and her colleagues to improve their group practice.

> *The general practitioner has always been a person who works in his corner, alone. [...] Yes, I appreciate my colleagues and I've learned a lot from them, I have no doubt about this, and I have no problem to admit this: you know, sometimes when you have a doubt, you call them to ask for advice ... But we still are free hitters. Yes, free hitters: we could not manage to harmonize the group yet. After all, this experience is a first step. Besides, you cannot put everything together just in a moment ... I think that in the future we'll have general practitioners that can work in group, this is the way for the next generation. We began this experience by our own, but I hope that, when we retire, new med students will be able to work within a group.* [CARE, doctor Rox]

This chapter entered into the patterns that emerged at the individual level between organizational identity perceptions and unrealized selves, inquiring how those patterns are

triggers of organizational identity variance at the organizational level. The chapter also addresses the mechanisms that at the organizational level mediate between individual fulfillment and organizational collective agreement, and show which cognitive and practical tactics actually softened potential and real conflicts arising from organizational identity variance.

Archival documents describe clear processes and procedures that are internal to the organizations, obtained with processes of norming and maintained with periodical meetings in which professionals describe weekly activities and address unclear cases. At the same time, the coding highlights tactics that professionals used in order to buffer actions and perceptions that are coherent with their initial unrealized selves. From the cognitive side, the individuals instilled in the shared organizational attributes meanings that reflect their unrealized self, while from the practical side, professionals buffer their different interpretations of community hospitals with role differentiation and work-arounds, leveraging on grey areas of internal agreements.

The next chapter inquires mechanisms that reinforce this equilibrium.

6. Evidence from the field. Reinforcement mechanisms: positive identity work dynamics

During the interviews and throughout the documents, the experience of community hospital was often connected to a process of growth and evolution, both at an individual and at the organizational level. For example, the next quote represents an example of this process of growth, at the individual level:

> *[Working in the hospital community] definitely changes you: you get enriched. When you are a doctor and you're old as I am, while time passes by, you just settle in, you fixate on your things, and you forget a lot. Working here let you receive a constant stimulus. The reason is really practical: if a peculiar clinical case happens in the community hospital, you just go and check it. It's easier to get yourself updated.*
> *Then, there is the debate with the others. It's clear that you can think in a different way than your colleague, but still there is a debate.*
> *If you're alone in your office, you can also be keen in studying your books, but you can't stand it alone, after a while you simply get lost.* [ARCMED, doctor]

The continuous attempt for development is also observed at the organizational level, referred to the organization as a whole. For example, the same interviewee later adds:

> *Let's say that this expectation undoubtedly grew, slowly, but it grew. At the same time we became aware of our ability, aware of the opportunities we can offer. At first we were perhaps a little scared. Now we know that we can do something, we know we can succeed ...* [ARCMED, doctor]

Coherently with the qualitative studies and the grounded model theory development (Strauss & Corbin, 1998), I went back and forth from data to literature several times. During that process, the positive organizational scholarship was identified as the framework that best fits and theoretically supports the observed processes of growth and evolution. In fact, what characterizes this framework when dealing with identity work processes, is exactly the growth tension embedded in it. As Kreiner & Sheep (2009) states "identity work toward growth is distinguishable from other "garden variety" cognitive mechanism that do not inherently imply growth, such as cognitive dissonance reduction processes or impression management" (:25).

6.1 Positive identity work and the unrealized selves enactment: from individual to collective reinforcements.

The <u>developmental</u> form of positive identity is based on the dynamic nature of identity, moving from changes of identity's content towards desired future states (Dutton *et al.*, 2010). This form of identity work is well represented by the forms of crafting that try to enact the possible and ideal self over time, following the processes so far analyzed. For example several nurses from HEALTH and ARCMED explained how they conceived their role in the community hospital in a positive developmental perspective, because of the large autonomy and responsibilities they have there. For example nurse Alice in ARCMED states:

> *If a colleague of mine wanted to come and work here, I would say that is a good experience because it makes you more independent: usually in the hospitals the doctor gives orders and the nurse performs. Here it can happen that a patient has a fever on Saturday [doctors are not in the community hospital during week-ends] and then what can I do? Shall I call the emergency doctor just for a fever? That it is not anything serious, the patient is not going to die! So what I do is that I simply give a paracetamol to the patient, while in a hospital I could not do that because it was not decided by a doctor and I would first need to talk to the doctor. It's like taking care of a patient in his house: I look at what he previously had, I check if he has allergies, and then I can decide whether to give a paracetamol to him. I have this autonomy. One month ago, a patient needed to have an antibiotic and, despite the fact that the antibiotic was not listed in the patient's folder, I phoned the doctor and he authorized me to go on. We have autonomy here .*
> [ARCMED, nurse]

Even the observation conducted in ARCMED showed a doctor and the home-nurse Danny discussing in front of the blood analysis results just-arrived. Danny had just visited the inpatient at his house, and, once back at the community hospital, he discussed with a family doctor whether to re-admit the patient in the community hospital and which therapy to delivered to him for the next days. The two professionals had a constructive 5 minutes discussion during which the home-nurse explained to the doctor the inpatient's conditions, trying to cross her information with the interpretation of the blood analysis results. They eventually reached a common decision about admitting him and about the best therapy to give

to him. As a HEALTH nurse explains "*Here I have a equal relationship with doctors, I can discuss with them. I could not do that in classic hospitals*".

Another example of developmental growth enabled by the working in the hospital is reported by doctors in MEDITEAM and HEALTH. MEDITEAM is situated in the same structure of the town hospital, just at a floor below it. The doctors can thus easily access diagnosis machines as well as hospital doctors' advices for constructive discussions, whenever they need them. Similarly, ARCMED is located in a building with offices where specialist doctors visit every week (e.g. neurologist, physiatrist, ..). Doctor Mary of ARCMED explains how this represent an opportunity to develop a positive identity:

> *We work together here, you work in close contact with hospital specialists, I have a direct contact with them, so I work better. Specialists don't advice us just by telephone: we can directly talk to them, such as with the eye doctor, the orthopedic surgeon or the gynecologist. And being in close contact with them, you learn a lot and, from a cultural point of view, you grow.* [ARCMED, doctor]

Similarly, the structural form of positive identity work considers the perception of compatibility of multiple identities. Nurse Alice from ARCMED, for example, works in the community hospital because she wants to complete her master as a nurse coordinator, and she cannot study after a full-working day as a surgery nurse ("*too much stress, too busy days!*"). Her positive work identity is a structural positive identity that can complement her nurse identity and her master student identity. In the next passage, she explains:

> *I grew up in this area, then I worked in the city, and when I had the chance to come back I took it. The type of structure didn't driven my decision to come here, if I had to choose because of the structure, I would have stayed in a biggest hospital [...] On a professional level I wasn't really excited when I came in, and even now... well from the nursing technical perspective this place does not rewards me a lot: basically you practice what you learnt in your first year degree. To me, this solution fits what I need because I am now attending a*

university course [she is attending a master], and when I finish my work here in the community hospital, I still have energies for studying on my books. Before moving here I worked in intensive care unit. And if I still worked there, I could not make it – that would be really exhausting). [ARCMED, nurse]

Also the alternative selves enactment can be connected to a structural positive identity work. The community hospital structure lets its participants enact different identities in a complementary way, and those multiple identities could hardly coexist outside the community hospital. For example, doctor Jordan in CARE enacted his alternative self of informatics engineer caring about the community hospital's information systems and its web site, as well as the family doctor identity. Doctor Karl from MEDITEAM recalls his career as university researchers coordinating partnerships between Universities and his community hospital, so that he can take part to medical research projects, by supporting the university researchers in the data collection and data analysis activities.

Beside the compatibility among different work-selves, evidence also reports a search for compatibility between the professional self and the other selves. For example several women (nurses from CARE and ARCMED, other professionals as the physiotherapist and some care givers, and a few doctors) declare that they chose to work in the community hospital so that they could spend more time with their families ("*Here I am in my hometown*", "*I married my husband, and I decided to move here to his town, although this is such a small town*", "*I decided to go for the family and I left the previous work*"). Another doctor from WEALTH declares that the flexibility that this structure gives him can let him organize his time to be part of the alpinist club that "*is a central part of my life, it's something that you can understand only if you tried it. […] I don't know what I could be without my excursions*".

I thus argue that the negotiations that individuals took within the community hospitals to enact their desired selves or their multifaceted identity brought them to individually

experience a positive identity growth. These positive identities, in particular the developmental and structural forms of positive identities, thus result strictly connected with the concepts of alternative, possible and ideal selves.

I also argue that the realization of those positive identities is the result of a mediation process: the new organizational form crafting is an opportunity to enact a personal self, but, to succeed, the individual needs to mediate her positive growth finding a role in the organizational collective crafting.

The positive individual fulfillment is a central condition for professionals' participation in the community hospital, and the experience of a positive identity plays a central role in keeping the organizations alive. This condition thus makes those positive individual processes central for the collective crafting of the new organization and for its maintenance. The developmental and structural processes of positive identity work are thus significant not only at the individual level, but – most of all – at the collective level as reinforcement mechanisms of the organizational crafting and maintenance.

6.2   *Positive organizational identity and its consequences at the individual level.*

Beside the developmental and structural forms of positive identity, field evidence show that doctors, nurses and other professionals of community hospitals developed other forms of positive work-related identities as member of organizations with a positive organizational identity. In fact, if an organization is esteemed by the self and others, individuals infuse these positively valued attributes into their self-definitions as members of the same organization (Dutton, Dukerich, and Harquail, 1994).

From Dutton *et al.* (2010) the first positive identity form is the virtuous positive identity. All the case studies reported strong virtuous organizational positive identities. Virtuous characteristic are often and extensively reported in archival documents or during interviews

(being "*a support for the families*", "*a support for old citizens*" "*the reference for the town*" "*the only and necessary structure*"…). Of course the healthcare sector and the territorial nature of the organizations facilitate the development of those kind of positive attributes. Nonetheless, other classical virtuous attributes that are not driven by sector and context characteristics emerged from the coding.

Several case studies reported virtuous characteristic of the organizational identity, such as union, friendship, family-like structure. For example a doctor in ARCMED states "*first of all, we are friends, doctors and nurses. A lot of people crave for such a trusted and friendly hospital. You know, several organizations failed just because of internal fights among the doctors and the nurses!* ". The same could be said about CARE ("*We are a group of friends, […] we are born from the bottom*"). Similarly, HEALTH head nurse explains and plays around this union:

> *In the last two years, we came to know each other. With someone I have great relationships, for example I'm really close with the doctor who came before. You share all the stories and experiences and, eventually, you become part of this great family. Sometimes the doctors are glad to find someone who can be hospitalized here [we laugh]. Yes, yes, I swear it happened!* [HEALH, head nurse]

Moreover, more than a case reported resilience and integrity as organizational characteristics. For example, the next quote from ARCMED shows how keen the actors were on those characteristics. Doctor Truffle insists saying:

> *"We are all satisfied. We are still a bit afraid of the rumors regarding cuts: we know that the director will have to remove some services and this preoccupies us. However, all five of us are together. We really fight. We are tough. Even with the politicians. Individually we have our own political ideas, but we know that any politician who does not behave as he should, can hurt the whole group. If we feel threatened, we write articles on the newspapers. […] We are honest and sincere, and no one can accuse us"* [ARCMED, doctor Truffle]

Another form of positive identity work from Dutton *et al.* (2010) is the evaluative form. The positive evaluative identity captures the positivity that arises because one's social group is evaluated positively by the self or others (Dutton *et al.*, 2010). Throughout the case studies, appreciations are collected both at the individual level and at the organizational level by patients, families, and other healthcare professionals, and help developing positive identities. For example, the WEALTH manager told the following story:

> *"On Monday we had a party to celebrate the tenth anniversary of our structure, and the nicest compliment that the vice-director and I received was from an old lady who is now hospitalized here [...]She was taken on a trip for a pilgrimage to Our Madonna della Salute - the preserver of Health, and suddenly she told us: "I'm tired, take me home." This phrase explains everything: our aim is to make everyone feel at home. "* [WEALTH, manager]

Similarly ARCMED made a great effort in order to be positively evaluated from their inpatients and families. Doctors and nurses explain *"We always say to patients, if there is something wrong, just come and report it to us, so that we can improve ourselves"* and they made a great effort to grasp inpatients comments with surveys published in their documents:

> *"You see: we surveyed [he reads some graphs on a book] citizens' perceptions related to the kindness of the doctors, to the medical examination, to the availability and clarity of explanations ... [he browses the folder]. You see, the conclusion was this [he points at a chart]: "How do you value the visit you received?" - 10% excellent, 54% good, 20% adequate, 15% poor 1% extremely poor. So 85% is satisfied."* [ARCMED, doctor]

Organizational positive identities have an effect even at the individual level since individuals translate positive organizational attributes into attributes of themselves. Those positive dynamics reinforce the positive effects that the structural and developmental positive identity already had at the individual level.

6.3 Accidental crafting as a positive reinforcement opportunity

The basic mechanism driving the community hospital creation moves from a crafting activity that started from the individuals' struggle to enact their unrealized selves and unfolds in a collective crafting related to the creation and maintenance of the community hospital. The output was a positive identity developed by the involved individuals and at the organizational level. Those processes intentionally look for a certain positive identity work that employees' jobs currently do not enable, and reach a positive identity through collective crafting.

This last paragraph shows, from data evidence, how the new organization collective crafting can benefit from another positive reinforcement driven by an accidental crafting. The accidental crafting occurs when employees unintentionally discover a positive identity through crafting (Wrzesniewski *et al*., 2013). Accidental crafter unintentionally discovers opportunities for cultivating one or more positive meanings or identities within his activities, as elements that he did not consider before engaging in jolt. The coding process allowed me to track a significant number of accidental crafting processes, that happened once the actors have already been involved in the community hospital and eventually contribute to the positive identity development.

For example doctor Race from ARCMED is now very keen in pursuing his professional development through group practices and he conceives the community hospital as his biggest opportunity to achieve this growth. In a passage from the interview, he admits that the opportunity for professional improvement was discovered only in a later stage of his involvement in the community hospital:

> *No, at the beginning this [professional improvement] was not expected. To me, at*
> *the beginning, we were only friends trying to improve life in this town. There was*
> *a structure that was closed and needed to be strengthened, and we agreed with*
> *the local government that we wanted to value the territory more than anything*

else. We realized that without a hospital, the whole population would have left.
[ARCMED, doctor Race]

Similarly doctor Jordan was initially involved in the collective crafting in CARE with a

clear intention of enacting his role of family doctor as a "all-round doctor", strongly

opposed to the role of hospital doctor. During the interview he admits that throughout

the years, he discovered a positive identity in imbuing his role in the community

hospital with some attributes and meanings that are proper of the hospital doctor role.

He goes on explaining how he now enacts a mixed identity of family doctor "as a

peculiar hospital doctor". He reasons it out with the following words:

> *I was one of those that at the beginning of this adventure, if you had told me that I*
> *would have become a hospital doctor, I would have told you that you're crazy!*
> *Then, with the sensitivity that I have (I think it's one of my few strengths), I got*
> *involved in this community hospital. [...] I would have never believed it. 'Cause I*
> *started with the idea of following my father's footsteps. My father was a family*
> *doctor in little town in the south of Italy, he was always there, always working,*
> *always available, and he represented the good and the bad of the medicine. [...]*
> *In this sense, we [community hospital doctors] have become particular hospital*
> *doctors, we are hospital doctors that keep using general practitioners' methods*
> *and tools.* [CARE, doctor Jordan]

The same accidental crafting happened for the covering doctor in ARCMED, an

external family doctor who has been supporting the other family doctors in the

community hospital for the last years. Through accidental crafting, he discovered a

positive meaning in the close relationships that a "countryside family doctor" has with

his inpatients, differently from the relationships he has when he works back in town.

> *I like it a lot. Graveyard shift is a necessity, not a choice, and I don't have my own*
> *patients yet because I'm just a covering doctor here. But, you know, after so many*
> *years, everyone knows me here in town, people talk to me, they trust me. They*
> *trust me. Even too much! I sometimes feel that they [the patients] exaggerate.*
> *They are so intimate with me, so direct, they tell me all their personal life details.*
> *You know, in the countryside it's like that. But look, I almost prefer to work here*
> *rather than back in town. You are isolated here, that's true, but people are more*
> *direct, less pretentious, simpler. Yes, they are less pretentious than in the city. I*
> *think that, right now, if the city healthcare structure offered me a job, I'm not sure*

I would accept: I would really be in trouble, I mean, I don't know what I would choose, I'm not sure I want to leave this place and I honestly don't know if I would leave. I'm fine here, even if I'm far away from home. Because here it's like being in a family. Even with some nurses, I have a fraternal relationship; and I feel good with patients... I'm very comfortable here . [ARCMED, covering doctor]

As represented by the previous examples, the coding phase allowed me to observe that accidental crafting could bring new unexpected positive meanings and identities to the involved actors. The opportunity is identified as significant for a positive identity work development from the individual and thus repeatedly grasped and enacted, until it is included in the crafting effort.

This process is quite different from the one I have so far presented. The crafting processes so far analyzed moved from the individuals' struggle to enact their unrealized selves. This effort included agency and intentionality from the involved individuals, that followed a process of individual positive identity work. On the contrary, the accidental crafting conveys a non-intentional opportunity-driven framework.

This additional accidental crafting acts as a reinforcement mechanism that is injected in the collective crafting. It also contributes to create a positive identity as an output of the process.

To sum up, the coding allowed me to grasp different forms of positive identity connected to the settlement and maintenance of the new organizations.

First of all, there is a strong connection between the unrealized selves enactment and the developmental and structural forms of positive identity for the individuals. Unrealized selves are triggers of the collective crafting: they push individuals to be involved in the crafting of the new organizational creation in order to have a more positive individual identity and have a role in the collective crafting phase.

Secondly, the organization can develop a virtuous and evaluative positive identity, with positive consequences on the evaluative and virtuous identities of its components.

At last, once an individual is involved, the organizational structure and its internal dynamics give wider opportunities for accidental crafting, that can also be a mechanism leading to positive growth.

The final process results thus strongly empowered by positive dynamics: while a job crafting (individual or collective) would develop a positive identity only with regard to the individual identity successfully enacted, the new organizational crafting leverage on a set of different positive processes. I argue that those individual and organizational interrelated positive identity works, the different forms of positive identities and the intentional and non intentional crafting represent the great potential of organizational creation and maintenance through collective crafting.

7. A Grounded Model on the Process and Conclusions

My initial research objective was to explore how a new form of organization (e.g. Greenwood & Suddaby, 2006), as Community Hospital in the Italian healthcare sector, could emerge in a loose regulated institutional context, understanding how micro processes lead to different local organizational arrangements. This objective was aligned with calls for studying how processes originating at the individual level can change organizations or even create new organizational arrangements able to affect institutional dynamics (Chreim *et al*., 2007; Powell & Colyvas, 2008; Smets *et al*., 2012). Coherently, I expected to study a set or organizations that, although still potentially different from one another (Navis & Glynn, 2010; Navis *et al*., 2012), were at least coherent within their borders.

However, data showed organizational identity variance within organizational borders (e.g. Pratt & Rafeali, 1997), and, since the very first interviews, the interviewees' involvement into the creation of the new organizational arrangement seemed to be coherent with a path of fulfillment of professional "so far" unrealized selves. A unexpected pattern between organizational identity perception and unrealized selves emerged, coherently with recent articles about selves and job crafting (Obodaru, 2012; Oyserman *et al*., 2006; Berg *et al*., 2010). The resulting grounded model considers the balancing between individual fulfillment and collective agreement and shows which cognitive and practical tactics actually softened potential and real conflicts.

My findings disclose the process that leads from the search for the enactment of different self-concepts to positive identities, through the creation of a new organizational arrangement.

Figure II. A Grounded Model on the Process Linking Self-Comparison to Positive Identity.
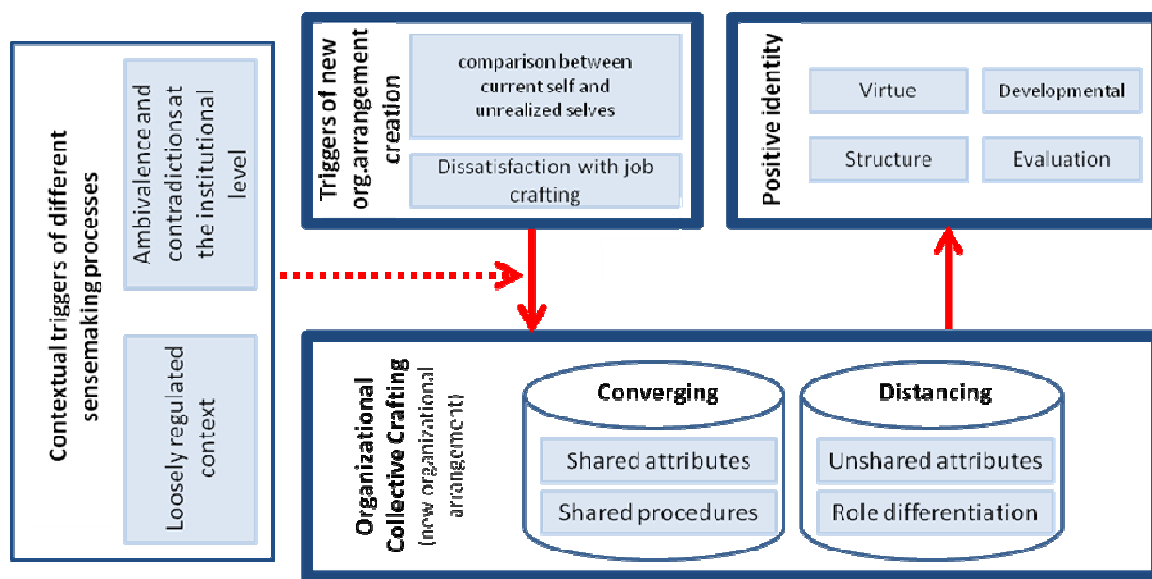
The healthcare professionals that I have studied were moved by compelling self-concepts based on the comparison between their current selves and their unrealized selves (possible, ideal or alternative selves). Since their previous attempts of job crafting failed to turn their self-concepts into actual selves, professionals coalesce to found a new organizational arrangement called community hospital.

The resulting process has been named organizational collective crafting.

The context played a significant role in supporting the triggering power of those unrealized selves: the loose definition of community hospital at the Regional and National level and the perceived institutional contradictions triggered various sensemaking processes by the actors involved. The actors thus embrace the contradictions and the context looseness, taking it as an opportunity to enhance the realization of their alternative, ideal, and possible selves.

Since community hospitals respond to the need for the enactment of different self-concepts (e.g., hospital doctors, all-round doctors, psychologists) at the same time,

mechanisms balancing divergent and convergent forces at the organizational level are necessary.

Regarding divergent forces, insiders provide different interpretations of the core and distinctive attributes of the organizational identity that are in line with their self-concepts. For instance, a all-round doctor sees community hospitals as facilities where he can treat all of his patients (aged people, cancer-stricken patients, post-acute patients dismissed from hospitals) offering a service that involves families and caregivers as well. Conversely, a family doctors who has previously given up a career as hospital doctors or has never had the opportunity to pursue that career sees community hospitals as a service for specific patients like aged people in which healthcare professionals interact with patients only.

To play out their self-concepts to the highest degree, organizational members enact different roles, such as gatekeepers with institutions or data collectors and analysts.

Different meanings attributed to identity labels (and the associated preferences for some organizational practices) and different roles are counterbalanced by setting convergent forces. Professionals seek to coalesce around shared organizational attributes and practices. As a new player entering the healthcare sector, professionals look for the community hospital legitimation from other institutional actors by claiming about its core and distinctive attributes. They presented it as a facility run by family doctors providing short-term treatments to their non-acute patients: an entity placed at an intermediate position between established hospitals and families. By doing so, they differentiate the new organization from hospitals (where acute patients are cured) and from long-term facilities like nursing homes. The convergent forces are represented by opportunities for norming during which insiders discuss, construe, and change coordination mechanisms and operating procedures.

As an outcome of the process leading to the establishment of new organizational arrangements to fulfill different self-concepts, individuals feel a positive identity, in that they

are convinced to offer the best treatments to their patients, sense a compatibility between their different social identities, perceive to be evolving professionally over time, and/or believe that their efforts are deeply valued by many stakeholders, patients especially.

7.1. *Theoretical contributions*

My study on the creation of a new organizational arrangement such as a community hospital bears important insights on how identity work originating from individuals can influence organizational outcomes and larger social systems. Consistent with previous studies (Ibarra, 1999; Wrzesniewski & Dutton, 2001; Pratt *et al*., 2006) that show how identities undergo continuous adaptation, I offer a complex account of how professionals strive to reduce the gap between their perceptions of possible or alternative selves and their actual selves, and of the consequences of such effort at the organizational and institutional levels.

By doing so, I contribute to the comprehension of the consequences of self-comparisons, organizational identity variance, and positive identity, by introducing the concept of organizational collective crafting.

Unrealized selves and self-comparisons debate

I first contribute to a recent, but flourishing, scholarly conversation on the influence that not only 'who we are', but also the cognitive representations of 'who we could be' or 'who we could have been' exert on attitudes and behaviors in the workplace (Berg *et al*., 2010; Obodaru, 2012). Alternative or possible selves are the self-concepts that we might have given up when making life or career choices, or that we may not have yet had the opportunity to enact, but that lurk in our mind as unanswered calls.

Extant research has till now posited that they influence internal crafting of the self or the activation of job crafting activities in the workplace, as well as leisure activities the more the individuals perceive the existence of enactment opportunities (Obodaru, 2013).

I expand on these studies by showing a stronger agential role of identity work that can go beyond an internal self-crafting to potentially affect others, up to promoting organizational growth and change. Since there are no chances to enact new self-concepts in existing healthcare services, and the individual enactment opportunities were not enough satisfying, my professionals engaged in collective processes to set an organizational arrangement where they could play out their professional identities.

Organizational collective crafting

I introduced the concept of organizational collective crafting as a process related to identity work processes and addressing organizational design and change.

Organizational collective crafting differs from all the other crafting processes especially for the output of the process. Literature already studied identity-driven crafting process as processes that have effects at the individual level and at the job level (Berg *et al*., 2010; Leana *et al*., 2009). We know that job crafting has the potential to bring positive outcomes also to the entire organization (Lyons, 2008; Tims & Bakker, 2010). Nonetheless, organizational elements such as tools, organizational roles, procedures or artifacts are not the main targets of so-far studied crafting processes. Organizational collective crafting addresses such elements.

Concerning the process itself, my evidence show that the dynamics leading from unrealized selves to the organizational arrangement originate individually and unfolds

collectively. The process of organizational collective crafting comprises some dynamics that are already recognized in the literature and, at the same time, adds some new elements to them.

Organizational collective crafting heavily builds on the job crafting identity work dynamics. This is confirmed in two ways. First, evidence show that, before engaging in the community hospital creation, individuals attempt micro-crafting adjustments of their jobs (see paragraph 3.2 for examples of micro adjusting trials). Secondly, once engaged in setting of the organizational arrangement, my informants (albeit all family doctors, nurses, social aids, and managers collaborating daily) interpreted and construed different roles at the organizational level that were consistent with different interpretations of the community hospital's organizational identity originating from their different self-comparisons.

This pattern is in line with the role identity theory (Ashforth, 2001). Individuals give meaning to their role by defining what their tasks should be (role boundary), what patterns of interactions they should enact (role set), and what values pertain to their role (role identity). Enacting different roles as family doctors or as nurses in the same organization makes it possible for professionals to play out the different attributes that are consistent with the professional identity that they are recuperating (alternative self or interrupted self) or building (possible self or ideal self).

Other dynamics that are recalled in the organizational collective crafting are the ones recognized salient in other processes of collective crafting. The construct of "collaborative job crafting" is an important addition to job crafting theory since it "incorporates the social embeddedness that both enables and constrains individual behavior" (Leana *et al*., 2009 :1185).

My emerged grounded model shows that the described process of organizational collective crafting differs from the other collective crafting processes so far addressed in the literature (Leana *et al*., 2009; Mattarelli & Tagliaventi, in press) because of some elements.

First of all, the organizational collective crafting is a negotiation process where it is not necessarily true that the collective crafting converge around a common vision (Leana *et al*., 2009; Mattarelli & Tagliaventi, in press). Mattarelli & Tagliaventi (in press) show collective crafting as the refinement of an individual job crafting activity. The authors bring the examples of a R&D head manager that starts an individual job crafting aimed at including in his job the organization of courses and visits outside Tunisia. The collective crafting that follows is a refinement activity connected to the individual crafting of organizing courses and visits:

> *"In Tunisia, for instance, Amed, the R&D head, asked a developer's advice on the idea of training sessions to be held at the beginning of any new project. They ended up agreeing that formal training should not be the only the way to satisfy their need for learning, but that face-to-face interactions with Italian teammates is necessary to make it an ongoing opportunity:*
> *Bijan [agreeing on Amed's proposal]: I think a course offered here by Italian Phard professionals would definitely help. New entries would get precious knowledge and old-timers would revamp their attachment to the organization.*
> *Amed: Another important initiative would be to have us visit Italy more frequently.*
> *Bijan: I believe both of them are necessary right now.*
> *...*
> *Bijan: Well, why don't we write a piece of paper and send it to Luigi?"* (:Mattarelli & Tagliaventi, in press: 22).

Differently, the organizational collective crafting is a negotiation process rather than a refinement process. For example a nurse from HEALTH (who entered in the Community hospital trying to enact a interrupted self of a nurse in a lung specialist ward, saying "*to me specialized wards such as surgery are at the top, they are THE medicine, and that is it*") explains how she wanted her community hospital to chose procedural documents (sheet for inpatient's medical records and therapy sheets) that are already used in other hospitals, despite the fact that not all doctors agreed at the beginning.

[In normal hospitals,] in every ward where I worked we had the so-called nursing papers: for every shift rotation (morning, evening, and night) we had to fill them to track the inpatients' therapies. For the community hospital, we were inspired by those papers. Of course, we somehow had to keep track of our interventions and to deliver that information to our colleagues. So we took some old templates from the pulmonary ward's papers and we import them in the community hospital. In comparison with the pulmonary ward templates, we removed the header and we change some topics so that the nursing papers could fit the community hospital. We did the same with the unique-therapy paper: we decided that in the community hospital we had to have the same papers that other hospitals wards have. Thus we took templates (I don't remember now from which ward... I guess from the medicine), and we brought them here. We essentially managed to convince the family doctors to work as hospital doctors: as for our nursing papers, they have now to report the prescribed therapies on templates. This was kind of difficult. Most of all, it was difficult to obtain the therapy template. [HEALTH, nurse]

In an another similar case, the head nurse of CARE (who was struggling to enact her interrupted self as a headnurse in a specialized hospital) explains how tough she had "to fight" with the family doctors to insert at the organizational level an administrative procedure that forces them to use a common register listing psychotropic drugs.

Usually the family doctors prescribe medicines and drugs for a patient directly at his home, using their personal prescription pad. Thus, the patient can buy the drug he needs in external pharmacies. I have been one of those fighting with the director of the local healthcare unit: […] I wanted to have the same procedures that I had in the hospital: the register and the drugs' papers! Because in the nursing home or in the protected house, these registers are not mandatory by law: they just buy medicines for each patient, they label them with the patient's name and they don't mind to register them properly. Do you get it? It's not mandatory to have a drug register for those structures. But to me, this was worrisome, 'cause I thought: "I have a ward with internal patients, we are part of the local healthcare unit, why shouldn't we have a procedure that secures us that we are doing things in a proper way?!" I know it's boring to manage a drug register: you have to check it, to register new drugs and their consumption, etc etc., but in this way, if an inspector comes he knows that – let's say - the morphine box is of the hospital's! Otherwise I should demonstrate for each patient's box, that the patient needs the morphine and that we used a proper amount of it. […] And then it's alarming to think that other nurses could mix up the morphine boxes! I mean, this is just a little thing, but it was not easy to let the family doctors understand this, to let them accept this with the right mood and to ask them to have a community hospital's prescription pad where all the doctors take note for drugs' prescriptions. You know, they use to have a personal prescription pad when they

prescribe drugs... So, all this, was just to say: this is an example of an administrative procedure which has been introduced. [CARE, head nurse]

The previous quotes are examples of the negotiation characteristic of organizational collective crafting, differentiating it from a process that simply refines the proposed individual crafting.

Secondly, so far literature addresses the collective crafting as a process where every enacted crafting activity is going to contribute in a further direction to others' ideas. For example Leana *et al*. (2009) narrated a crafting process by a group of teachers, where everyone contributed to enact the common vision of high-level education. Mattarelli & Tagliaventi state that their offshore professionals "agree that new ideas, collectively refined, may help play out that common identity further. Consequently, backing colleagues is a 'win–win situation'" (:24). On the contrary, organizational collective crafting can become a matter of mediation, negotiation and conflict between different actors.

Third, so far contributions dealing with collective crafting always approached it as a process strictly related to a profession. "Communities of practices" literature already analyzed crafting as a collaborative activity carried out by informal groups of employees that jointly determine changes sharing objectives, with effects at both at the organizational level (e.g. Orlikowski, 1996) or at the professional field level (e.g. nurse profession from Reay *et al*., 2006). Leana *et al*. did not use a community of practice perspective, but they also address the collective crafting from the point of view of a group of teachers inquiring their professional development as high quality early education teachers. Similarly, Mattarelli & Tagliaventi (in press) consider collaborative job crafting as "rooted in a common professional identity" (:24). Differently, my grounded model shows that collective organizational crafting is not rooted in a professional identity collective crafting. Rather, evidence support the idea that the collective process is a matter of negotiations among different actors that try to find their own identity work realization and negotiate its enactment at the organizational level with other actors.

Actors then negotiate their role, organizational structures, procedures and artifacts as a collective process of identity work, in a way that is not necessarily connected to a common shaping of a professional identity.

Agency in crafting processes

The agential component plays a central role in the grounded model so far described. In fact, the perspective adopted describes the creation of a new organization embedding agency at different levels of analysis.

Moreover the agency driver is naturally connected with a perspective of dynamic nature of identity – the so called processual view of identity. Pratt (2012) delves into those dynamics distinguishing three bases of those identity processes: the relational base (e.g., social identity approaches, which include ingroup–outgroup categories), behavioral base (e.g., role-based approaches), and symbolic base (e.g., narrative approaches). All those bases, both at the individual and collective level can represent also fields of agency enactment.

My grounded model presents agency at the individual level through an agentic crafting process. The idea that identity can be constructed at the individual level is usually addressed by researchers looking at identity work processes, moving from aspirations or identity threats (e.g. Petriglieri, 2011). Literature offers different hints explicating the processes of individual's agentic pursuing of identity grow. Between them there are the experimenting with possible selves, the choice of network relationships, and the ability to manage multiple identities and to build a complex identity (Caza & Wilson, 2009; Pratt & Kraaz, 2009), coherently with the perspective of my contribution considering indentity as a network of selves.

In this study, individual-level agency is embedded in the unrealized selves enactment as trigger of the whole process.

Buildig on Wrzesniewski *et al*.' (2013) archetypal types of crafters, my model can also be interpreted as recalling two types of crafting processes that are strongly agency driven: the alignment and the aspirational crafting. From Wrzesniewski *et al*.' (2013) definitions, the alignment and aspirational crafters intentionally look for a certain positive work identity that employees' current jobs do not enable. The *alignment crafter* is a crafter with a preconceived vision of the future state that she wants to join: she engages in job crafting to fix a misalignment between her current job (and thus its work meaning / identity) and what she wants her work-meaning or identity to be. The alignment crafter creates new opportunities within the job to pursue the misalignment fix. An example presented in the previous chapters can be the CARE head nurse who, in the first years of CARE, strove to craft her own position as a coordinator of hospital beds, after her interrupted self as a hospital head nurse. An alignemence crafter is also the nurse from ARCMED that decides to enter the community hospital crafting process because of a work-family balance need. Differently the *aspirational crafter* crafts herself into a desired future state that she does not currently experience, without a preconceived image. This crafter operates by recognizing opportunities to job craft in order to develop new work meanings and aspects of identity. Most of the presented evidence fits this archetypal type. An example is represented by the doctors who strive for a group relationship because of a professional development towards a less burocratic or more specialized work; or the nurses who want to imbue their identity with more autonomy or with more soft-psychological skills. For its own nature, alignment crafting may take longer to unfold than aspirational crafting, but alignment crafters may stand to benefit more in the long run because creating new opportunities may enable greater change over time than just exploiting existing opportunities.

The mechanisms supporting the agentic processes of identity construction mainly deals with the doing of an identity. Pratt (2012) calls for the "importance of doing, acting, and inter acting" (:6). He states

> *"At the micro level, residents develop professional identity by working, assessing work-identity integrity violations, customizing identities, and having those identities validated or not (Pratt et al., 2006). Thus, constructing identity comes as individuals both act (e.g., working) and react (e.g., customizing) with others in their social environments."*(:6)

In fact, evidence shows a relationships among the unrealized selves and the roles, procedures and other organizational elements chosen and enacted by the informants at the organizational level. The doing of the wanted identity includes the necessary negotiations. Beside the doing, the role identities have to be verified by coworkers. This latter point is particularly salient if we consider that identities are socially constructed, but they also need to be affirmed or verified by others (Milton & Westphal, 2005; Ashforth, 2009; Milton, 2009). To this regard, I argue that in the model the importance of regular meetings is twofold. On one hand, they are a coordination mechanism that informs community hospital members about patients' statuses and sustain shared and standardized procedures. On the other hand, meetings are the mechanism through which professionals acknowledge reciprocal expertise, and pave the way for the coexistence of different identities.

Moreover the interaction among actors enables the accidental crafting as reinforcement mechanism of my grounded model (paragraph 6.3). The accidental crafting (Wrzesniewski *et al.*; 2013) occurs when employees unintentionally discover a positive identity through job crafting. Accidental crafters unintentionally discover opportunities for cultivating one or more positive meanings or identities within the job, as elements that they did not consider before engaging in jolt. This kind of crafting is an opportunity-driven process, and it is quite

different if compared to the other forms of agency-driven crafting. The accidental crafting is included in my model only as a reinforcement mechanism.

At the organizational level, agency is embedded in the organizational identity variance (different perceptions of organizational identity, as a divergent cognitive mechanism – chapter 5). My model shows how individuals perceived the organizational identity in different ways, coherently with the unrealized selves they wanted to carry on, and how the status of organizational identity variance did not end in internal conflicts. Other scholars already defined agency as a matter of interpretation. For example Zilber (2002) states that "actors are carriers of institutional meanings, their interpretations can be considered as expressions of agency, and the of institutionalization involves not only actions, but meanings as well." (:237).

Organizational identity variance

At the organizational level this study presents the concept of non homogeneous organizational identity (see chapter 5). Non homogenous perceptions of organizational identity among internal members immediately call classical construct of hybrid (Golden Bidden & Rao 97; Pratt & Rafaeli 97; Glynn 2000), multiple (Pratt & Foreman, 2000; Fiol, 2001; Glynn *et al.,* 2000; Scott, Corman & Cheney, 1998; Hsu & Elsbach, 2012) and ambiguous organizational identities (Corley & Gioia, 2004). The grounded model includes a similar concept (defined as organizational identity variance) and inquires related dynamics, thus contributing to the literature in four different ways.

First, the model adds complexity to the relationship between the organizational and the individual level. In fact, the model connects the organizational identity to the individuals'

unrealized selves, adding complexity to the usual connection of the organizational identity with actual selves. In fact, the contributions that tried to understand how organizational identity variance emerged taking a micro-perspective, called for a fit between the actual professional identity and the perceived / wanted organizational identity. For example, Pratt & Rapheli (1998) and Hampris & Brown (2002) show the self-enhancement through a perspective of fit between actual professional identity and organizational identity perceptions. Pratt & Raphaeli (1998) show how different nurses vehiculated their actual professional identity with different symbolic dressing choices and how that choices reflected the organizational identity variance. Differently, Glynn (2000) inquired the individual self-enhancement with a perspective of resources and capabilities: in her study about an orchestra with a multiple organizational identity, individuals were looking for a fit between their controlled resources and capabilities and the wanted organizational identity, in order to achieve self-enhancement. Pushing even further this connection between actual identity and organizational identity, Hsu & Elsbach (2012) consider both a resources and capabilities view (chronic accessibility of experience-based organizational identity categorization) and a self-projection view (self-esteem of positively valenced organizational identity categorization).

Between the micro-explanation debate of variance in organizational identities, I contribute to enlarge the search of fit between individual identity and organizational identity, by considering as significant drivers of fit not only the actual characteristics (e.g. actual selves, identities, and/or capabilities), but also the unrealized selves and future states that individuals desire.

Secondly, the model describes variance not between subgroups (as so far represented in the literature) but among individuals, independently from their professional families or from the organizational units to which they belong. Previous studies addressing multiple or hybrid

organizations often considered divergences of perceptions as related to professional families. For example Glynn (2000) studies conflicts in an orchestra driven by divergences among musicians and managers; or Hsu & Elsbach (2012) studied variation in University identity confronting employees and students. Differently, my field evidence shows different organizational identity views among actors and those perceptions cannot be grouped by professional families nor organizational units.

Third, my grounded model shows that organizational identity variance can exist without creating disrupting conflicts at the organizational level, although literature identifies it as a source of issues and costs. So far benefits of a multiple organizational identity have been recognized as a characteristic that facilitate the relationships with external stakeholders, so that organizational members can – time after time - leverage on the organizational identity that best fits the stakeholder to which they relate (Pratt & Corley, 2012; Pratt & Foreman, 2000; Gioia *et al*., 2010). On the other hand, Pratt & Foreman (2000) – in their seminal article - explain that "organizations with multiple identities may be more likely to engage in intra-organizational conflict and /or to expend valuable resources in negotiating among entities holding different identities. […] Furthermore, multiple identities can cause ambivalence and thus have significant effects on the strategic management of the organization. For instance competing mental maps of who we are and where we are going can impede strategic decision making and / or subsequent strategic implementation." (:23).

Thus, most of the time literature addressing organizational identity variance focused on the tactics to manage the convergence of organizational identity perceptions, and explained whether and how to overcome that divergences from the managerial point of view (Pratt e Foreman, 2000; Brown & Starkey, 2000; Corley & Gioia, 2004).

However, my case studies did not present evident issues of coordination nor internal conflicts.

Moving from the grounded model, I claim that, in order for different possible and alternative selves to be enacted within a same social setting, different interpretations of organizational identity features have to coexist; different interpretations underpinning the same labels can become an ongoing state when individuals strive to fulfill heterogeneous self-concepts, enacting their agency through different interpretations.

Beside the benefits of variance as a flexible leverage towards external stakeholders (already recognized in literature), I thus propose this internal dynamic as another benefit of organizational identity variance, since it enables both positive identity at the individual level and innovation at the organizational level.

At last, my work also taps into the mechanisms that allow for the coexistence of different interpretations of organizational identity attributes without sparking a high degree of inner conflict. The main mechanisms are the divergent forces of role differentiation and cognitive distancing, and the convergent forces of common attributes and procedures gathered through the opportunities for norming. Role differentiation supports individuals' search for a thorough enactment of their self-concepts, whereas regular meetings prompt individuals to continuously discuss and shape common norms to regulate organizational behaviors. The balancing between those divergent and convergent tactics can be seen as the continuous negotiation among organizational actors necessary to give voice to heterogeneous self-concepts within a single organizational arrangement.

Positive identity debate

Eventually, my study adds to the current conversation on the importance to apply a positive lens to the construction of identities by linking the process of enactment of possible and

alternative selves to the experience of positive identities in the workplace (Roberts & Dutton, 2009; Dutton *et al.*, 2010). I argue that the process of identity construction that I account for is first and foremost a search for constructing more positive identities.

My evidence unravels how community hospital members' identity content became more positive according to the four types of positive identity (virtue - the attributes used to define the self include virtue and strength features; development - the perception that identity is capable of progress and adaptation overtime; evaluation - the identity is considered favorably by others and herself; structure - the different facets of identity are harmonious and related to each other in complementary ways). I disclose how professionals defined themselves as more caring, helpful, and resilient as a consequence of being engaged in the community hospital, since it benefited the local community and patients in many ways. As my professionals engaged more and more in community hospitals, changes in the content of identity were coupled with changes in its evaluation, since they perceived different stakeholders' gratefulness and appreciation. The structural perspective can help me explain why professionals stressed different interpretations of the same community hospital's features: those latter were the salient features that they saw as characterizing their longed-for professional identity. The projection of values and attributes of the professional role onto the organizational identity favored a feeling of harmony and complementarities.

Finally, I show that my professionals' motivation to enact a different identity was entailed by a desire to place themselves into a trajectory of positive development that connected the past (enacting alternative selves traded-off in the past), the present (be a family doctor), and the future (striving for a possible self).

To my knowledge, this is the first study that shows how individuals' search for positive identity influences not only their work and personal wellbeing, but also the construction of organizational arrangements.

7.2. *Managerial implications and Limitations*

Understanding the organizational creation as a process of change that naturally arises from identity movements could have both managerial and policy implications. The process of unrealized selves enactment and its consequences on the above-levels qualify identity mechanisms not only as generative instruments at the motivational and cognitive level, but also as great instruments of innovation which turn the natural positive work into an organizational and institutional creative power.

Such a knowledge could push managers and policy makers to exploit those natural identity processes, through the variation of control (or centralization) upon individuals. Regarding management processes, for example, the positive identity framework has suggested the existence of different kinds of organizational orientations towards positive identities. *Impeding* organizations inhibit individuals' identity growth, while *directing* organizations usurp or co-opt individual efforts at identity growth, mandating specific types and processes of growth through an high control. On the contrary, *enabling* organizations take a non-threatening position, deferring identity growth to individual control. *Partnering* organizations let that managerial practices and individual's agency co-construct individual identity growth (Kreiner & Sheep, 2009). Discovering the processes that link individual positive identity growth with their effects at the organizational level offers to the managers the opportunity of influencing (or not) those processes and to exploit their consequences.

Another practical implication regards the role of the loose institutional condition as a context enabling innovations. The case study of Italian community hospital, in fact, grew under the condition of loose regulation. The loosely institutionalized new organizational forms at the field level were initially admitted but never regulated in their deep forms: this condition let different organizations to grow with respect of different territorial needs and of

different professionals' needs. As Powell & Colyvas (2008) suggest, a view on micro-dynamics and on its effects will bring to a deeper knowledge of the nature of the success of a form, rather than focusing only on its diffusion. Understanding how change can happen from the bottom and how institutional contradiction or multiple logics are an opportunity for individual's identity growth and affirmation offers to policy makers the opportunity of exploiting the natural bottom-up processes of innovations that better fit the context where they are settled. Policy makers could thus dedicate deeper attention towards natural-arising forms, and could analyze those forms as hints of local needs and characteristics, deciding whereas to facilitate or not their rising.

Future research should be considered in the light of this study's limitations. First, results derive from an inductive multi-case study. Consequently, although the model that I built has theoretical significance (Yin, 2003), it does not claim any statistical generalization. More research is required to understand whether the relations that I observed need further refinement or hold in other settings.

My study presents also limits on the data collection. The emerged grounded model let me induct the described process of organizational collective crafting as triggered by individuals' unrealized selves. Although the archival documents helped me triangulate the interview data so that I could rebuild the story of my case studies, a similar study with a longitudinal data collection could generate a lot of valuable insights. A longitudinal study mainly disclosing the initial dynamics of organizational creation (Gioia *et al*., 2013) could deliver hints on the organizational construction process, especially enriching the picture of collective crafting with micro dynamics such as the tracking of micro-changes of organizational identity perceptions and of negotiated roles.

Even though data collection and analysis ended when theoretical saturation was achieved (Strauss and Corbin 1998), the collection of a higher number of observations would have offered an even richer picture of potential conflicts and work-arounds that individuals enact in order to address the state of organizational identity variance.

Moreover, future research needs to take more into account the role played by the institutional context and logics. Roberts *et al.* (2009) link positive identity construction to the issue of contradictions by inviting researchers to elucidate the apparent paradox according to which the tension between enabling and disenabling elements can strengthen positive identity search even more than what enabling elements alone could do. A deeper analysis about what institutional contradictions professionals perceive when trying to construe organizational arrangements, which institutions legitimate community hospitals and which do not, and how professionals react against difficulties, would definitely enrich the understanding of the process and allow me to build a more comprehensive multi-level model.

Finally, I believe that the process that I have accounted for can yield interesting hints on the dynamics that undergird the birth and growth of other new organizational arrangements like start-ups and academic spin-offs. New firms can in fact be created by academics who have nourished the vision of self as entrepreneurs or by employees who have reluctantly given up on the possibility to establish their own company some time in the past. Since organizations are often the products of the joint effort of individuals pursuing different self-concepts, I hold that the process that I have outlined can help managers handle organizational identity construction or change in contexts characterized by multiple individual expectations, as well as inspire additional research aimed at bringing together individual aspirations and organizational outcomes.

8. Appendix

8.1. Appendix 1. Tables summarizing data sources

Table. Types of analyzed documents[13]

Level	Sources of Data
Organizational level	Internal documents, templates, presentations, reports and rules. Other external documents related to the community hospital, such as local newspapers, local tv news, local meetings and territorial reports.
Regional level	Regulatory Regional laws from the 20 different regions, with particular focus on the 5 regions related to the different case studies. Local regional healthcare reports.
National institutional level	Statements of policy changes by Medical professional association Statements of policy changes by professional Unions Summary of government reports Reports of national healthcare biannual plans.

Table. Details of the interviews conducted (2 prelimiary interviews excluded)

	CARE (1996)	ARCMED (1999)	MEDITEAM (2000)	WEALTH (2003)	HEALTH (2009)
Number of intervieewes	11	10	5	9	5
Roles	1 general manager, 5 doctors, 1 head nurse, 2 nurses, 2 OSS	3 doctors, 1 head nurse, 1 night doctor, 3 nurses, 1 physioterapist, 1 home nurse	1 coordinator, 1 heard nurse, 1 nurse, 2 doctors	2 head nurse, 1 external doctor, 1 social assistant, 2 nurses, 2 OSS, 1 general manager & director	1 coordinator, 1 head nurse, 1 nurse, 2 doctors of the core group

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[13] See chapter 4 and 5 for a detailed list of analyzed documents

Table. Documents collected at the organizational level

	Types of documents internal to the organization	Local institutions	other forms of local data
CARE (1996)	Internal book & internal procedures (20 pages);		2 videos from local tv news (20 mins); local newspapers ARTICLES
ARCMED (1999) 90 pages	Guidelines (1999 and updated). Official model definition and description of the community hospital. Doctors agreements with CH and organizational nurses structure. Web description about history of the organization (1999, then updated); Internal Official templates, flow charts and procedural papers (organizational model – roles, activity plan and tools, admissions proceduresm discharging procedures, inpatients recovery rules …). Analysis activity-related data for every year from 2001-08. (inpatients descriptive statistics; pathologies addressed; diagnosis confirmed; health services delivered; demission descriptive statitistics; data regarding multiple recoveries in CH). Resources utilization group data (ratios regarding professional resources and internal activities) from years 2003-2007. Cost analysis for years 2004-07. Key performance index design analysis (2009). Coauthored book describing CH story and choices of 10 years of activities (2009)	Report from the local healthcare commission visiting the CH (2008); official debate proceedings of in the regional political council discussing the appropriate label for the structure (2011); official answer from regional council (2012)	
MEDITEAM (2000) 130 pages	*(2000) News release to kick off the Community hospital experiment;* (2000) project description regarding Community hospital (work methodologies; clinical characteristics regarding assistance - e.g. pathologies admitted; population admitted; roles and responsibilities; medical interactions; doctors and nurses interaction; documents; costs affiliations; communicational strategies) *(2002) proceedings comparing this experience with others in Italy; *(2011) internal data analysis presentation; *(2011-12) 2 articles describing the community hospital on a medical review;	1 municipal declaration; *(2002) local healthcare commission template census activity; *(2000) internal local healthcare commission deliberation regarding community hospital kick off.	Local newspapers articles * IL MESSAGGERO VENETO (2012); *IL SOLE 24 ORE SANITÀ 30 ottobre - 5 novembre 2001; *MESSAGGERO VENETO Sabato 10 novembre 2001; *IL GAZZETTINO Martedì 13 novembre 2001 *IL GAZZETTINO Sabato 17 novembre 2001 *MESSAGGERO VENETO Sabato 17 novembre 2001 *IL SOLE 24 ORE SANITÀ 27 novembre - 3 dicembre 2001

WEALTH (2003) 120 pages	LOOK FOR ONLINE DESCRIPTIONS . * Internal documents describing clinical inpatients template documents; internal documents describing prescription and diagnosis; internal documents desribing pharmaceutical and other services purchasings. (questi solo mostrati a voce, non li ho)	* (2003) internal regional council debates on the organizational definition; *Regional healthcare commission report about territorial healthcare supporting systems (published year:2011 - data regarding years: 2008- 9- 10) . * Definition of Community hospital from Regional institutions (1 delibera from 2004; 2 papers and 2 tables - 11 jan. 2013 & 24 dec 2012)	
HEALTH (2009) 25 pages	*Internal guidelines (2009 and updated); *Internal templates for admission procedures (2010) ; Internal templates for recovery info (2010); *Internal presentations with analyzed key performance indexes and other data (2010 -2011)		

Table. Institutional context, National level analysis – Sources of Data

National level - Sources of Data   **(documents related to the *Italian Community Hospital* template)**
*National healthcare plans (PSN Piano Sanitario Nazionale, from 1998 to 2014) (2003-05; 2006-09 are the significant plans)   *Official guidelines for experimental organizational solutions (e.g. 2009) from: Healthcare and Social politics Ministry; from Agendas National Agency for Regional healthcare services.   *Summary of government reports; Studies of the local healthcare institutions (ULSS Unità Locale Socio Sanitaria);   *Statements of policy changes by Medical professional association (e.g. from Fimmg Federazione Italiana Medici Medicina Generale, and other professional associations) and their publications on payment, systems, medical care models, and health care reforms. This statements are taken from official documents, professional newsletters, public declarations on national and local newspapers and on videos.   * Statements of policy changes by professional Unions (e.g. SNAMI Sindacato Nazionale Autonomo Medici Italiani, SIMET Sindacato Italiano Medici del Territorio, SMI Sindacato Medici Italiani) and Collective National deals regarding Unions and Ministries.   *specialized organizational healthcare contributions: conferences' proceedings and published researches[14]   *significant articles on national press (e.g. Sole 24 ore)

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[14] In particular: "L'ospedale di comunità in Italia - Studio della normativa nazionale e regionale" from Bellentani 2009; "Evoluzione della organizzazione sanitaria territoriale" from Caruso 2008

Table. Regional data regarding community hospital regulation (data sources and content).

Region[15]	Have or had community hospitals?[16]	Regulated? When and where for the first time? (*defined* if characteristics described; *mentioned* if not described)	year
Umbria	yes #	yes. 1997 (ospedale di comunità è previsto dalla L.R. 3.2.1997, n. 34: "Riorganizzazione della rete ospedaliera regionale" + PSR dal 1999). 1999 (deliberazione del Consiglio regionale 1.3.1999, n. 647 stabilisce che l'ospedale di territorio rappresenta l'evoluzione del concetto di ospedale di comunità.). Defined.	1997
Toscana	yes ###	yes. PSR 1999-01 kick off of first experiences of country hospitals mentioned, defined as ospedali di comunita' in PSR 2002-04	1999
Friuli Venezia Giulia	yes #	yes. Piano di intervento a medio termine (PIMT) 2000-2002 ospedale di comunita' mentioned and explained.	2000
Puglia	yes ##	yes. PSR 2002-2004. Ospedale di comunita' o Unità di degenza territoriale defined.	2002
Valle d'Aosta	yes #	yes. 2002 -2004 (PSSR - Country hospital mentioned).	2002
Liguria	yes #	yes. PSSR 2003-2005 ospedale di comunita' mentioned as possible solution; D.C.R. 8 agosto 2006, n. 29: struttura ospedaliera di continuità assistenziale mentioned. No CH mentioned in the later documents (CH never defined)	2003
Marche	yes #	yes. PSR 2003-2005 (ospedali di comuinta') defined.	2003
Calabria	yes ##	yes. PSR 2004-06, ospedale di comunita' o ospedale di distetto defined (specific chapter)	2004
Veneto	yes ###	yes. DGR n. 2481 del 6 agosto 2004 "strutture sanitarie intermedie" o "ospedali di comunita'". Lancio sperimentazione. L.R. 9-3-2007 n. 5: definizione.	2004
Piemonte	yes #	yes. D.G.R. 7 marzo 2005, n. 75-15004. Ospedale di Comunità mentioned. DGR n. n. 28-2690 del 24-4-2006 definizione Ospedale di Comunita'.	2005
Campania	yes ##	yes. 2006 Ospedale di comunita' just mentioned, not defined.	2006
Lazio	yes ##	yes. DGR n. 424/06 (ospedali di comunita') defined.	2006
Sardegna	yes. #	yes. 2007. Piano regionale dei servizi sanitari 2006-2008 mention money for 2 ospedali di comunita' to be experimented. Ospedale di comunita' defined.	2007
Lombardia	yes #	yes. PSR 2007-2009 mentions Ospedale di comunita' as innovative regional projects. Defined.	2007
Abruzzo	yes # (2013)	yes. Piano Sanitario Regionale 2008-2010	2008
Molise	No	yes. PSR 2008-10 (approved 2009) Contry hospital just mentioned, not defined.	2009
Basilicata	No	L'art. 20 della L.R. 4 agosto 2011 n. 17. parla di Ospedali Distrettuali	2011
Emilia-Romagna	yes #	No	-

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[15] Sicilia and Trentino Alto Adige are missing.

[16] The number of # represent how spread Community hospitals are in the Region. # from 1 to 2; ## from 3 to 4; ### more than 5.

Appendix 2. Interviews protocol.

Below I attach the protocol to which I referred during the interviews. Coherently with a perspective of theoretical sampling (Glazer & Strauss, 1967), the protocol evolved during the data collection and analysis.

<div align="center">***</div>

Carriera e identità sul lavoro

1. Mi può raccontare a grandi linee la Sua carriera professionale? Quali studi ha effettuato e che esperienze lavorative ha avuto?

2. Mi può parlare del Suo lavoro? In particolare come definisce la Sua professionalità?[17]

4. Mi può brevemente raccontare una Sua settimana tipo?

Alternative selves

5. Ripensando a degli episodi particolarmente salienti, dei momenti di svolta nella sua vita… mi può raccontare di questi punti cruciali che a Suo avviso hanno poi incanalato e definito la Sua carriera professionale?[18]

6. Ha mai pensato a come la Sua carriera si sarebbe potuta sviluppare diversamente proprio a partire da quei punti di svolta?[19]

L'esperienza OC

7. Relativamente al Suo coinvolgimento con il mondo "ospedali di comunità", come è attualmente coinvolto in questa esperienza? *(aiuti: quale è il Suo ruolo e quali sono i Suoi compiti all'interno di questa struttura?)*

8. Questa esperienza come si combina con le altre Sue attività lavorative e non? Dovendo gestire tutte queste attività, se ci sono dei conflitti o degli imprevisti dovuti a scarsità di tempo, come li gestisce di solito? *(aiuto: c'è una attività prioritaria?)*

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[17] Da Ibarra, 1999

[19] Questa domanda e la precendete è ispirata ad Obodaru (2012): domanda creata da me, interpretata dalla riflessione metodologica del suo articolo

Pre- coinvolgimento[20]

9. Proviamo a ritornare ora al momento del Suo primo coinvolgimento in questo "mondo":

- Lei aveva avuto modo di farsi un'idea di questo modello anche prima di esservi coinvolto (o comunque prima di iniziare a lavorarvi concretamente)? E Come?

- Cosa La ha portata ad intraprendere questa esperienza legata agli ospedali di comunità?

- Quale tipo di aspettative aveva allora verso questo modello? (aiuto: in termini di valori, cosa potrò fare, che tipo di relazioni potrò avere, a quale network posso accedere, che attività potrò seguire, quale idea di sé e del suo ruolo professionale avrebbe potuto realizzare..)

- Tutti questi valori, attività, relazioni, idee di sé, … Come sono cambiati nel momento di transizione dal lavoro al di fuori di questa esperienza all'ingresso in questo mondo?

L'aspetto agentico e motivazione dell'azione[21]

10. Ora le chiederei di pensare all'organizzazione dell'ospedale in cui lavora come ad una storia da raccontare. Magari una storia che si svolge in capitoli. Mi può descrivere come è avvenuta l'organizzazione dell'ospedale?

- Per ogni capitolo riuscirebbe a ricordare uno o due episodi in cui lei è stato personalmente coinvolto? In particolare sarebbero interessanti degli episodi in cui lei crede di aver dato (o di aver scelto di non dare) il Suo particolare contributo.

- Perché ha cercato di proporre questo tipo di cambiamento / contribuire in questa direzione? (cosa la ha portata ad effettuarlo?)[22]

- Ricorda dei momenti in cui qualcuno o qualcosa ha cercato di ostacolarLa in particolar modo? Invece episodi in cui è stato particolarmente incoraggiato o facilitato?

- Come sono i rapporti che avete nel panorama istituzionale (es. Regione, AUSL)

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[20] Da protocollo Kreiner et al, 2003

[21] Struttura per storie ispirata da Creed et al (2010). – situational level

[22] Berg, Wrzesniewski & Dutton, 2010

- Le è capitato di relazionarsi, conoscere (di persona o per sentito dire) o scambiare opinioni con altri colleghi, professionisti o gruppi che gravitano attorno a questo modello? Di quali gruppi o colleghi si tratta?
  - Cosa ha trattenuto e cosa ha lasciato di questi gruppi ? *(aiuto: In termini di trasmissione di buone pratiche e competenze, di valori associati alle scelte, di visione, …)*
  - Crede che la vostra esperienza abbia influenzato altre esperienze? Se sì, come? *(aiuto: In termini di trasmissione di buone pratiche e competenze, di valori associati alle scelte, di visione, …)*

11. Cosa farebbe se, per un motivo o per l'altro, le venisse data la possibilità di modificare questo tipo di organizzazione? O meglio, come sarebbe diversa l'organizzazione che vorrebbe rispetto a quella attuale?[23]

12. A livello professionale, crede che le aspettative di realizzazione personale di cui parlavamo prima siano state appagate – incarnate da questa nuova esperienza organizzativa? Oppure sono forse state modificate in itinere, abbandonate…
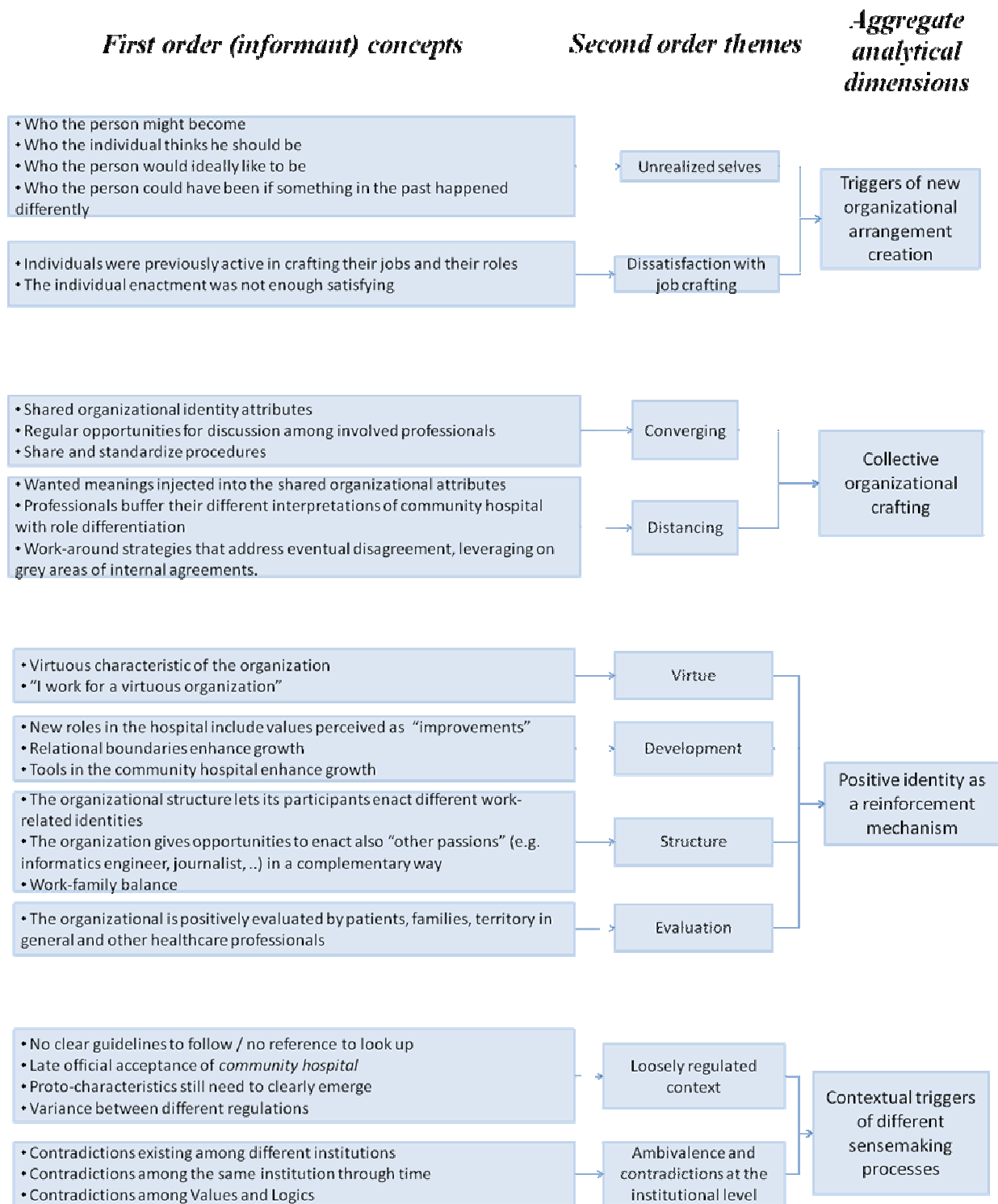
Domanda di chiusura: la riforma attuale

13. Posso chiederle cosa ne pensa della riforma in sanità di cui si sta tanto parlando ultimamente (centri h24 per l'accoglienza dei pazienti etc etc). Come la vede collegata rispetto a quello di cui abbiamo parlato ultimamente (se lo è)?
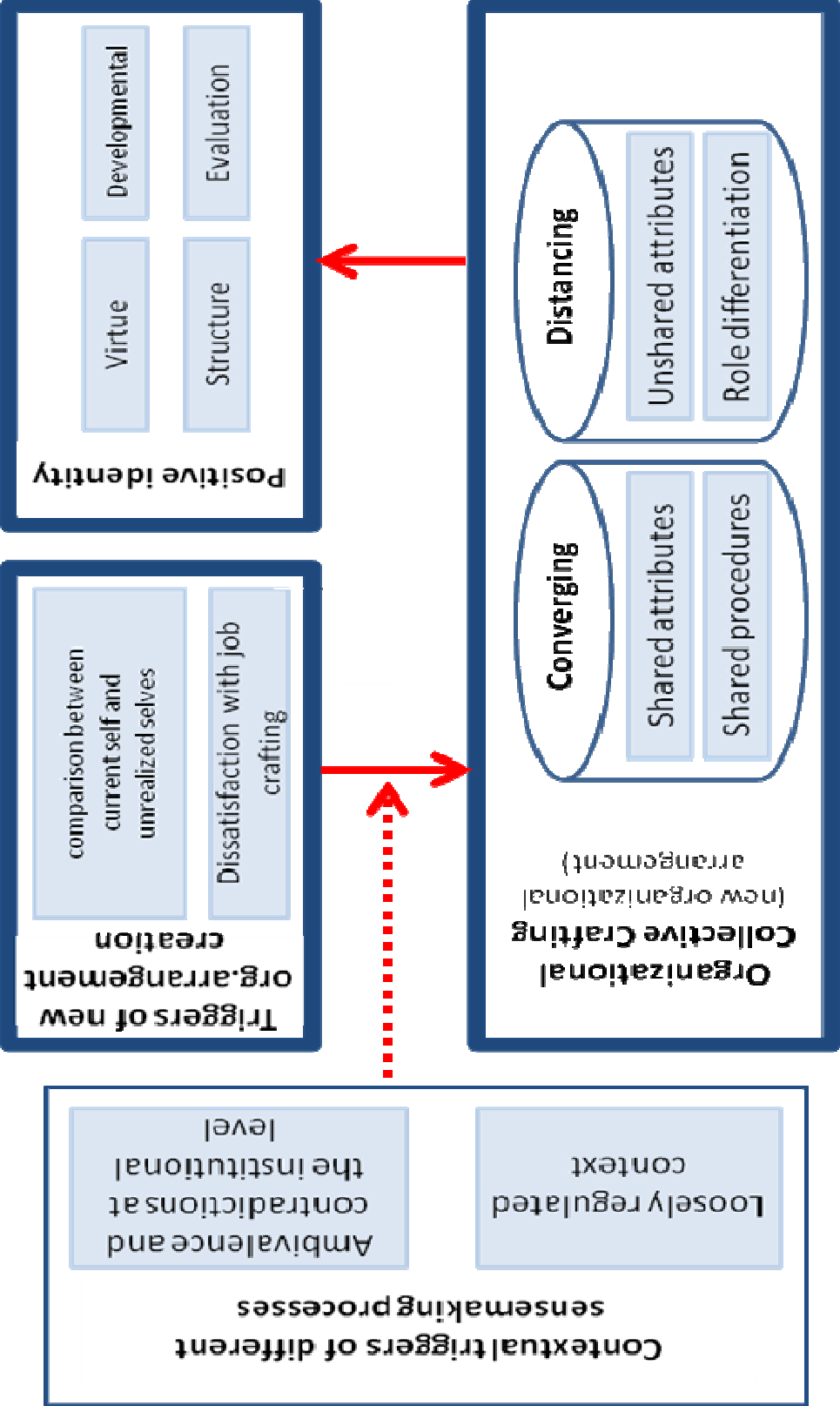
14. C'è qualcosa che vorrebbe aggiungere o che vuole precisare?

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[23] Berg, Wrzesniewski & Dutton, 2010

Appendix 3. Data structure and grounded model.

First order (informant) concepts   Second order themes   Aggregate analytical dimensions

- Who the person might become
- Who the individual thinks he should be
- Who the person would ideally like to be
- Who the person could have been if something in the past happened differently

→ Unrealized selves

- Individuals were previously active in crafting their jobs and their roles
- The individual enactment was not enough satisfying

→ Dissatisfaction with job crafting

→ Triggers of new organizational arrangement creation

- Shared organizational identity attributes
- Regular opportunities for discussion among involved professionals
- Share and standardize procedures

→ Converging

- Wanted meanings injected into the shared organizational attributes
- Professionals buffer their different interpretations of community hospital with role differentiation
- Work-around strategies that address eventual disagreement, leveraging on grey areas of internal agreements.

→ Distancing

→ Collective organizational crafting

- Virtuous characteristic of the organization
- "I work for a virtuous organization"

→ Virtue

- New roles in the hospital include values perceived as "improvements"
- Relational boundaries enhance growth
- Tools in the community hospital enhance growth

→ Development

- The organizational structure lets its participants enact different work-related identities
- The organization gives opportunities to enact also "other passions" (e.g. informatics engineer, journalist, ..) in a complementary way
- Work-family balance

→ Structure

- The organizational is positively evaluated by patients, families, territory in general and other healthcare professionals

→ Evaluation

→ Positive identity as a reinforcement mechanism

- No clear guidelines to follow / no reference to look up
- Late official acceptance of *community hospital*
- Proto-characteristics still need to clearly emerge
- Variance between different regulations

→ Loosely regulated context

- Contradictions existing among different institutions
- Contradictions among the same institution through time
- Contradictions among Values and Logics

→ Ambivalence and *contradictions* at the institutional level

→ Contextual triggers of different sensemaking processes

The emerged grounded model is reported in the picture below

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