Multiple Identity Interactions: Implications for Work Outcomes

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This thesis is presented for the degree of Doctor of Philosophy of The University of Western Australia

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The research involving human data reported in this thesis was assessed and approved by The University of Western Australia Human Research Ethics Committee. Approval #: [RA/4/1/8006]. Written patient consent has been received and archived for the research involving patient data reported in this thesis.

The following approvals were obtained prior to commencing the relevant work described in this thesis:

- WA Country Health Services (WACHS) Human Research Ethics Committee (HREC) approval (2016/10)
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Signature: (Sonia Raghav)

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ABSTRACT

Preliminary evidence suggests that multiple identities shape important outcomes in organisations, such as individual stress and well-being, intergroup conflict, performance and change. The ability to negotiate one’s multiple social identities has become an important issue for many people given the increasing social complexity of modern society. In addition to understanding the intrapersonal experience of holding a variety of identities, this thesis also seeks to understand how these multiple identities affect interpersonal relations and communication patterns. Integrating the identity literature with the concept of relational coordination, I assess the impact of intrapersonal and interpersonal interactions on relational coordination, which I propose in turn affects the quality of performance, job satisfaction and the emergence of group affect. This research also considers important potential moderators of the relationship between identity patterns and relational coordination such as team training, team meetings, use of boundary spanners, leadership training, communication training and use of social (informal) events. These moderators may serve as important points of leverage for organizations to improve relational coordination and enhance positive implications of multiple sources of identity in teams.

This research examines the multiple identities, relational coordination and team outcomes in the context of patient care teams in healthcare settings by utilizing a mixed-method/multiple source research design to investigate the research topic. The research combines qualitative analysis of experiences of healthcare providers in the initial phase followed by quantitative modelling of the multiple identity relationships. The reason for mixing qualitative and quantitative data for this research was to create value through deep elaboration and triangulation, that is, creating value through holistic understanding and focusing on the similarity or overlap in findings that emerge from both methods to increase confidence in the overall results. Triangulation not only helped to confirm findings from qualitative phase through the quantitative phase but also extended insights in the understanding of the topic. Research on multiple identity interactions is limited and it is believed that methodological plurality would help in interpreting the complexity of the topic to a greater extent.

The data was obtained from multiple sources, namely, doctors, nurses, health care administrators and patients across Western Australian public hospitals. In the first phase, 87 exploratory interviews with healthcare professionals informed model and hypotheses development and design of a survey conducted in a second phase of the research across 37 healthcare teams in four Western Australian hospitals. The study provided evidence of the mediating role of relational coordination in the
negative relationship between intrapersonal identity conflict on work and personal outcomes, as well as the importance of organizational practices in mitigating the negative consequences of intrapersonal identity conflict.

Together, the study contributes not only to the identity and team literature but also provides important recommendations for policy guidelines in healthcare management.
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Chapter 1: Introduction and Literature Review

Overview

The thesis addresses the question, “How does the intrapersonal experience of holding a variety of identities affect interpersonal relations and communication patterns and effectiveness in teams?” Integrating the identity literature with the concept of relational coordination, I assess the impact of intrapersonal identity and interpersonal interactions on relational coordination, which I propose in turn affects the quality of performance, job satisfaction and the emergence of group affect. This research also considers important potential moderators of the relationship between identity patterns and relational coordination such as team training, team meetings, use of boundary spanners, leadership training, communication training and use of social (informal) events. These moderators may serve as important points of leverage for organizations to improve relational coordination and enhance positive implications of multiple sources of identity in teams. The context was patient care teams in healthcare settings, and I utilized a mixed-method/multiple source research design to investigate the research topic. The data was obtained from doctors, nurses, health care administrators and patients across 4 public hospitals. In the first phase, 87 exploratory interviews with healthcare professionals informed model and hypotheses development and design of a survey conducted in a second phase of the research across 37 healthcare teams. The study provided evidence of the mediating role of relational coordination in the negative relationship between intrapersonal identity conflict on work and personal outcomes, as well as the importance of organizational practices in mitigating the negative consequences of intrapersonal identity conflict. Together, the study contributes not only to the identity and team literature but also provides important recommendations for policy guidelines in healthcare management.

Introduction

An ‘identity’ is a self-referential description that provides contextually appropriate answers to the question “who am I” or “who are we?” (Ashforth, Harrison, & Corley, 2008). The concept of ‘identity’ (which refers to content) can be distinguished from ‘identification’ (which refers to the extent to which that identity content is integrated into the individual’s self-concept) (Hodgkinson & Ford, 2012). “Identity” and “Identification” are considered as root constructs in organisational studies in that most entities need to have a sense of who or what they are, who or what other entities are, and how the entities are associated (Ashforth et al., 2008; O’Reilly, Chatman, & Guion, 1986).
Suggesting that a person might hold multiple identities refers to the collection of identities available for individuals to identify with or be categorised according to (e.g. culture, organisation, profession, workgroup) (Bodenhausen, 2010; Kang & Bodenhausen, 2015). The multiple identities conceptualization of self has long been acknowledged by psychologists, sociologists and philosophers (Jones & McEwen, 2000; Tajfel, 1982; Tajfel & Turner, 1987; Thoits, 1983). The fact that people have multiple identities, based on dimensions such as culture, organisation, profession or work group is becoming increasingly salient in organisations as they operate across national or regional boundaries and utilize teams (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Ramarajan, 2014). As a result, the ability to negotiate one’s multiple social identities has become an important issue for many people given the increasing social complexity of modern society (Brook, Garcia, & Fleming, 2008).

As I review below, organisational research that examines the concept of multiple identities is still in its infancy (Alvesson, Ashcraft, & Thomas; 2008; Kang & Bodenhausen, 2015; Ramarajan, 2014). Most research on multiple identities has focused on perceiving and experiencing one type of identity (such as multiple racial identities) or the intersection between two types of identities (such as a racial identity and a gender-based identity) and neglected the broader spectrum of multiple identities and the inter-relationships between them (Kang & Bodenhausen, 2015; Ramarajan 2014; Ramarajan, Berger, & Greenspan, 2017; Ramarajan, Rothbard, & Wilk, 2017). While research on dual identities has played a pivotal role in understanding the diverse effects of identities and relationships between identities, this narrow conceptualization of identities provides only limited understanding of the complexity of multiple identity interactions, shedding little light, for example on how people navigate cultural or professional identities alongside their other identities. It is these more complex interactions that are likely the most problematic for psychological well-being and work place effectiveness, as these multiple groups may represent different priorities, values, and goals in one’s life, that may conflict or compete.

Interestingly, research on the link between multiple identities and outcomes has produced mixed results. For example, research has reported that multiple identities increase positive work outcomes such as psychological engagement and performance (Caza & Wilson, 2009; Cheng, Sanchez-Burks, & Lee, 2008; Tadmor, Tetlock, & Peng, 2009) and intergroup tolerance and cooperation (Brewer & Pierce, 2005; Richter, West, Van Dick, & Dawson 2006). Yet other research has indicated negative outcomes such as devaluation of one’s identity (Pratt, Rockmann, & Kaufmann, 2006) and emergence of negative emotions and social division (Fiol, Pratt, & O’Connor, 2009; Settles, 2004; Shih & Sanchez, 2005). When these intrapersonal identity conflicts combine in the context of a work team, there is the
potential for a host of problems and issues to arise. The lack of empirical research on context, moderators, or mediators of the relationship between multiple identities and work outcomes may be the reason for these mixed results, indicating the need for future research on novel intermediate variables to explore and understand the interaction of various multiple identities (Ellemers, Rink, Thye, & Lawler, 2005; Kang & Bodenhausen, 2015; Ramarajan, 2014). Further, very little research has attempted to understand multiple identities and the social psychological processes involved in team work (Wilcoxon, Luxford, Saunders, Peterson, & Zorbias, 2011).

As I will review below, a key process likely affected by identity conflict is relational coordination (RC), defined as “a mutually reinforcing web of communication and relationships carried out for the purpose of task integration” (Gittell, 2002b, p.300). Research suggests that higher levels of relational coordination produce higher levels of quality and efficiency of performance by enabling participants to manage their task interdependencies (Gittell, 2000; Gittell, 2002; Gittell, 2008). Relational coordination also improves job satisfaction by providing the social support to enable resilience in the face of stress (Gittell, 2008; Gittell, Weinberg, Pfefferle, & Bishop, 2008).

As I explain in detail in the chapters that follow, I examine multiple identities, relational coordination and team outcomes in the context of patient care teams in healthcare settings. Patient care teams are becoming increasingly common in healthcare organisations (Mitchell, Tieman, & Shelby-James, 2008). Team members interact with each other on a daily basis and develop an affiliation at the team level which results in a team identity. Members within the team often have differing professional certifications (physicians, nurses, allied health care staff, and healthcare administrators), which comprises a professional identity. They also have an affiliation to a particular hospital, which constitutes an organizational identity. Finally members of these patient care teams often have different cultural backgrounds. Specifically, an important cultural distinction for many members is whether they were trained overseas or domestically. Each of these affiliations and distinctions represent a potential source of identity (See Figure 1).

This dissertation examines how these multiple identities (cultural, organisational, professional and team identities) interact intrapersonally within each member of patient care teams, and whether a central tendency for a similar level of identity conflict characterizes a given patient care team. The project also examines the impact of such multiple identity interactions on outcomes such as quality of patient care provided by the team, clinician job satisfaction and emergence of group affect. Relational
coordination is a proposed mediator of the relationship between team identity conflict and team work outcomes. Finally in an exploratory way, the research considers important potential moderators of the relationship between identity patterns and relational coordination such as multidisciplinary training, multidisciplinary meetings, use of boundary spanners, leadership training, communication training and organising social events. These moderators may serve as important points of leverage for organizations to improve relational coordination and enhance positive implications of multiple sources of identity in teams. In the sections that follow, I discuss in detail the different identities that this research will investigate, and then address the relationships among them.

Figure 1: Sample Identity Profile for an ICU Overseas Trained Doctor Working as a Member of Multidisciplinary Team (Including Doctors, Nurses, and Allied Healthcare Staff) at one of the Hospitals.

Note. Red line=conflict

Thickness of line denotes strength

Cultural Identity (CI)

Culture is a complex and multi-level, multi-facet construct, representing the sum of total of the learned behaviour of a group of people, and referring to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, symbols and rituals, through individual and group striving (Erez, &
Gate, 2004; Leung, Bhagat, Buchan, Erez, & Gibson, 2005, 2011; Straub, Loch, Evaristo, Karahanna, & Srite, 2002). Most social scientists today view culture as consisting primarily of the symbolic, ideational and intangible aspect of the human societies and how the tangible cultural elements are interpreted, used or perceived by a group of people (Straub et al., 2002). Therefore, culture is a phenomenon at the group, institutional, or societal level and has strong relevance for predicting individuals’ behaviour (Chao & Moon, 2005). Research on cultural differences has shown that self-concept orientations are influenced by the society in which one is raised (Chiu & Hong, 2013; Hofstede, 1980; Kashima, 1995), with particular emphasis on the national societal context (Hofstede, 1980). Individuals possess a cultural identity which can be defined as ‘significant way(s) in which a person defines oneself as connected to culture (customary beliefs, traditions, practices, values and language)’ within the nation in which they have spent much of their life (Berry & Candis, 2013, p.52). However, recent literature has emphasized that ‘cultural identity’ is an individual’s perception of their cultural background and not necessarily derived from one’s supposed biological inheritance or national boundaries (Dogra, 2001; Kirkman, Lowe, & Gibson, 2006, 2017; Taras, Rowney, & Steel, 2009; Taras, Steel, & Kirkman, 2011, 2016).

Education and its primary components-curriculum, teaching and learning, are a major socio-cultural venue from which an individual’s experiences and identities are invented, racialized and remembered (Berry & Candis, 2013; Prideaux & Edmondson, 2001; Wexler & Burke, 2011). Because of the strong relationship between education and culture, one can argue that an important element of cultural identity is the nation where the individual received his/her education. For example, Kleinman, Eisenberg and Good (1978) asserted that health care providers bring with them into the patient care setting their unique training within specific health care systems and there are negative consequences of ignoring these aspects of culture in provision of patient care.

In the health sector, there have been some studies that document the impact of culture on medical practices in different countries. Angel andThoits (1987) presented a theoretical framework for understanding the impact of culture on the processes of symptom recognition, labelling, and help-seeking behaviour in different ethnic groups; the underlying assumption here was that the subjective experience of illness is culture bound. Similarly, studies by Meeuwesen, van den Brink-Muinen and Hofstede (2009) and Napier, Ancarno and Butler (2014) found that ideas about health are cultural and perceptions of physical and psychological wellbeing differ substantially across and within societies. These studies argue that health-care provision should be made more culturally sensitive as poor health-
care outcomes can be attributed to factors that are beyond the control of care providers such as cultural systems of values.

In the current context, there is a recognized distinction between identity arising from medical qualification and clinical training domestically (i.e., within Australia) as compared to such certification from overseas (outside Australia). Overseas trained health care professionals who received their health care training outside of Australia are an important part of the Australian workforce. Yet, as I will show, these multicultural individuals seem to be torn in a struggle between their multiple identities that include not only their cultural identity, but also their organisational, professional and team identities.

Organisational Identity (OI)

Organisational identity is often conceptualized as the congruence of individual and organisational values (Hall, Schneider, & Nygren, 1970; Pratt, 2000), as the perception of oneness with or belongingness to the organisation (Ashforth & Mael, 1989), or as the process of incorporating the perception of oneself as a member of a particular organisation into ones general self-definition (Dutton, Dukerich, & Harquail, 1994). Ashforth et al. (2008) have suggested that an individual will identify with her organisation to the extent that the organisation represents values that she personally values. For example, if the hospital in which I am employed explicitly states “service to the public” as a primary aim, and I personally view my own life goals as including service to the public, then I am likely to strongly identify with my organisation. Documented organisational outcomes of organisational identification include increased cooperation, effort, participation and the organisationally beneficial decision making (Bartel, 2001), intrinsic motivation (Van Knippenberg & Van Schie, 2000), task performance (Van Knippenberg, 2000) and information sharing and coordinated action (Gracie, Gall, Jones, Paulsen, & Callan, 2006), job satisfaction and work adjustment (Carmeli, Gilat, & Wardman, 2007) and organisational citizenship behaviour (Dukerich, Golden, & Shortell, 2002), as well as reduced turnover and turnover intentions (Mael & Ashforth, 1992; Van Dick, Wagner, Stellmacher, & Christ, 2004). Researchers have also identified potential negative implications of identification for organisations such as continued commitment to a failing organisational project (Haslam et al., 2006), over identification and loss of individual identity (Elsbach, 1999; Michel & Jehn, 2003) and resistance to organisational change (Haslam et al., 2006). Rikett’a (2005) meta-analysis implored the necessity of research on moderators in light of the heterogeneity of results regarding the relationship between organisational identity and outcomes. In addition, much of the research on organisational identification examines it in isolation, disregarding the other identities that an employee may hold. Hence, Ramarajan (2014)
recommends expanding the research to multiple identities rather than just one or two identities most often in focus, and then revisiting important antecedents and outcomes of multiple identities.

**Professional Identity (PI)**

Professional identity is an individual's self-definition as a member of a profession and represents a sense of connection to the values and emphasis of the profession, with a profession defined as a discipline base or subgroup with specialized training within a given industry (Adler, Kwon, & Hecksche, 2008; Bell & Nkomo, 2003; Giuliani, Tagliabue, Regalia, Glaveanu, & Cangia, 2018; Ibbará, 1999; Pratt et al., 2006). Tajfel and Turner (1987) considered professional identity to be a special condition in social identity given there is often a close link between one's personal identity and professional identity in which professional identity provides a frame of reference that enhances a sense of belonging and uniqueness, and from which one carries out professional roles (Pratt et al., 2006). Psychological processes involved in the construction of professional identity have been identified in the literature. For example, Pratt et al. (2006) followed medical residents over a period of 6 years, focussing on the psychological processes through which they construct their professional identities, and found that identity construction was triggered by work-identity integrity violations, such as an experienced mismatch between what physicians did and who they were. Elements of professional identity emerged and became more coherent as a result of these confrontations. Chreim, Williams and Hinings (2007) note that the professional aspect of roles and identities has received little attention from researchers. For example, Molleman and Rink (2015) introduced a conceptual framework for understanding the antecedents of a strong professional identity among medical specialists and its consequences for the quality of healthcare. They posit that a strong professional identity improves the overall work productivity within a speciality, but impedes the efforts of medical specialists to work effectively with others outside their domain because of the experience of identity threat. However, there is limited empirical research that investigates the impact of professional identity in concert with other identities of relevance in a given context.

**Team Identity (TI)**

A work team is defined as “a group of people with complementary skills who are committed to a common purpose, performance goals, and approach, for which they hold themselves mutually accountable” (Carrier & Kendall, 1995; van Knippenberg & van Schie, 2000). Work teams are smaller than work units, in that a department such as human resources is likely divided into several subsets of
individuals with shared accountability for a given task or service. Identities develop within work teams, and have been shown to influence team effectiveness and coordinated action (Ashforth & Mael, 1989; Henttonen, Johanson & Janhonen, 2014; Mitchell, Boyle, Parker, Giles, & Chiang, 2015; Mitchell, Parker, & Giles, 2011).

Multidisciplinary teams (also referred to interchangeably as interdisciplinary teams as suggested by Leathard, 1994), are task groups whose members are from different professions (Curran et al., 2009), and constitute a particular type of work team in which members carry different disciplinary identities. Multidisciplinary team work, in the context of healthcare, is described by Jefferies and Chan (2004, p. 211) as: “the main mechanism to ensure truly holistic care for patients and a seamless service for patients throughout their disease trajectory and across the boundaries of primary, secondary and tertiary care”. Carrier and Kendall (1995, p.321) describe such work as “implying a willingness to share and indeed give up exclusive claims to specialist knowledge and authority, if the needs of clients can be met more effectively by other professional groups”.

Multidisciplinary teams are intended to promote creativity, increased breadth of knowledge and skills, increased performance, civilised task-related debate, unity within an organisation via positive inter-functional contact and the cross-fertilization of ideas between representatives of different professions while engaged in the attainment of goals (Cunningham & Chelladurai, 2004; Keller, 2001; Lovelace, Shapiro, & Weingart, 2001; West, Borril, & Unsworth, 1998). However, evidence also indicates that interdependence within multidisciplinary teams creates internal conflict with accompanying low trust, low commitment to the group and output, resistance to knowledge sharing and integration, and less than ideal performance (Badea, Jetten, Czukor, & Askevis-Leherpeux, 2010; Cottrell & Neuberg, 2005; Cunningham & Chelladurai, 2004; Hansen, Mors, & Lovas, 2005; Schmader, Johns, & Forbes, 2008; van Knippenberg, De Dreu, & Homan, 2004; Walton & Cohen, 2007). The suggestion is that interdependence and contact is, of itself, insufficient to improve interpersonal relationships within multidisciplinary teams (Brewer, 1996b). For example, examining healthcare settings, Cheung, Milliss, Thanakrishnan, Anderson and Tan (2009) concluded that within a multidisciplinary team, it cannot be assumed that different professions will work together in pursuit of patient goals, and problems can occur through disagreements about patient management and demarcation of roles and responsibilities. Scholars have suggested that multidisciplinary team functioning may be improved if group-member self-definition can be changed from a state where a single level of identity is salient, to where multiple identities become contextually adaptive, and therefore simultaneously salient, through manipulation of
the processes underlying social comparison (Haslam, 2001; Van Dick, Wagner, Stellmacher, & Christ, 2005), yet little empirical work has examined this.

Multiple Identities

Work-related identities (e.g., organizational, professional or work team) are important to people and are becoming increasingly entwined with non-work identities (e.g., cultural identity) in the modern world characterized by increasing workforce diversity, decreasing job stability and the spread of communication technologies (Miscenko & Day, 2016; Ramarajan & Reid, 2013; Veldman, Meeussen, Van Laar, & Phalet, 2017). For example, given that employees can now work anywhere at any time on electronic devices, they may find more often that their professional or work team identity competes with their cultural identity expressed and exercised at home.

Scholars discuss five key perspectives that address questions on multiple identities — social psychological, micro-sociological, developmental/psychodynamic, critical, and intersectional. Social psychological approaches consist largely of research drawing on social identity theory (Tajfel & Turner, 1987) that stipulates that identities are connected to social groups and organised in a loosely fluctuating hierarchy in which only one identity, triggered by context, directs behaviour. In contrast, micro-sociological approaches are based on Identity theory (Stryker & Burke, 2000) in which identities are connected to roles and relationships and organised in a salience hierarchy. Developmental/psychodynamic conceptualization of self and identity views identity as an unfolding developmental process that takes place in the context of communities or significant others (Erikson, 1980; Higgins & Kram, 2001). Identity scholars (e.g. Alvesson et al., 2008; Alvesson & Willmott, 2002; Kenny, Whittle, & Willmott, 2011) who use a critical lens to study multiple identities use the Foucauldian idea that our identity is shaped through relationships of power. Lastly, intersectional approach (e.g. McCall, 2005; Yuval-Davis, 2006) explicitly embraces the notion of relationships among multiple identities. Ramarajan (2014) provides a comprehensive review of the five perspectives on multiple identities. This dissertation draws upon all five of the perspectives but is more focused on the social psychological approach.

Research has sometimes reported that multiple identities increase positive outcomes such as psychological well-being (Benet-Martinez, Hong, Settles, & Buchanan, 2014; Cruwys et al., 2013; Cruwys, South, Greenaway, & Haslam, 2015; Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten et al., 2015; Jetten, Haslam, & Haslam, 2012; Jones & Jetten, 2011; Haslam et al., 2008; Haslam, Jetten, Postmes, &
Haslam, 2009; Linville, 1987; Thoits, 1983); engagement and performance (Caza & Wilson, 2009; Cheng et al., 2008; Creary, 2015; Gresky, Eyck, Lord, & McIntyre, 2005; Hanek & Lee, 2015; Leong & Crossman, 2015; Tadmor et al., 2009); and intergroup tolerance and cooperation (Brewer & Pierce, 2005; Ellemers et al., 2005; Fombelle, Jarvis, Ward, & Ostrom, 2012; Richter et al., 2006).

Yet other research has indicated negative outcomes such as psychological stress (Benet-Martinez et al., 2014; Brook et al., 2008; Downie, Koestner, ElGeledi, & Cree, 2004; Giuliani et al., 2018; Kang & Bodenhausen, 2015); devaluation of one’s identity (Ellemers, Rink, Derks, & Ryan, 2012; Pratt et al., 2006); emergence of negative emotions and social division (Ellemers et al., 2005; Fiol et al., 2009; Settles, 2004; Shih & Sanchez, 2005).

**Structure and Relationship of Identities**

Research examining relationships among multiple identities has proposed a variety of types of relationships. Some studies have suggested that these identities operate independently of each other (Anteby & Wrzesniewski, 2014; Cooper & Thatcher, 2010; Johnson et al., 2006); whereas others have examined the way in which multiple identities can be structured hierarchically (Ashforth, 2007; Ashforth & Johnson, 2001; Sluss, Ployhart, Cobb, & Ashforth, 2012), or salient simultaneously (Ramarajan, 2014). I review these three approaches and then propose a synthesis among them.

**Independent Identities**

Using the first approach, scholars advocating independent structural arrangements suggest accounting for the influence or effect of each identity on outcomes of interest separately. For example, Anteby and Wrzesniewsky (2014) examined the multiple forces that shape the identities of young adults and concluded that each has different effects, such that blending different goals and identities into one ‘unified’ identity would be dysfunctional for these young adults. Likewise, others have shown that group, organisational and professional identities have independent and distinct relationships with different aspects of burnout because each has qualitatively different communicative origins, different developmental processes, and thus different outcomes for individuals, organisations, and organisational communication (Lammers, Atouba, & Carlson, 2013). Similarly, Johnson et al. (2006) accounted for how a person’s workgroup, organisational and professional identities each affects job satisfaction independently, and Vough (2012) performed a qualitative case study investigating how professionals construct their workgroup, organisational and professional identities based on discrete properties.
Hierarchical of Identities

According to the second approach, identities are characterized as being arranged in a hierarchy of prominence, where the prominence of the identity depends upon the degree to which one gets support from others for an identity, is committed to the identity and receives extrinsic and intrinsic rewards from the identity (Burke, 2003; McCall & Simmons, 1978; Mussweiler, Gabriel, Bodenhausen, & Insko, 2000; Stryker & Serpe, 1994). A salient identity (also referred to as a “strong identity” and captured based on ratings of identity strength) can be defined as one that is likely to be activated frequently across different situations (Stryker & Serpe, 1994). Burke (2003) has emphasized the effect of structural location of the identities on identity processes i.e. the multiple identities that one holds may come to share meanings in response to the structural conditions in which the identities are played out.

Ashforth (2001) suggested that situational relevance and personal importance are key factors that influence where an identity is in the hierarchy of multiple identities. Accordingly, research on biculturalism has used the hierarchy perspective to understand how two cultural identities are switched on, based on the social context (Briley, Morris, & Simonson, 2005). Similarly, research examining relative identification between two or more identities has also used the hierarchy framework. For example, Vora and Kostova (2007) examined relative identification between dual organisational identities. Stryker and Serpe (1982) compared the relative importance of religious identity to other roles such as parent or worker. Kuhn and Nelson (2002) examined four identities (workgroup, division, organisation and profession), by capturing the pattern of relative identification. The measure consisted of the standard deviation of the four identity scores where a high standard deviation indicated that some identities were quite strong and others were weaker.

Relationships Among a Plurality of Identities

A third approach recognizes that individuals may have multiple identities salient at the same time (Ashforth et al., 2008; Creary, Caza, & Roberts, 2015; Curtin, Kende, & Kende, 2016; Dutton, Roberts, & Bednar, 2010; Epitropaki. Kark, Mainemelis, & Lord, 2017; Meister, Sinclair, & Jehn, 2017; Pratt & Rafaeli, 1997; Rabinovic & Morton, 2016; Ramarajan, Berger, & Greenspan, 2017; Ramarajan, Rothbard, & Wilk, 2017; Roccas & Brewer, 2002; Scheuringer, 2016; Sluss et al., 2012; Vora & Kostova, 2007). For example, a ‘knowledge activation view’ considers identities as knowledge nodes, that can be co-activated to direct behaviour, such that behaviour is not directed by a single salient identity (Cronin, 2004; Greenwald & Pratkins, 1984; Higgins, 2000; Kruglanski, Kruglanski, & Higgins, 2007; Marco, 2008;
Ramarajan, 2014), but given one of the primary functions of identity is to act as a guide for individual thoughts and behaviours (Baumeister & Twenge, 2013; Goffman, 1990), holding multiple identities often means managing or juggling numerous influences on ones’ thoughts and behaviours. Recent research argues that the meaning given to a particular social category can depend substantially on its interactions with other detectable identities, even to the point of altering judgements of category membership. For example, Ramarajan and Reid (2013) suggested that non-work identities such as national cultural identity can impact organisational and occupational identities. A comprehensive understanding of the number of identities and the relationship between them is important to underpin the complexity of multiple identities. At least three relationships might exist, including integration, enhancement, and conflict.

**Identity integration.** The degree of integration across identities has often been investigated in the literature on race and biculturalism and shown to be generally associated with positive outcomes, such as creativity (Cheng et al., 2008; Leung, Maddux, Galinsky, & Chiu, 2008; Maddux, Adam, & Galinsky, 2010; Mok & Morris, 2010a; Tadmor, Galinsky, Maddux, & King, 2012), enhanced integrative complexity (Ramarajan, 2014; Tadmor et al., 2012; Tadmor & Tetlock, 2006) and professional success (Tadmor et al., 2012) along with positive personal outcomes such as healthy psychosocial development (McAdams, 2001). Integration can be viewed as blurring of spatial, temporal and cognitive boundaries that divide areas of a person’s life (Ashforth, 2001; Benet-Martinez, 2012; Ramarajan, 2014; Syed, 2010; Syed & McLean, 2016). Many studies of multiple cultural identities (e.g. Brook et al., 2008; Cheng et al., 2008; Fitzsimmons, 2013) conceptualize and measure identity integration as overlap in meaning. Studies on bicultural individuals provide evidence that identity integration is an individual difference construct that describes the degree to which two cultural identities are perceived as compatible with each other (Benet-Martinez & Haritatos, 2005). Such studies document that bicultural individuals with high identity integration perceive their two identities as largely compatible and complementary, and do not find it problematic to identify with both cultural groups at the same time. Similarly, an empirical study by Cheng et al. (2008) found that higher levels of identity integration predicts higher levels of creative performance in tasks that draw on identity-relevant knowledge domains. Fitzsimmons (2013) suggests that ‘identity integration’, which ranges from separated to integrated, and ‘identity plurality’, which ranges from single to multiple, create a map of possible ways to organise multiple cultural identities. The concept of “social identity complexity”, developed by Roccas and Brewer (2002), draws on ideas of overlap or integration in meaning and content across identities and suggests that high perceived overlap
in group memberships implies that the different ingroups are actually conceived as a single convergent social identity.

However, acknowledging one’s multiple identities and encouraging the integration of those identities (such that distinctions are lost) may be detrimental for the individual. Identity theorists from post-modern and social constructivist orientations (e.g., Gergen & Gergen, 1986; Kraus, 2007; Schachter, 2004) have argued an integrated identity is not necessarily a desirable or an adaptive identity to maintain. Similarly, Ashforth, Kreiner and Fugate (2000) suggested that identity integration may often lead to confusion and anxiety over enacting different identities, and this may then translate into a loss of productivity. At least one empirical study has documented that biculturals with low identity integration have higher cognitive complexity, defined as the capacity to analyse and interpret people, ideas and objects in a multidimensional manner (Benet-Martinez, Lee, & Leu, 2006).

Identity enhancement. A second type of relationship among identities has been described by scholars suggesting that people experience benefits from multiple role identities (such as the ability to fulfil many work demands) when one role intersects with another and results in identity enhancement (e.g. Caza & Wilson, 2009; Creary & Pratt, 2014; Pratt & Foreman, 2000; Rothbard & Ramarajan, 2009). This has also been referred to as ‘identity synergy’ (e.g. Caza & Wilson, 2009; Creary & Pratt, 2014; Pratt & Foreman, 2000; Rothbard & Ramarajan, 2009). Identity synergy is a term perhaps first used by Pratt and Foreman (2000) to describe organizational identities which a firm might develop which are synergistic, that is they work in concert to help ensure the viability and longevity of a firm. Social network theorists (e.g. Burt, 2000) and developmental process researchers (e.g. Higgins & Kram, 2001) suggest that individuals with multiple social identities have better access to resources such as trust and information in organisations that strengthens them to endure stress and hardship and/or take on new and more demanding challenges. Fombelle et al. (2012) empirically demonstrated that marketers can leverage customers’ multiple identities by using identity enhancement as a driver of organisational identification; this study states that identity enhancement occurs when individuals’ involvement with an organisation facilitates their pursuit of other important social identities.

Identity conflict. Identity integration and enhancement aside, by far the most commonly investigated relationship among identities is the conflict that can ensue across them. Identity conflict is defined as conflict between the “values, beliefs, norms and demands” inherent in individual and group identities (Ashforth & Mael, 1989: 29). This conflict arises when individuals feel that they must give
precedence to one particular identity to satisfy certain identity-based expectations, and therefore cannot express or validate other identities (Ashforth et al., 2008; Brook et al., 2008; Burke, 2003; Burke & Stets, 2009; Cadsby, Servatka, & Song, 2013; Karellaia & Guilien, 2014; Mok & Morris, 2009; Rabinovic & Morton, 2016; Stryker & Burke, 2000; Voss, Cable, & Voss, 2006). In particular, research has shown that people can experience conflict between multiple work identities or between work and non-work identities (Creed, DeJordy, & Lok, 2010; Dalton, & Chrobot-Mason, 2007; Kreiner, Hollensbe, & Sheep, 2006; Ramarajan & Reid, 2013; Veldman et al., 2017).

Previous research has found that conflict or interference between one’s personal and social identities leads to many negative psychological (such as less life satisfaction, lower self-esteem and greater depression) and performance (poorer job performance) outcomes (Brook et al., 2008; Cooke & Rosseau, 1984; Downie et al., 2004; Fried, Ben-David, Tiegs, Avital, & Yeverechyahu, 1998; Haslam et al., 2008, 2009; Humphreys & Brown, 2002; Jetten et al., 2012, 2014; Parasuraman & Greenhaus, 2002; Settles, 2004; Williams & O’Reilly, 1998). For example, Settles, Jellison and Pratt-Hyatt (2009) examined the identity interference between woman and scientist identities and reported that such interference was associated with lower well-being, identity satisfaction and science performance perceptions. Similarly, a recent study by Veldman et al. (2017) found that female police officers’ experience of gender-work identity conflict led to negative work and health outcomes such as lower work satisfaction and motivation, higher burnout, and turnover intentions. Thus, interference of identities may create a sense of psychological pressure that diminishes the effective use of coping strategies (Cooke & Rosseau, 1984) or overtax available cognitive resources (Fried et al., 1998), and this can have negative effects for one’s work organization.

For example, Ramarajan, Rothbard and Wilk (2017) examined the effects of identity conflict and enhancement on sales performance in employee-customer relations. However, the study focused only on the individual level of analysis and examined conflict and enhancement between only two identities. Ramarajan, Berger and Greenspan (2017) examined charity sport events, student teams, and two experimental samples; the authors found that generally experiencing identities as enhancing, rather than conflicting resulted in prosocial outcomes. However, mutually enhancing, mutually conflicting, and independent identities were not significantly different from one another in their relationships with outcomes.

Gibson, Dunlop, Caprar and Raghav (2016) also gathered empirical evidence that in addition to understanding the strength of a single identity, it is important to know how members’ multiple identities
combine and interact with each other in influencing team processes and outcomes. Across two samples, one consisting of engineers at a global mining company and the other a diverse panel data set, the authors found that beyond team identity, the degree of conflict across multiple identities explained additional variance in team processes and outcomes. Further, they found that the effects of conflict among identities are stronger than other types of relationships among identities (Gibson et al., 2016). Thus, although the focus in the past in the team literature has been on team identification, this study shows that it is important to consider team identity alongside other sources of identification. In other words, a strong team identity alone will not lead to team effectiveness until unless it is compatible with other affiliations such as cultural or professional identities.

Molleman and Rink (2015) advocate further research into the inter-relationship between organisational and professional identities to understand both the positive and negative effects of professional identities. Chreim et al. (2007) traced institutional influences on professional role identity construction by building bridges across institutional, organisational and individual levels of analysis. Findings indicate that reconstruction of professional identity is enabled and constrained by an institutional environment that provides interpretive, legitimating and material resources that professionals adopt and adapt. Chreim et al. (2007) urge future research to consider integration of both micro and macro perspectives to understand the dynamics of professional identity in the context of organisational and work-unit identities.

Context characteristics may be promising avenues to explore with regard to how professional identity interacts with organisational identity. Hekman, Bigley, Steensma, & Hereford (2009) examined the effects of perceived organisational support (POS) and perceived psychological contract violation (PPCV) on the combined effects of organisational identity and professional identity among physician employees in a large managed care health organisation. Findings indicate that the association between POS and employee work performance was most positive when organisational identity was high and professional identity was low and least positive when organisational identity was low and professional identity was high; association between PPCV and employee performance was most negative when organisational identity was low and professional identity was high and least negative when organisational identity was high and professional identity was low. They implore future research to look at the relative importance and interaction of different identities that affect employees.

Recent research has also suggested individuals can have different relationships among the multiple identities they hold, such that some are in conflict while others are not (Benet- Martinez &
Haritatos, 2005; Rothbard 2001). Ramarajan (2014) proposed the concept of an “intrapersonal identity network” to conceptualise multiple identities, providing a means of conceptualizing how multiple identities can operate as a system in which nodes (identities) are linked via ties (relationships such as conflict, enhancement, integration) to form patterns, configurations and constellations of identities (the identity network). This opens up the possibility of examining several possible structural configurations. For example, centrality (Freeman, 1979) captures when an identity is more likely to influence or be influenced by other identities within a network, and perhaps a highly central identity in a centralized network can destabilize the entire system of identities if it becomes threatened. However, to date there has been very limited empirical research examining intrapersonal identity networks within individuals, in part due to the complexity of administering network measures regarding identities with enough fidelity to capture the variety of identities one individual might hold and the possible different relationships among them, to a large enough sample to draw sound conclusions.

In a comprehensive cross-level review on workplace identities, Horton, Bayerl and Jacobs (2014) differentiated between intra-unit conflicts (intrapersonal conflicts within a single individual) and inter-unit conflicts (conflict across different individuals or groups) and outlined the different roots, moderators and reconciliations of these conflict types. Intrapersonal conflicts included ‘work-family’ conflicts (Byron, 2005), “work-leisure” conflicts (Staines & O’ Connor, 1980), conflicts between occupational identities and personal identities (Kreiner et al., 2006; Settles et al., 2009) and between ascribed social identities and chosen work roles (Bell, 1990). They argued that these intrapersonal identity conflicts must be considered alongside the identity conflicts that occur across levels of analysis such as between team and organisational identities.

**Relationships Among Identities and Team Processes**

In addition to understanding the intrapersonal identity experience, I also seek to understand how identity dynamics may be related to team processes. Here, in line with Gittell (2006), I focus on relational coordination, defined as the coordination that occurs through frequent, timely, high quality and problem-solving communication, supported by shared goals, shared knowledge and mutual respect. Gittell (2006) highlighted the importance of these coordination processes, but we have yet to understand how they are affected by identity interactions.

Research which has investigated identity and team processes has demonstrated mixed and complex findings (Battilana & Dorado, 2010; Golden-Biddle & Rao, 1997; Greenhaus & Beutell, 1985;
Horton et al., 2014). For example, Richter et al. (2006) examined the relationship between group boundary spanners’ work group identification and effective intergroup relations in health care organizations and found that this relationship was moderated by boundary spanners’ levels of organizational identification, thus supporting a dual identity model. In another study, Brewer & Pierce (2005) found that perceived overlap among ingroup memberships is negatively related to ingroup inclusiveness and tolerance for outgroups, such that individuals with high overlap of identities (i.e., each of the identities share common features) are less tolerant and accepting of outgroups in general than those with low overlap.

Yet, other research suggests that multiple identities within team members can cause social division. The very process of identifying with a social group may promote inter-group conflict, because it fosters within-group bias (Turner et al., 1999). That is, one means of maintaining a positive view of oneself is to hold a negative view of others who are not members of one’s social group. For example, Li, Xin and Pillutla (2002) demonstrated that identity-based factionalism is a prevalent inter-unit dynamic in joint venture management teams and Fiol et al. (2009) indicated that identity was a basis of ongoing intergroup conflicts in a community hospital. Similarly, Battilana & Dorado (2010) demonstrated that the effects of intra-unit dissonance may filter through an organisation’s fabric causing subgroup conflicts at a lower level.

Scholars of team identification have often implied that having a salient team identity that takes precedent over other identity affiliations that are represented in the group (such as organisational, professional and cultural affiliations) is beneficial. For example, Mitchell, Parker and Giles (2011), investigating the moderating roles of team and professional identity in inter-professional effectiveness in health care, found that in absence of a strong sense of team identity, professional diversity was negatively related to effectiveness. Yet, a single, salient common team identity may imply that the views, knowledge, and priorities associated with one’s other identities must be sacrificed. As reviewed earlier, this can be detrimental and frustrating for individuals (Anteby & Wrzesniewsky, 2014; Crisp, Stone, & Hall, 2006; Fiol et al., 2009). Hence there is a need to better understand when and how intrapersonal relationships among multiple identities may help or hinder interpersonal relationships and relational coordination within teams.
Identity Dynamics and Work Outcomes

Research on the link between multiple identities and outcomes such as psychological well-being, work engagement, productivity and performance has produced mixed results. Research has sometimes reported that multiple identities increase positive outcomes such as psychological well-being (Linville, 1987; Thoits, 1983) and engagement and performance (Caza & Wilson, 2009; Cheng et al., 2008; Tadmore, Tetlock, & Peng, 2009). Yet other research has indicated negative outcomes such as psychological stress (Brook et al., 2008; Downie et al., 2004); devaluation of one’s identity (Pratt et al., 2006); and emergence of negative emotions and social division (Fiol, Pratt, & O’Connor, 2009; Settles, 2004; Shih & Sanchez, 2005). Empirical research examining patterns of relationships among identities and how they amplify or constrain outcomes in organisations is very sparse. Yet we know that identification can have positive benefits (Caza & Wilson, 2009; Tadmore, Tetlock & Peng 2009). Hence there is a need to understand the specific implication of identity inter-relationships for outcomes in organizations.

Organizational Practices and Identity Dynamics

The organisational structures that predict high levels of relational coordination are those that connect across different functions rather than reinforcing the silos that separate them (Gittell, 2006; Gittell, Seidner, & Wimbush, 2010; Hartgerink et al., 2014; Romero, Senaris, Heredero, & Nujiten, 2014). Prior work suggests establishing relational structures such as hiring and training for team work, team meetings, team conflict resolution, performance measurement and rewards, boundary spanners, protocols and information systems (Gittell & Douglass, 2012). Yet, we know little about the influence of these practices specifically on the coordination challenges posed by identity dynamics. It may be that the same practices help to overcome such challenges. For example, given identity conflict is often a result of entrenched in-group and out-group distinctions, where by the individuals perceives the goals and perspectives of each identity group they affiliate with as incompatible, it may be that organizational practices which help to reduce in-group and out-group distinctions, promote the accomplishment of shared organizational priorities. For example, Gittell, Godfrey and Thistlethwaite (2013) demonstrated that communication and relationship patterns are impacted by the self-concept that a person holds and organisational practices that can modify such patterns can be an important point of leverage for organisations. However, given research examining how such process pertain to identity conflicts is nearly non-existent, there may also be other practices which help to address identity-related
coordination challenges, which pertain to clarification of priorities or incorporation of feedback from clients, customers, and other recipients of the teams’ work.

By way of summary, the intrapersonal impacts of identity conflict across three or more identities is not well understood. Scholars in this domain have urged future work to examine the myriad possible relationships among more than three identities and to also take a team-level approach to investigate multiple identities, so that the influence of intra-individual identity conflicts can be examined at other levels of analysis. Therefore, extending these prior approaches, this dissertation is an attempt to investigate the gaps in our understanding of multiple identities by taking into account four identities, as well as a team context, with rich, ongoing interpersonal interactions.
Chapter 2:  
Current Approach and Model: A Synthesis

Recognizing the complexity identified in prior research, this dissertation examines the potential relationships among both non-work and work identities, including cultural, organisational, professional and team identities. Prior research reviewed in Chapter 1 indicated that these four identities are often primary sources of identification for workers. Further, the focus for my proposition development below is on the potential effects of patterns of conflict among the identities, based on the early evidence from multiple identity research suggesting that effects of conflict among identities are stronger than other types of relationships among identities (Gibson et al., 2016).

As I will elaborate in this chapter, my model considers how these multiple identities (cultural, organisational, professional and team identities) interact intra-personally within each member of a multidisciplinary team. I then propose that a central tendency among members to experience identity conflict among one’s identities will have a detrimental impact on the team. Specifically, I address the impact of identity conflict on the quality of patient care delivered by healthcare teams, arguing that relational coordination mediates this relationship. I also argue that a strong team identity contributes to relational coordination, but that the effect of identity conflict remains, even after controlling for strength of team identity.

Finally in an exploratory way, the research also considers important potential moderators of the relationship between multiple identity conflict and relational coordination such as multidisciplinary training, multidisciplinary meetings and use of boundary spanners. These moderators might serve as important points of leverage for organisations to improve relational coordination and enhance positive implications of multiple sources of identity in teams. In addition, these practices likely strengthen the team identity. I next develop specific preliminary propositions about these relationships, which are summarized in Figure 2.
Figure 2: Preliminary Research Model

**Propositions**

**Identity conflict and relational coordination.** Research that links intrapersonal identity conflict and relationships within a group more generally is still very limited. One early study by Gaertner, Dovidio and Bachman (1996) showed that banking executives holding two work identities were likely to have dysfunctional group relationships. Other recent research has begun to explore relationships among identities within the team context, but primarily as a back-drop, rather than as a means of overcoming identity challenges, and rarely as a mechanism for how identities interact. For example, the Ramarajan, Berger, and Greenspan (2017) study mentioned earlier found an effect of individual identities on helping behaviour in the context of student teams, but did not examine team outcomes. Likewise, Horton and Griffin (2017) examined the extent to which individuals held strong identities, and found that doing so was related to team processes. However, they did not examine whether individuals experienced their identities as in conflict, nor did they capture team outcomes.

I propose that the most important ramifications of intrapersonal identity conflict will be on the interpersonal interactions with in the team. Specifically, a central tendency in a team for intrapersonal identity conflict is likely to negatively affect relational coordination. Relational coordination captures the
interdependent interaction that occurs through frequent, timely, high quality and problem-solving communication (Gittell, 2006). Relational coordination is expected to result in fewer missed signals between employees with different areas of functional expertise, due to the information processing capacity that is created through shared goals, shared knowledge and mutual respect (Cramm & Nieboer, 2011, 2012; Havens, Vasey, Gittell, & Wei-Ting, 2010; Young et al., 1998).

Interpersonal and intergroup relations can be impacted by whether an individual experiences multiple identities in positive or negative ways as this will influence ones’ thoughts, judgments and behaviours relevant to more harmonious group relations. When a team has a high level of identity conflict, this affects relational coordination because identity conflicts can alter members’ attributions of behaviour and distort communication and coordination. For example, when different functions come into contact within a multidisciplinary team, this tends to produce in-group favouring social comparisons which can be threatening to the members of a devalued social identity subgroup (Aquino & Douglas, 2003; Chrobot-Mason, Ruderman, Weber, & Ernst, 2009; Hornsey & Hogg, 2000a; Jehn, Chadwick, & Thatcher, 1997; Jehn, Northcraft, & Neale, 1999). Social identity can also be threatened by implied loss of distinctiveness of the function-based social identity through immersion in a multidisciplinary team (Hornsey & Hogg, 2000a; Steele, Spencer, & Aronson, 2002). Those from higher status functions may feel threat through being positioned as psychologically equivalent with lower status groups (van Knippenberg et al., 2004). This identity threat can engender competitive thoughts, feelings and behaviours within the multidisciplinary team (Li & Hambrick, 2005), reducing the relational coordination.

Cheung et al. (2009) concluded that within a multidisciplinary health care team, it cannot be assumed that different professions will work together in pursuit of patient goals, and problems can occur through disagreements about patient management and demarcation of roles and responsibilities. Working in multidisciplinary teams can be experienced as difficult for a number of reasons. For example, professionals can find themselves torn between allegiance to their profession and to working to realise team goals. The latter often requires an ‘unlearning of traditional patterns of professional interaction’ (Lang, 1982). However, this is not easily done, and team members often report low team identification but high professional identification (Onyett, 1997; Onyett, Pillinger & Muijen, 1995), which can reduce coordination with the team. For example, Mitchell et al. (2011) found that in the absence of a strong sense of team identity, professional diversity has a negative effect on team effectiveness; when threat to professional identity was perceived by members, their diversity stimulated hostility towards other professions, and was detrimental to performance. This is important evidence that functional diversity
may not necessarily be positive or negative, rather the performance outcomes of professionally-diverse groups are contingent upon team processes, in particular relational coordination.

In turn, relational coordination is likely very important for team outcomes. Although not yet extensive, there is research that has established benefits of relational coordination in multidisciplinary teams. For example, relational coordination has been shown to result in higher levels of quality and efficiency of performance by enabling participants to manage their task interdependencies (Gittell, 2000; Gittell, 2002, 2006; Romero et al., 2014). Relational coordination also improves job satisfaction by providing the social support to enable one’s resilience in the face of stress (Gittell, 2008; Gittell et al., 2008).

Relational coordination is particularly relevant for coordinating work that is highly interdependent, uncertain and time-constrained (Gittell, 2006), such as that found in healthcare settings. Hospitals are notorious for operating with well-defined silos that engender turf battles between them. Several studies in healthcare settings have demonstrated the importance of relational coordination. One such study is by Romero et al. (2014) who examined relational coordination in healthcare management of lung cancer. Through interviews with clinicians at two levels (primary level and specialist level), the study found that in absence of relational coordination practices, effective knowledge transfer between the two levels was lacking. Another recent study found a positive relationship between relational coordination and integrated care delivery in healthcare settings (Hartgerink et al., 2014). This study found that the enhancement of team climate and attendance of diverse professionals during multidisciplinary team meetings improved relational coordination. Furthermore, this study underscored the importance of enhancing relational coordination between medical specialists and other professionals. Evidence thus far also suggests that relational coordination among care providers promotes improved relationships with family members (Weinberg, Lusenhop, Gittell, & Kautz, 2007).

I therefore argue that relational coordination mediates the relationship between team identity conflict and team outcomes. This is because conflict between multiple intrapersonal identities is likely to hinder the communication and relationship patterns between members of multidisciplinary teams and thus compromise the distal outcome of quality of patient care. At least one study has acknowledged the role of identity, relational coordination, and outcomes, but has yet to test these relationships empirically. Gittell, Godfrey and Thistlethwaite (2013) argued that communication and relationship patterns are influenced by professional identities, and not easily changed, and that the amalgamation of
inter-professional collaborative practice and relational coordination will improve healthcare outcomes. The following proposition captures the expected relationships:

**P1: The mean level of conflict among cultural, organisational, professional and team identities in multidisciplinary patient care teams is negatively related to quality of patient care provided; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better work outcomes.**

**Strength of team identity.** Scholars have argued that the management of inter-functional diversity requires bonding of diverse social identities within a unifying higher order social identity (Mannix & Neale, 2005; Mitchell et al., 2011). Team identity may provide this unification. In support of this, Mitchell et al., (2011) investigated the moderating roles of team and professional identity in interprofessional effectiveness in health care. They found that in absence of a strong sense of team identity, professional diversity has a negative effect on effectiveness. However, this is a rare example of research which addresses identity issues in multidisciplinary health care teams.

In addition to ameliorating the negative impact of inter-functional diversity, team identity is argued to enhance team collaborative behaviours and perception of shared goals (Chen & Tjosvold, 2002; Eckel & Grossman, 2005; Sethi, Smith, & Park, 2001). In contrast, a situation in which teams share a weak sense of team identity will be characterized by a retained focus on other identities such as cultural or professional identities (Brewer & Brown, 1998). Teams with weaker team identity will be more likely to develop ingroup/outgroup categorizations based on other identities leading to hostility and information-withholding towards the outgroup, which constrains the breadth of knowledge available to the teams as well as the extent to which disparate knowledge sources will be integrated through constructive interprofessional interaction (Brewer & Brown, 1998). Hence, I proposed that a strong team identity likely improves relational coordination:

**P2: Team identity strength is positively related to relational coordination.**

**Managerial points of leverage.** Although identity conflict may be common in healthcare teams and may reduce both relational coordination and quality of care, there are likely points of leverage for managers and organizations that can ameliorate this situation. Specific moderators were inductively derived through the first phase of the research (described in the next chapter), but sample concepts and propositions are presented here, by way of illustration. The organisational practices that predict high levels of relational coordination are those that connect across different functions rather than reinforcing the silos that separate them (Gittell, 2006; Gittell, Seidner & Wimbush, 2010;
Hartgerink et al., 2014; Romero et al., 2014). Prior work suggests establishing relational structures such as hiring and training for cross-functional work, cross-functional conflict resolution, cross-functional performance measurement and rewards, cross-functional boundary spanners, cross-functional protocols and cross-functional information systems (Gittell & Douglass, 2012). Such organisational practices can moderate the relationship between intrapersonal identity patterns created by multiple identities and relational coordination in a significant way as such structures can be argued to minimise intrapersonal identity conflict within members of a cross-functional team, and thus facilitate better relational coordination and distal outcomes. This is because (as reviewed earlier) identity conflict is often a result of entrenched in-group and out-group distinctions, where by the individuals perceives the goals and perspectives of each identity group they affiliate with as incompatible. Organisational practices can help to reduce in-group and out-group distinctions, promoting and emphasizing the accomplishment of shared organisational priorities. For example, Gittell, Godfrey and Thistlethwaite (2013) demonstrated that communication and relationship patterns are impacted by the self-concept that a person holds and organisational practices that can modify such patterns can be an important point of leverage for organisations. Here, I focus on three of these: multidisciplinary training, multidisciplinary meetings and use of boundary spanners.

**Multidisciplinary team training.** Multidisciplinary team training refers to training provided to all health professionals together in a given unit (doctors, nurses, and allied healthcare staff) to work as a team to promote competent and effective healthcare outcomes. A significant determinant of multidisciplinary team functioning may be the presence of team members who identify with the team, and hence have a personal commitment to multidisciplinary care approach, that does not conflict with other priorities. Cheung et al. (2009) concluded that within a multidisciplinary health care team, it cannot be assumed that different professions will work together in pursuit of patient goals, and problems can occur through disagreements about patient management and demarcation of roles and responsibilities. Therefore, multidisciplinary team training becomes important to develop and nurture the team identity between different functions in a multidisciplinary team.

Simulation has been used successfully for training technical skills and recent studies have shown that this form of training can also be used for training team dynamics and non-technical skills such as communication and coordination between team members to achieve better patient care outcomes (Bayliss-Pratt, 2013; Kneebone et al., 2006; Moorthy, Vincent, & Darzi, 2005; Yee, Naik, & Joo, 2005). In many areas of healthcare such as emergency medicine (Shapiro, Morey, & Small, 2004), trauma
resuscitation (Holcomb et al., 2002), anaesthetics (Gaba, Howard, Fish, Smith, & Sowb, 2001), critical care (Lighthall et al., 2003) and surgery (Tan, Pena, Altree, & Maddern, 2014), institutions are beginning to incorporate teamwork elements as part of training, but very few studies focus on the multidisciplinary aspect of team training. This study aimed to explore the prevalence and use of multidisciplinary training, in addition to the moderating effect of such training on identity conflict and relational coordination within multidisciplinary teams.

**P3: Multidisciplinary team training moderates the relationship between the mean identity conflict in multidisciplinary teams and relational coordination, such that multidisciplinary team training reduces the negative consequences of identity conflict for relational coordination.**

**Multidisciplinary team meetings.** According to organization design theory, multidisciplinary team meetings are central for multidisciplinary team work (Galbraith, 1974). Multidisciplinary team meetings increase performance of interdependent work processes by facilitating interaction among professionals and are increasingly effective under conditions of high uncertainty (Galbraith, 1974). As such, team-meetings have high information processing capability; they are expected to facilitate frequent, timely, accurate and problem-solving communication and coordination among professionals in a work process (Gittell, 2006; Leso et al., 2013). Thus, multidisciplinary team meetings strengthen the accuracy of communication as well as the shared goals and shared knowledge dimensions of relational coordination. For example, in an examination of multidisciplinary team meetings in oncology, Leso et al. (2013) found that such meetings result in open and non-judgemental communication between multidisciplinary specialists and optimise patient care outcomes. However, in absence of concrete multidisciplinary meeting processes and practices, multidisciplinary team meetings can be time-consuming, expensive and inefficient. The authors suggested streamlining the meeting processes to improve efficiency without losing the considerable benefits associated with regular meetings. Another study provided evidence that multidisciplinary meetings improve patient experience in hospitals and are an indispensable tool for communication between different specialities (Ruhstaller, Roe, Thurlimann, & Nicoll, 2006), but did not identify the mechanisms by which this is accomplished.

Hartgerink et al. (2014) investigated the relationship between multidisciplinary team-meetings and relational coordination among professionals delivering care to hospitalized older patients. They found that frequency of multidisciplinary team meetings was unrelated to relational coordination, but the number of disciplines represented during meetings had a positive relationship with relational
coordination. This study underscored the importance of enhancing relational coordination between medical specialists and other professionals delivering care to patients.

Multidisciplinary team meetings in the healthcare setting take the form of patient rounds, a long-established practice in hospitals in which the providers involved in the care of a particular patient discuss that patient’s case, either at the bedside or in a separate conferencing area. This usually involves interaction and communication between doctors, nurses and allied health care staff working as a unit, as a result they are likely to change the nature of the relationship between identity conflict and relational coordination, as expressed in the following:

*P4: Multidisciplinary team meetings moderate the relationship between the mean identity conflict in multidisciplinary teams and relational coordination, such that frequent multidisciplinary team meetings reduce the negative consequences of identity conflict for relational coordination.*

**Boundary spanners.** Staff members whose primary work is to integrate the work of other people around a project, process or customer can serve a boundary spanning role (Davenport & Nohria, 1994; Galbraith, 1995). Because boundary spanners enable new information to be incorporated on an ongoing basis, they are typically used when tasks cannot be fully programmed in advance. Because they build understanding between areas of functional expertise, they are expected to add value when existing boundaries are highly divisive (Galbraith, 1995). Multidisciplinary boundary spanners strengthen the frequency and timeliness of communication as well as the shared knowledge dimensions of relational coordination. Boundary spanners in health care settings can support the controlled transfer of specialized knowledge between groups, increased cooperation by liaising with people from different groups and improving efficiency by introducing ideas from one isolated setting to another (Long, Cunningham, & Braithwaite, 2013). The intrapersonal identity conflict that an individual experiences in workplace may also be attenuated with the help of boundary spanners, by providing relevant information to individuals and reducing ambiguities about the goals and priorities of different groups that the individual may identify with.

Although there is little empirical evidence that boundary spanners improve performance by facilitating interaction among participants (Gittell, 2002), some have found empirical evidence supporting the proposition that boundary spanners are increasingly effective as uncertainty increases (Khandwalla, 1974; Lawrence & Lorsch, 1967). For example, Heng, McGeorge and Loosemore (2005) in their study of department managers of an Australian hospital found that facility managers had high boundary-spanning potential. Long, Cunningham and Braithwaite (2013) in their systematic review of
collaborative networks found that a key challenge in health service management is to understand, analyse and exploit the role of boundary spanners to connect disparate groupings in large systems. Finally, Creswick and Westbrook (2010) used social network analysis to identify strategic people that can act as boundary spanners among ward staff of an Australian teaching hospital.

In healthcare settings, boundary spanner roles include case managers, case coordinators and primary nurses (Ferrua et al., 2016). Case managers and case coordinators are staff members responsible for coordinating the care of the patients assigned to them (Levy & Stevens, 2003; Morrison et al., 2012). In some hospitals, nurses play a coordination role through a model called primary nursing (Ferrua et al., 2016). Primary nursing is a staffing model in which patients are assigned to a single nurse for the duration of their stay. The primary nurse is only one of many who actually provide care to the patient, but the primary nurse is responsible for coordinating the care of the patient from beginning to end of the stay. Such individuals may help mitigate the negative relationship between intrapersonal identity conflict and relational coordination:

**P5: Multidisciplinary boundary spanners moderate the relationship between mean identity conflict in multidisciplinary team and relational coordination, such that their presence reduces the negative consequences of identity conflict for relational coordination.**

**Points of leverage for increasing team identity.** Finally, I propose that the managerial points of leverage such as multidisciplinary training, meetings and boundary spanning roles can potentially facilitate development of a strong team identity. Many scholars have suggested that a combination of organisational and managerial practices can help in development of a strong team identity (Byrne, 2005; Mitchell et al., 2015; Onyett & Ford, 1996). For example, Byrne (2005) suggested team development training for developing a strong team identity in members of multidisciplinary teams. In a recent study in healthcare sector, Mitchell et al. (2015) found that ‘leader inclusiveness’ enhances team performance through an increase in shared team identity and a reduction in perceived status differences. However, there is limited research that has empirically investigated the role of multidisciplinary team training, multidisciplinary team meetings and boundary spanners in development of a strong team identity in context of multidisciplinary teams.

For example, multidisciplinary team training is likely to help the team establish a team identity. Professionals are trained separately – often referred to as the ‘silo effect’ (Peck & Norman, 1999), and different disciplines rarely encounter each other until they are expected to come together and function as a ‘multidisciplinary team’. Not only are the professions trained and educated separately, they rarely if
ever receive training in multidisciplinary working (Yates, Wells, & Carnell, 2007). Another important factor in successful multidisciplinary team working is whether individual professionals feel valued for the unique expertise they bring to the team, in addition to the generic expertise they share with other members of the group (Burns, 2004). If the issue of specialism vs. genericism is not clarified within teams, certain professionals may feel their professional identity being eroded over time (Onyett & Ford, 1996), and begin to exhibit a high degree of ambivalence towards working with teams (Peck & Norman, 1999). However, if the team can successfully identify shared core roles and responsibilities, and distinguish these from the specific unique skills that individuals and disciplines contribute, this can facilitate a common identity.

Multidisciplinary team meetings are also likely to increase the strength of the team identity, because they facilitate interaction among professionals and are increasingly effective under conditions of high uncertainty (Galbraith, 1974). Multidisciplinary team meetings also strengthen the accuracy of communication (Gittell et al., 2010). Interaction and effective communication among different functions through use of multidisciplinary meetings could lead to development of a strong team identity. Finally, boundary spanners integrate the work of other people around a project, process or customer (Davenport & Nohria, 1994; Galbraith, 1995). Boundary spanners in health care settings can support increased team identity by liaising with people from different groups and improving efficiency by introducing ideas from one isolated setting to another (Long, Cunningham, & Braithwaite, 2013). Boundary spanners can facilitate development of a strong team identity by providing relevant information to individuals and reducing ambiguities about the goals and priorities of different groups. Hence I proposed:

**P6: Multidisciplinary team training, multidisciplinary team meetings and use of boundary spanning positions in multidisciplinary teams are positively related to strength of team identity, such that more prevalent is the use of such organisational/managerial techniques, the stronger the team identity.**

**Overview of Research Design**

With these preliminary relationships identified, a comprehensive mixed-method study was designed. Mixed methods (MM) research is defined as a research approach or methodology that employs qualitative research exploring the meaning and understanding of constructs together with quantitative research assessing magnitude and frequency of constructs (Gibson, 2017). MM is considered appropriate for research questions that call for real-life contextual understandings, multi-level perspectives and cultural influences (Creswell, 2003). It offers a pragmatic perspective that values
both objective and subjective knowledge (Morgan, 2007). Gibson (2017) examined the value of mixed-method research and concluded that mixed method research creates value by increasing generalizability across contexts and cases, by providing deep elaboration of phenomenon that cannot be understood by either qualitative or quantitative methods alone, for triangulation across evidence and instances and for interpreting complex patterns that would have remained superficial otherwise. Edmondson and McManus (2007) advocate that a mix of qualitative and quantitative data is particularly appropriate for developing or intermediate theory that draws from different bodies of literature to propose new constructs or theoretical relationships.

Research methods can be classified not only on the basis of type of data (qualitative, quantitative or mixed) but also on the basis of the source of data (single source versus multi-source) (Gibson, 2017). A single source data is collected only from the focal entity whereas a multi-source data is collected from both inside the focal entity and from outside of the focal entity (Gibson, 2017). Thus MM research design could be mixed method/single source or mixed-method/multi-source. Gibson (2017) in her analysis of MM research found that use of mixed-method/multi-source research is still very rare in organizational science in spite of its many advantages.

A qualitative study was designed to explore the views, experiences, beliefs and affiliations of individuals working as members of multicultural and multidisciplinary teams in hospitals with the intent of understanding the impact of intrapersonal identity dynamics on relational coordination within the team and work outcomes.

A qualitative design was deemed to be particularly relevant for gaining a deep insight into the context before commencing with the quantitative phase. Many scholars have advocated the use of qualitative research design to understand the context, to unfold the meaning of people’s experiences and to uncover the lived world prior to scientific explanations (Grbich, 2013; Kvale, 1996). Often, qualitative methods are believed to provide a 'deeper' understanding of social phenomena than would be obtained from purely quantitative methods alone (Grbich, 2013).

Ramarajan (2014) has suggested that qualitative methods are well-suited to understanding the identities that people hold. Similarly, others have argued that using only a quantitative survey-based approach to the study of identity makes it virtually impossible to fully examine the performative, embodied and narrative character of identities (Giddens, 1991; Ja´rvinen, 2004; Monrad, 2013; Zahavi, 2007). Furthermore, if it is not complimented by qualitative understandings, a quantitative approach
using closed-ended questions has the drawback of (in advance) delimiting the frame of meaning that respondents can draw upon when characterizing themselves, making qualitative preliminary work a necessary precondition for the quantitative investigation of identities (Monrad, 2013; Zuckerman, Kim, Ukanwa, & Rittmann, 2003).

A few studies have solely used a qualitative interview based approach to comprehend identity dynamics. For example, the Meister, Sinclair and Jehn (2017) paper mentioned earlier, which examined identities of senior women leaders working in male-dominated industries, utilized an in-depth qualitative design. Vough (2012) performed an interview-based case study investigating the accounts employees provided as they made sense of their identification with their workgroup, organization, and profession in an architectural firm. Interview based accounts were informative in understanding the content of “sense making” about identification and contributed to extending theoretical insights on the topic.

As another example, Creed, DeJordy and Lok (2010) carried out in-depth interviews to understand how homosexual ministers in Protestant denominations address the contradiction between their religious and sexual identities. They used interview methodology to understand the complex interplay of personal identities in an organisational context as this approach aligned well with their poststructuralist stance on identity construction in which personal identity is viewed as an ongoing reflexive accomplishment that addresses the questions “Who am I?” and—by implication—“How should I act?” Inductive, thematic analysis of the interviews helped to understand more fully the construction and contradiction of personal identities under investigation.

Essers and Benschop (2007) used narrative interviews to understand the complex interaction of ethnic and professional identities, specifically in female ethnic minority entrepreneurs. A holistic analysis of the interviews revealed how professional identities as entrepreneurs were constructed in situations when various identities were salient and contested at the same time. Interviews were deemed particularly relevant to investigate the processes by which identity categories were produced, experienced, reproduced and resisted in everyday life, and this holistic understanding was not possible by quantitative methods alone. Similarly, Pratt et al., (2006), through a 6 years qualitative study of medical residents, built theory about professional identity construction and in a separate study, Glynn, Barr and Dacin (2000) studied latent identity conflicts between professional groups in a symphony orchestra by conducting in-depth semi-structured interviews.
Still other studies have used a sequential mixed-method research design in which the qualitative phase is deemed very important and precedes or succeeds the quantitative analysis. For example, Kreiner, Hollensbe and Sheep (2006) examined how members of a particularly demanding occupation (e.g. priests) conduct identity work to negotiate an optimal balance between personal and social identities using both surveys and interviews. Similarly, Lammers, Atouba and Carlson (2013) used an explanatory sequential mixed data analysis of survey and interview data collected at an information technology organization to examine the relationships between group, organisational and professional identities and the experience of burnout. Ely (1995) examined how women’s proportional representation in the upper echelons of organizations affects professional women’s social constructions of gender difference and gender identity at work. Qualitative and quantitative data were used to examine the same phenomena from different methodological perspectives, in the spirit of triangulation. Qualitative interview-based analysis revealed important nuances in women’s experiences and provided a context for understanding and interpreting statistical relationships revealed in the quantitative analysis, and the quantitative analysis provided evidence to corroborate the findings from qualitative phase.

Using this approach, I combined qualitative and quantitative methods in a sequential, mixed methods research design (Creswell & Plano-Clark, 2011; Gibson 2017) to give both depth and nuances through a preliminary interview format followed by standardized systematic comparisons of large numbers of individuals through quantitative modelling. In the subsequent analysis, I have used both a ‘convergent validation approach’ (Gibson, 2017; Jick, 1979) focusing on the similarity that emerged from the qualitative and quantitative phases but also a ‘holistic/contextual approach’ (Gibson, 2017; Jick, 1979) by designing the quantitative phase to extend insights from the interview study. Thus, this sequential design not only allowed for triangulation but also elaboration of data.
Chapter 3: Phase I Exploratory Qualitative Study

Overview

The literature reviewed in earlier chapters suggests four important priorities for theory building. First, there is a need to understand which identities are salient in members of healthcare teams and also understand the ‘qualitative meaning’ of each identity in the specific context of multidisciplinary teams. Second, we know little about the structure and relationship between the identities that surface within an individual during team interactions, specifically whether they are independent of each other, arranged in a salience or prominence hierarchy, or whether they combine together to regulate social behaviour of individuals in multidisciplinary teams. Third, we need a better understanding of the impact of intrapersonal identity dynamics on interpersonal relationships and relational coordination within the team. Research so far has provided contradictory results where multiple identities are sometimes reported to lead to intergroup cooperation and harmony and sometimes to intergroup conflict and social division, and poor work outcomes. Finally, the literature lacks a clear delineation of potential organisational practices that can help mitigate the negative consequences of identity conflict and improve relational coordination.

To address these aspects of theory building, this qualitative study was guided by the following research questions: (1) What identities manifest in members of multidisciplinary healthcare teams and what is the content (meaning) of each identity that surfaces during multidisciplinary interactions? (2) What is the structure and relationship between multiple identities (independent, hierarchy, conflict, integration or synergy) that are held by members of multidisciplinary teams? (3) How do multiple identity configurations play out in interpersonal relationships, relational coordination, and outcomes? And finally, (4) What organisational practices can mitigate negative consequences of identity inter-relationships and improve relational coordination and outcomes in multidisciplinary teams?

Partner Organisations and Sample

The sample included members of multidisciplinary teams in two public sector Western Australian hospitals, namely, Hospital A and Hospital B. Hospital A is a regional hospital whereas Hospital B is a metropolitan hospital. Staff members were sampled from all departments that utilized the multidisciplinary model such as Medicine, Emergency, Intensive Care Unit, Sub-Acute/Rehabilitation and Surgery. The departments of Mental Health, Obstetrics and Gynaecology and Paediatrics were
excluded from the research design as per ethics guidelines. The interviews included both domestically and overseas trained doctors, nurses, allied healthcare professionals (physiotherapist, occupational therapist, dietitian, pharmacist, social worker) and healthcare administrators.

A total of 87 participants were included across the 2 hospitals, 53 in Hospital A and 34 in Hospital B. In Hospital A, we interviewed 24 doctors, 15 nurses and 14 allied healthcare staff. Amongst the 53 staff members interviewed, 22 were overseas born and trained, 24 locally trained and 7 were born overseas but received their medical qualification in Australia. In Hospital B, 10 doctors, 13 nurses and 11 allied healthcare staff were interviewed. Amongst the 34 staff members interviewed, 16 were overseas born and trained, 15 were locally trained and 3 were born overseas but had Australian medical qualification. Table 1 shows the demographic distribution.

Table 1: Demographic Distribution for Phase 1 Interviews

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Interviews</th>
<th>Doctors</th>
<th>Nurses</th>
<th>AHC</th>
<th>Overseas trained</th>
<th>Locally trained</th>
<th>Born overseas; Australian qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site1: Hospital A</td>
<td>53</td>
<td>24</td>
<td>15</td>
<td>14</td>
<td>22</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Site2: Hospital B</td>
<td>34</td>
<td>10</td>
<td>13</td>
<td>11</td>
<td>16</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>34</td>
<td>28</td>
<td>25</td>
<td>38</td>
<td>39</td>
<td>10</td>
</tr>
</tbody>
</table>

Data Collection

Data was collected using semi-structured interviews, held on-site in hospital buildings at participant’s convenience. The ‘structured’ dimension of the semi-structured interview format allowed for meaningful and standardized comparisons across interviews, whereas, the ‘unstructured’ aspect allowed for greater depth and individuality (Denzin & Lincoln, 2011). The flexibility of this approach, particularly compared to structured interviews, also allowed for the discovery or elaboration of information that was important to participants but was not previously thought of as pertinent by the research team.

The protocol included 24 questions pertaining to demographics, identity dynamics, relational coordination, managerial points of leverage and outcomes. The interviewer was also able to pursue interesting comments and themes arising within an interview in more detail; this unstructured
dimension allowed for greater depth and individuality in each interview and further allowed to explore intrapersonal and interpersonal dynamics in the team through interviewees’ perspectives. The interview protocol is attached as Appendix A.

The ‘identity’ section of the interview protocol contained questions to probe the nuances of identities under investigation. For example, to explore the meaning of ‘cultural identity’ interviews probed not only country of birth, but also other potential sources of cultural orientations, such as where participants had lived and worked and where they had received their medical qualification. Given that the healthcare systems in most first world countries are becoming increasingly reliant on overseas trained healthcare staff due to skills shortage (World Health Organization, 2018) and healthcare teams are becoming increasingly multicultural, I wanted to explore the meaning of ‘cultural identity’ as well as how it interacted with other identities such as organisation, profession and team.

Similarly, to clarify the content of ‘team identity’, the identity section had a question that asked whether the members identified with the whole department or a smaller sub-set within the department such as the set of staff on the roster that day, or the set of staff on a particular shift. Relationships between identities were explored by including questions on how individuals balanced the demands between their different affiliations such as the culture, team, profession and the organisation. The section on team processes investigated the extent of interpersonal coordination between team members and had questions around communication practices, patient coordination, proactivity in helping team members and sharing responsibility for errors among team members.

Questions on ‘managerial points of leverage’ such as prevalence and utility of organisational/departmental practices were also included. Finally, I asked about the quality of care provided by the team, as well as prevalence of objective measures of patient care outcomes such as patient and clinician satisfaction surveys. I also probed for recommendations that might improve relational coordination and patient care outcomes. The interviews were an hour in duration on average. All interviews were audio-recorded and informed consent was sought for this recording and for all other procedures.

**Overview of Coding Procedure**

Interviews were transcribed verbatim and this resulted in 1750 single spaced pages of text database. These language texts were analysed using N-Vivo 11, a computer based qualitative research package. Coding is a fundamental task in most qualitative projects—it involves gathering all the material
about a particular theme, concept or case together for further exploration (Glaser & Strauss, 1967; Strauss & Corbin, 1998). A code is the label you apply to a set of material; a word or short phrase to represent the selected data (Lee, 1999).

During the coding process, in order to develop insights into new phenomena, I utilized open coding, defined as “the analytic process through which concepts are identified and their properties and dimensions are discovered in data” (Glaser & Strauss, 1967, 2009; O’Reilly et al., 2012; Strauss & Corbin, 1998). Alongside this, I also engaged in ‘directed content analysis’ (Hsieh & Shannon, 2005) in which initial coding starts with a theory or relevant research findings and these themes are also investigated in the data. The purpose of this approach is to validate and/or extend a conceptual framework or theory (Miles & Huberman, 1994). In this step I engaged in a priori coding, using codes which had been constructed from existing theoretical perspectives rather than empirical observations (Crabtree & Miller, 1999).

I also further refined the code usage as it emerged, discussing with other experts in the field any discrepancies in code definitions to ensure a consistent understanding of when to apply a code. In keeping with interpretive research based on qualitative data (Locke, 2001; Miles & Huberman, 1994; Reay, Golden-Biddele, & GermAnn, 2006), throughout this analysis I moved iteratively between the data, the emerging themes, and existing theory in several phases.

Table 2 depicts the data structure that emerged.
### Table 2: Data Structure

<table>
<thead>
<tr>
<th>First Order Codes</th>
<th>Second Order Codes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of training and qualification as cultural identity</td>
<td>Content of Identity</td>
<td>Intrapersonal identity dynamics within multicultural and multidisciplinary teams</td>
</tr>
<tr>
<td>Country of birth as cultural identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rostered team for the day as team identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity strength</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrapersonal identity conflict</td>
<td>Intrapersonal Identity Conflict (within a person)</td>
<td></td>
</tr>
<tr>
<td>Navigating intrapersonal identity conflict</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive intrapersonal identity interactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural identity vs. team and professional identity</td>
<td>Interpersonal identity conflict (between people)</td>
<td>Interpersonal relationships within multicultural multidisciplinary teams</td>
</tr>
<tr>
<td>Professional identity vs. team and organisational identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navigating interpersonal conflict</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative impacts of identity conflict</td>
<td>Emergence of team identity conflict</td>
<td></td>
</tr>
<tr>
<td>Convergence to identity conflict</td>
<td>Relational coordination</td>
<td></td>
</tr>
<tr>
<td>Compilation to identity conflict</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient care coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proactively helping team members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary team training prevalence</td>
<td>Multidisciplinary team training practices</td>
<td>Managerial points of Leverage and Outcomes</td>
</tr>
<tr>
<td>Multidisciplinary team training utility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal (social) events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary Meetings prevalence</td>
<td>Meeting practices</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary Meetings utility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boundary spanners prevalence</td>
<td>Boundary spanning practices</td>
<td></td>
</tr>
<tr>
<td>Boundary spanners utility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence and utility of Communication training</td>
<td>Communication and leadership training practices</td>
<td></td>
</tr>
<tr>
<td>Prevalence and utility of Leadership training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient perception of patient care</td>
<td>Patient outcomes</td>
<td></td>
</tr>
<tr>
<td>Clinician perception of patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician job satisfaction</td>
<td>Clinician outcomes</td>
<td></td>
</tr>
<tr>
<td>Group affect</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### First Order Codes

The process of ‘a priori’ and ‘open’ coding resulted in a total of 38 first order codes. Table 19 (see page 154) contains these codes and sample excerpts for each. Rather than explain each of these first order codes, I briefly review several illustrative examples below.
**Cultural identity.** Although several respondents mentioned the country in which they were born as a source of identity, perhaps more interesting was that several respondents mentioned that the country where they received their medical qualification and training was a source of identity, and had a big impact on their views on organisations and teams. This was coded as “country of qualification and training as cultural identity”. Said one respondent:

*I would imagine the country of training would have some impact more than the country of birth. I think that somebody who’s born in a different country who then trains in a certain system - I imagine they would probably end up in that system because at least for me I had very little understanding of what actually happened in a medical team until I did my training and then the cultural norms were set by my training institutions, I think.*

Another respondent reiterated the importance of the place of medical qualification and training in these words:

*Having worked with a variety of different nurses and other allied health professionals from other cultures, I think it (the country of medical qualification and training) does impact. I think the health systems in which we grow up and that we’re trained in shape our paradigm of how care is to be delivered, in what manner it’s to be delivered. Possibly some of the philosophies that we have in regards to care, I think generally across all disciplines we have a value and a belief in assisting others. I think sometimes some of the differences come about in how we go about doing that and whose role what parts of that. So I think that’s how the culture affects.*

**Team identity.** As another example of a first order code, when asked about their team identity, respondents often talked about how they identified more with their rostered daily team or shift, rather than the whole department as a team, and this was coded as “rostered team for the day as team identity”. As one respondent said:

*I would probably look at my team as changing every day, depending on the shift that I’m working with. I mean yes there is one big group of, I don’t know, about 15 consultants, 20-odd registrars, probably about 16 residents and interns from the medical point of view, then there’s the senior nursing staff and the more sort of clinical based nursing staff. So there’s this one big team interaction but on a day to day basis the team would be who you’re working with on shift that day. There’s this sort of bigger group that your vision, the people that you’ll make your plans with for the future but you might not see them there for weeks.*

**Intrapersonal identity conflict.** Respondents often discussed the conflict or struggle they faced inside themselves, with respect to their affiliations with the organisation, team, profession and also their cultural identity in terms of overseas trained or locally trained, and these were coded as “intrapersonal identity conflict”. An example excerpt for ‘intrapersonal identity conflict’ is:
I sometimes feel a struggle between the organisation and my team and my profession. For example, the ICU (Intensive Care Unit) has limited patient beds and we as intensivists have clear practice guidelines on who can be admitted in ICU or not. Sometimes when the hospital bed capacity is full, there is pressure to admit patients in ICU who may not be critically ill and can be easily managed on the ward. It is a difficult decision to take because if we admit such patients in ICU, we might not have a bed for a critically ill patient who arrives later who actually needs the ICU support more; moreover my team will be deskilled over a period of time if we keep accepting patients who are not critically ill, it is also a waste of the hospital resources. My training as a doctor and intensivist suggests that we should only take in patients who actually need ICU support and this practice will be good for the team as well but then I also understand the hospital constraints.

This sentiment was echoed by a number of other respondents. Another respondent said:

It is difficult sometimes because the demands of the bigger picture of the hospital, so take for instance today. So the hospital as a whole, you know, we need to increase the amount of discharges because we don’t have any beds. So I take that on board at the senior management meeting in the morning but then when you come back to here I know what the capabilities are of the team within here. .... Yes, absolutely, with the demands of what is needed for the hospital business, compared to what I know is within safe working practice as a registered nurse of what we should and shouldn’t be doing...that would probably be, you know, a daily struggle.

Interpersonal conflict. Respondents also talked about interpersonal conflict within the context of the multidisciplinary team and these were coded based on the identities in conflict. For example, a common conflict was between “cultural identity versus team or professional identity”:

I think that where that person got their qualification, he was a psychiatrist and I think that psychiatrists ruled the world where he came from, whereas in the team that we were working in with him, it was a constant struggle to remind him that ......’Actually, I have something to contribute here and my profession has something to contribute here’ and, yeah, it was a constant problem... people come with their own interpretation of what a multidisciplinary team is and for some of those old school doctors it’s “Me up here and everybody else down there and they all better just do what I say” and that doesn’t work because that doctor doesn’t have social work skills, doesn’t have physiotherapy skills and needs those professions to consult.

Negative impacts of identity conflict. Respondents reported that intrapersonal identity conflict (internal conflict between their different affiliations), as well as interpersonal identity conflict (between members of the teams), had negative impacts. Respondents noted feeling stressed and frustrated and reported that their health and job satisfaction were negatively impacted. This was coded as “negative impacts of identity conflict”. As one respondent noted:

Working in healthcare multidisciplinary teams is difficult. When I came here, I had no concept of multidisciplinary teams; we had doctors and nurses but of course doctors run the show in my country. I
find that my enthusiasm for my job is decreasing and I feel very stressed because I feel pulled in different directions.

**Convergence of intrapersonal identity conflict.** Beyond these first order codes, an important additional code that emerged pertained to a process by which individual team members came to share a similar level of intrapersonal identity conflict. That is, even if each member originally held different degrees of intrapersonal identity conflict within themselves, over time this became more similar as they interacted together. This occurred as follows: Team member A may not be experiencing much identity conflict within themselves, but when working often with member B who has a high level of intrapersonal identity conflict, member A became increasingly aware of the internal identity conflict B and began to experience that internal identity dynamic as well. This emergence of similarity in intrapersonal identity conflict across team members was coded as ‘convergence of identity conflict’. As an example, one respondent noted:

*I think when a person is not happy within themselves or is stressed at work, it affects everyone in the team and that stress is shared across everyone. Over a period of time, there is a spill over effect and the team as a whole experiences conflict.*

Convergence of identity conflict implies that team members adapt to each other over a period of time as the team reaches a shared level of identity conflict. Consider one respondent who was an overseas-trained healthcare professional working in a new multidisciplinary patient care team. This professional noted a distinct difference in the norms of his new team as compared to his prior overseas medical training, which he described as a conflict between his team identity and his cultural identity. A specific instance where this came to the forefront pertained to how the team interacts with the families of the patients. The cultural norm for the newcomer was to avoid communication with the family around sensitive issues, but the team norm was to be open and honest with the patients’ families regarding the status of the patient. The newcomer hesitated to communicate directly with the patients’ families and this was interpreted as lack of communication skills or lack of empathy by other team members.

This event and the subsequent event cycle not only resulted in a new and different level of intrapersonal identity conflict in the newcomer, but as the members interacted and discussed this conflict, it also prompted identity re-valuation in other team members, such that they experienced new levels of identity conflict also. Over time, the overseas trained professional experienced less identity conflict, but the other team members experienced increasingly greater intrapersonal identity conflict.
Hence the level of identity conflict in each member became more homogenous over time. This could be said to indicate the emergence of a team level of identity conflict.

**Compilation of intrapersonal identity conflict.** As a final example of a first order code, analysis also revealed another way in which intrapersonal identity conflicts combine, which is more complex. In this instance, there is a re-occurring pattern of identity conflict across members, but not necessarily one in which all members adapt to others so that greater homogeneity occurs. Instead, in some teams, there was often an influential member whose identity conflict came to represent that of the group. Others may not have experienced a change in their own identity conflict over time, but yet the team was still characterized by the level of identity conflict held by the influential member. Often, this member held high status (i.e., the head of a department), but occasionally it was simply a particularly articulate or extraverted individual (even if low status). As one respondent (senior clinician and head of department) noted:

> When I joined this hospital around 4 years back, I came from a big tertiary hospital which had a team culture of people being very direct to each other. I started practicing here in the same way but the nurses interpreted my approach as authoritative and me not being a good team member. I think it was also because my training is not from Australia. In my country, communication training is not as important as clinical training but medical graduates here have good training. I was not aware of this but when I got to know how upset my team was and how it was leading to conflict in team, I talked to other doctors and nurses and changed my practice.

The event cycle described by the respondent shows how teams develop a level of team identity conflict that comes to characterize the team, but that it might not be due to convergence. Instead, a degree of variability or heterogeneity of identity conflict was retained across team members, but there is a re-occurring pattern that comes to characterize the team. Scholars such as Chan (1998), Fulmer and Ostroff (2016), and Morgeson and Hofmann (1999) have referred to this as ‘compilation process’ for the emergence of team constructs, hence the code ‘compilation of intrapersonal identity conflict’ captures what we observed in the analysis.

**Coordination of patient care.** As another example of first-order codes, many respondents focused specifically on the coordination of patient care. This was reported to be an implicit understanding of roles and responsibilities by different professional teams. As one respondent noted:

> Because it’s such a well-established structure in terms of roles and responsibilities, they are implied and assigned because it’s a well-established structure. In terms of priorities, certainly there is frequent discussion between the team members because priorities can change. For example, our physiotherapist may want to see the patient but the nursing priority may be more or a medical priority may be more.
Although priorities around patient care were discussed explicitly across team members in the cases of critical patients, most respondents felt there was sometimes a grey area regarding who was supposed to do what.

I think we have, I think we have a bit of a grey, bit of an overlap or a bit of confusion. Because we have a physio available, we think that they should be there for mobility assessment. If someone’s coming with asthma or pneumonia, we think that they should be looking at their chests. So because there’s an allied health team, I think roles that are educated with during your study are sometimes sort of taken away. The nurse could explore that overlap, those other roles of allied health.

This confusion regarding roles and responsibilities in patient care coordination was reported to lead to feelings of fear among staff that their traditional roles were being eroded and sometimes resulted in errors in patient care. Respondents indicated the need for members to be more flexible to undertake other people’s roles and responsibilities when the occasion demanded it:

I’ve been nursing since 1979 now, I think nurses are feeling threatened by the growth of other health disciplines who are doing jobs that traditionally were done by nurses. And I know that medicine’s feeling that too; nurses are now taking on more roles that were traditionally done by doctors, especially now we’ve got these nurse practitioners and what have you, so everyone’s feeling threatened, certainly within nursing and medicine, so there’s a lot of suspicion and fear within nursing that their roles are being eroded and taken away by social worker, by OTs (occupational therapists), by physiotherapists. I think it’s a false fear but I think there’s a bit of that going on.

Another respondent explained how if different professionals (such as doctors, nurses and allied healthcare staff) had agreed on a patient care plan, it was easier to share responsibility for outcomes. This also emphasized the need for more frequent collaborative discussion between different professionals:

I think if the care of the patient had been an agreed plan – so if for example while this patient’s been in hospital, the agreed plan was to do X, Y and Z and X, Y and Z were done and the patient was discharged home and then came back again with the same sort of complaint, I think there would be “Well, we did our best and it didn’t work”, so I think there would be some sharing of that. If there’s disagreement about that – like for example some team members are saying, “I think we should keep this person in and that they should go to rehab” and maybe the medical team say, “No, I disagree with this. Send them home.” [Then] if the person bounces back in, I think there is a little bit of, “Well, I told you so” and “I knew that that was going to happen” or, “That’s not what I wanted. If you’re disappointed, you probably need to take it up with them.” A little bit of a blaming sort of thing.

**Multidisciplinary team training.** Numerous first order codes captured techniques used by the organizations for training teams. Sometimes respondents discussed existing practices, other times they mentioned practices that were not currently in use, but that they thought would help. For example, within the code “multidisciplinary team training’ one respondent mentioned:
I think simulation multidisciplinary training would be extremely useful but maybe towards a greater goal, as part of a package of developing various skillsets like leadership for example. You know, because ultimately we expect all clinical staff, including doctors, to be leaders in our own field but to be leaders is not just to have an insane amount of knowledge or expertise in a field, it’s also about being able to bring out the best in each other and your team. And I think a lot of that depends on not just people management skills but communication skills and so on and that’s a huge part of working in a team.

As a second example of a first order code regarding practices, a number or respondents mentioned the ‘use of social (informal) events’ as a means of overcoming identity conflicts. Organising social events for bringing the team together were thought to be particularly useful by majority of the respondents. For example, one stated:

We’re quite big on that (use of social/informal events for team building) in Allied Healthcare Team. We try and do a lunch every month and that’s across the board for doctors, allied health, nurses. A few of us push that really hard. We’ve got kind of someone from each area that pushes that and that’s made a big, big difference to the way that the team works; it’s really brought the team together. We also have just other social events. If we want to do things together, we’ll try and suggest things - we have lottery syndicates – so we try and do things that include everybody and anybody that wants to be involved in it and it’s optional if people do or not; obviously it’s not compulsory that they should.

First order codes capturing outcomes. Respondents expressed that a lack of coordination resulted in poor outcomes of a variety of different types. For example, interviewees often provided examples of how a lack of relational coordination resulted in ‘errors in providing patient care’ which became an important first-order code. Communication breakdown and ambiguity regarding roles and responsibilities often caused a break in the care. One respondent indicated:

I was involved in a medication error not too long ago and it was actually the doctor’s fault. He prescribed the wrong thing but we didn’t have the medication so I sent it to pharmacy and they sent me the medication back and they said pharmacy should have also picked up on it but then I gave it and they said “Firstly it shouldn’t have been prescribed and then the pharmacy should have picked up on it” but then I copped the blame and the doctors, they just said, “Oh, sorry about that” and I was like “Oh”. Yeah, but usually that’s the hard thing: a lot of it does come back to the nurses because even if a wrong medication is prescribed or a wrong order’s given, if we give it we’re accountable, yeah, not the doctor.

As a second example of an outcome first-order code, respondents mentioned ‘patient readmission rates’ as an outcome affected by coordination. This issue appeared to be related to differences in priorities of different professional teams, and represented a dilemma between ‘efficient bed management’ and possibility of patients bouncing back with the same problem in the hospital. As explained by one respondent:
We need the beds because the patients that are sitting in ED (Emergency Department) are at risk but also there’s no point in sending a patient home unless you’ve had a completely multidisciplinary input and the patient’s got the supports at home that they need so they’re not going to bounce back through the door and again be a strain on the system. Yeah. And that happens and that happens when everybody’s under stress.

As a third example, many respondents mentioned ‘patient perception of patient care.’ Interestingly, when asked about patient satisfaction surveys, some said that they were not aware of any such survey being done at the hospital or department level. This indicated that probably either the surveys were not being conducted regularly or clinicians were not getting any feedback on the surveys conducted. Said one respondent:

I don’t know. I know we’ve got like customer feedback and complaint forms which are readily available to patients. So, you know, if they wanted to give feedback they could do it that way but I’m not aware of a patient survey.

A final example of a first-order code for an outcome is ‘group affect’ (George, 1990; Mason & Griffin, 2003), which has been defined in the literature as a shared perception of moods and homogeneous emotional states within a team (Shin, 2014), and represents an aggregate of the moods of the team members (Sy, Cote, & Saavedra, 2005). It was interesting to note that this developed specifically as a reaction to poor coordination, and was mentioned as a “daily struggle.” One Nurse Unit Manager (NUM) noted:

The demands of what is needed for the hospital business, compared to what I know is within safe working practice as a registered nurse of what we should and shouldn’t be doing... that would probably be, you know, a daily struggle... It becomes difficult and when I am stressed because I have to keep switching my priorities, it comes up in my behaviour and affects my team as well.

Second Order Codes

In Phase 2 of the analysis, I conducted axial coding, aggregating the first order codes into second order codes. Charmaz (2006) explains that axial coding re-assembles data that has been divided into separate codes. Axial coding can be used to investigate conditions or situations described in interviews, their actions and consequences by ‘relating categories to subcategories along the lines of their properties and dimensions’ (Strauss & Corbin, 1998, p. 123). The aim of axial coding is to add depth and structure to existing categories (Charmaz, 2006). This included relating concepts to each other and coding across concepts to identify themes for the relationships between variables. I also made comparisons and contrasts across respondents, which Miles, Huberman and Saldana (2014) identified as a helpful tactic for conclusion drawing and verification of aggregate themes.
I arrived at a set of 11 second order codes: (1) content of identity, (2) intrapersonal identity interactions (within a person), (3) interpersonal identity conflict (between people), (4) emergence of team identity conflict, (5) relational coordination, (6) multidisciplinary team training practices, (7) meeting practices, (8) boundary spanning practices, (9) communication and leadership training practices (10) patient outcomes, and (11) clinician outcomes. Illustrative examples of the second order codes are discussed below.

**Content of identity.** This second order code included the various affiliations and identities important to an individual within a multidisciplinary team such as ‘country of qualification and training as cultural identity’, ‘country of birth as cultural identity’, ‘organisational identity’, ‘professional identity’ and ‘rostered team for the day as team identity’. This code captured all the identities that became salient within an individual during multidisciplinary team interactions. Exemplifying this set of codes, one respondent said:

*Working as a member of a multidisciplinary team is a difficult task. I think the medical training as such teaches you that your opinion is right and it has to be based on medical facts. I take pride in my profession, in being a doctor and this sense of medical superiority was reinforced at my training institutions. Increasingly, I am realising the importance of other team members such as nurses and physiotherapists in the team but deep down I still carry that baggage (of medical superiority).*

In the example above, the respondent is referring to the pride s/he takes in their profession (professional identity) and the impact of the training institutions (cultural identity) in inculcating this strong professional identity and how this cultural and professional identity is in conflict with the team identity. Thus, it becomes apparent that multiple identities are activated at the same time and contested in the multicultural multidisciplinary context.

The team was often mentioned as an important source of identity, and coinciding with the literature (Ashforth & Mael, 1989; Henttonen et al., 2014; Mitchell et al., 2015; Mitchell et al., 2011), I came to code such insights as indicating the “strength” of the team identity. Research evidence shows that team identity enhances team collaborative behaviours and perception of shared goals (Chen & Tjosvold, 2002; Eckel & Grossman, 2005; Sethi et al., 2001). I noted instances when the team identity was the strongest affiliation that the person seem to hold. An example of this is:

*I guess my definition of a team is a group of clinicians or group of people working together using their expertise, training, values, to come together to ultimately provide care for a patient using the patient and their carers as part of that team as well, so we’re all focused on the same goal.*
However, other respondents did not show a strong team affiliation and demonstrated more allegiance to their profession or culture:

*I look at my team as in my Occupational Therapy Department team because that’s where we do all of our training and discuss our profession. But if I was really to think I’d probably think more allied health [my profession].*

**Intrapersonal identity conflict.** This second order code captured not only the conflict than an individual faced within him/herself between cultural, organisational, team and professional identities, but also how individuals navigated such intrapersonal conflict. An example excerpt is as follows:

*...sometimes I feel like there is a conflict between what your profession and the team, and the organisation demands. And often, you know, one of the values of the AASW, the Australian Association of Social Workers is around self-determination and that becomes a real sticking point when you start talking with people about somebody’s competency to be able to make those decisions. And, you know, poor old Mrs Smith is saying she wants to go home because she wants to look after her dog and that and as a social worker I should be supporting that but as part of the MDT they may well be telling me that Mrs Smith actually doesn’t have the ability to make those decisions. So, yeah, sometimes it is a conflict.*

The same respondent continues on how she manages such intrapersonal conflict:

*I think for us that (different identities/affiliations) becomes very interwoven because there are times when if I just stood on my morals as a social worker, we would have a hospital full of homeless people that have no family support, that have issues of living in the community and the addicts and that, you know, like if I just stuck to that. I have to balance the allegiance of the healthcare system and the hospital, so I have to balance the bed management, if you like, with my profession, our social work profession. So in most cases it’s around, you know, good safely timely discharge.*

Interestingly, very few respondents indicated positive interactions of identities under investigation, suggesting that it is rare in this setting to experience benefits from their multiple affiliations. Given how seldom these positive interactions were mentioned, it was difficult to discern from the transcripts whether these were instances of identity integration, defined as blurring of boundaries between different identities so that they were seen as one identity, or whether these identity interactions resulted in identity synergy, where the distinction between various identities was maintained, but co-activation of such identities resulted in positive results. This was noted as an important area for subsequent research. For example, one respondent, talking about cultural identity in terms of the country of birth, mentioned how that affiliation interacted with his organizational identity:

*I think certainly coming from Malaysia, which is where I was born and having lived in Malaysia and Singapore, there are cultural differences compared to Australia, I think mainly related to the view of family relationships and dynamics but also a lot more to do with respect for elders in society and families*
and I think at least personally I like to think that I've carried over that respect for my elders to my workplace.

**Interpersonal identity conflict (between individuals).** This code included conflict between individuals in the multidisciplinary team arising due to their cultural, organisational, professional and team affiliations. The code also included how team members navigated such interpersonal conflict. In the example below, the respondent is describing how his professional and cultural identities result in conflict with other professional groups in the team:

> When I left (my country), there was a compartmentalisation of medical and nursing care and there wasn’t a concept of this (multidisciplinary) team. I think the medical training as such teaches you that your opinion is right and it has to be based on medical facts and when you do get questioned from a nursing staff or allied health staffs, you can take it personally and sometimes unwillingly take your focus off the patient and it becomes personal for both the parties involved. So for example, when I came to Australia I had a lady. She was quite ill, quite terminal 80 year old lady, and she was at a risk of aspiration. So she wanted to eat ice cream but with the aspiration, when people are quite drowsy they can get it in the wrong way and it can go into the lung. But given that lady was likely to survive less than a day, I said, “O.K. Well, I’ll get you an ice cream”. So we authorised it but the speech pathologist as a part of allied health team, she felt quite uncomfortable with the decision and felt that it was very inappropriate. But my medical training till that point suggested that if a person is at the end of life you could be relaxed. But I had allied health staff and nursing staff alter my decision which caused some distress to the patient. And I really wish that the lady would have been able to fulfil her wishes.

Respondents discussed various means by which they navigate interpersonal issues. Most respondents indicated that they resolve such conflicts by putting ‘patient safety’ at the centre of the service they provide:

> I suppose I always come back to my core training. When we were trained, it was if you can always answer “why”, and it’s “for the better of the patient’s interest”, then that’s not ideally breaking any rules of law or, any kind of ethical rules. Then you should be able to come up with a plan that works within the policies, procedures, etcetera, that’s best for that patient.

Some respondents reported that honest discussion across team members and a holistic understanding of the context helped to resolve interpersonal conflicts. For example:

> I try and take a fairly open view and be sensitive to other people’s opinions and try and gain an understanding of where they’re coming from. So I’ll question, I’ll ask, seek clarification, to better understand where they’re coming from, because their point may be very valid and it might be that I need to change my point of view.

However, some respondents seemed to accept interpersonal conflict as a battle they did not want to fight as in their experience they did not have a fair chance of making their point of view heard
or appreciated. An allied health care professional explained how he navigates interpersonal conflicts in these words:

I would say ultimately that, look, the way our health system is structured – and I say this quite regularly to the consultants (senior doctors) – “That’s fine, you’re entitled to discharge your patient. It’s under your bed card. This is my recommendation. I’m not going to force you to follow that recommendation. This is what I think. I’ve documented that I don’t think the patient’s safe to go” if that’s the case and they can make their call from there to be honest. Yeah, I don’t see any point in really fighting that battle any more than it needs to be. Ultimately the legal responsibility falls with the consultant for that team and should anything happen it will come back to them and my documentation.

Hence, the interview analysis indicated that interpersonal identity conflicts across members of multidisciplinary teams were common, and that a variety of strategies were utilized to resolve them.

Emergence of team identity conflict. As another example of a second-order code, I combined the first order codes ‘negative impacts of identity conflict’, ‘convergence of identity conflict’ and ‘compilation of identity conflict’ into the second order code ‘emergence of team identity conflict’. Respondents often discussed feelings of stress and frustration they experienced when they had to make ‘trade-offs’ across the identity demands, meaning that they could not fulfil the demands of a particular identity, if they were enacting other identities.

Respondents also discussed how their team was negatively affected by their internal conflict just as they themselves were impacted by the identity dynamics of other team members. What often seemed to arise as a result of this was negative group affect, as the follow quote exemplifies:

I do believe negative vibes are contagious and can be picked up by the team members. I often feel stressed and upset because I have to keep juggling my priorities. It is a vicious circle. If I am upset, however hard I try, it comes up in my behaviour and I would say something to the nurse who then might say something to a junior doctor and it affects the whole team.

And finally, as mentioned above, a novel insight into the identity dynamics within the team was revealed in that there appeared in most teams to be an emergence of a ‘team level identity conflict’ which was due to either convergence or compilation processes. One respondent explained the emergence of team identity conflict in these words:

I think when a person is not happy within themselves or is stressed at work, it affects everyone in the team and that stress is shared across everyone. Over a period of time, there is a spill over effect and the team as a whole experiences the same level of conflict.

Relational coordination. As another example of a second order code, ‘relational coordination’ collated the first-order codes of communication practices, coordination of patient care, proactivity in
helping team members and sharing responsibility for errors. For example, most respondents noted the prevalence of both formal and informal communication channels between team members but felt the need for more collaborative communication across different professional teams within the multidisciplinary team. This was summed up by a respondent in the following way:

_I think the primary thing which is prevalent in health care is having the medical staff as the primary leading care but also the primary facilitator of the communication between the team. I don't think that happens here consistently...I think there's a lot of requests given or instructions given from the medical team but I don't think there's a lot of collaborative discussion, certainly not proactively._

Communication across disciplines was particularly challenging as expressed by this respondent:

_The communication between nurses is really good; like we’re constantly talking to each other. With doctors not so much, not verbal anyway. If there’s any orders or anything the doctors want the nurses to do, the only way we’ll find out is if we read patient notes; they won’t actually verbally tell us. And it’s really frustrating sometimes because you won’t get a chance to read the patient notes till hours later and you’ll look and you’re like, “Oh, I haven’t even done that. They didn’t even tell me”. Actually, it happened yesterday. I only read the notes in the afternoon. I sat down to write my notes and the doctors had done a round between seven and eight in the morning and I saw that they said that they wanted the dressing taken down. I said, “Well, I haven’t done it because they didn’t (verbally) tell me.”_

Analysis of interview transcripts indicated that communication was seen by most professionals to be the most important skill in a multidisciplinary context and almost all interpersonal issues were thought to be a result of communication breakdown between team members. There seemed to be silos across different professional teams within the multidisciplinary team and a lack of good communication which left many feeling undervalued and unappreciated. Many overseas trained professionals identified communication as their biggest challenge in adapting to their teams. These respondents often discussed the influence of their cultural norms on communication within the team and need for better communication training.

**Points of Leverage.** Finally, several of the second order themes pertained to points of leverage the hospitals utilized which helped to mitigate identity challenges. For example, as mentioned earlier, ‘training practices’ included multidisciplinary, non-clinical team training, which brought together all factions of a multidisciplinary team. This was rare but considered very important by most professionals. Most professionals reported not receiving any formal multidisciplinary team training at their organisation and a very few indicated that it was conducted informally on an ad hoc basis during ward rounds. As one respondent said:
No, not as such. I feel like they, as in the organisation, make the assumption that you will use your initiative in resourcing the multidisciplinary teams that are available or you might find out about some service by chance, you know, or by mistake or by liaising and learning from other staff members than actually having a day, saying “You’ve got all these services available” or a little directory or something, “This is the correct process for accessing them”, no, nothing like that.

Most professionals seemed to agree that multidisciplinary team training could be very useful in improving relational coordination among team members as also improving patient care outcomes. Some deemed it to be particularly useful for overseas trained staff who might have not worked in multidisciplinary teams before or as an intervention measure for teams having problems as regards relational coordination. For example:

I’m quite certain it will make a difference because, look, I am a strong proponent of a multidisciplinary approach in patient care and I personally feel that when people are actually chosen for a given job, more concentration is actually given on the clinical work and all over training is normally focused on the clinical work and not much emphasis is given to the non-clinical aspect which is equally important, if not more. So I’m quite certain that it’s an important aspect and if some training is given to senior and junior doctors and the nurse and allied health people together it will certainly help in patients’ care.

**Meeting practices.** Another second order code pertained to meeting practices. For example, all departments in both hospitals were reported to have weekly or fortnightly multidisciplinary team meetings. Such meetings were also reported to be conducted on a daily basis during hand-overs between shifts.

*Multidisciplinary meeting in ICU happens on every Tuesday for half an hour from 11:00 to 11:30am and we chose this time just to make sure that all the team members could attend that meeting. The consultant on the day takes the responsibility, every other team member would be present and we talk in details about the patient needs as far as different allied health input is required and during that time all the team members are more than welcome to give their input in the discussions. And that way I think it has really helped us to bridge the gap where every team member feels a part of the team and I think it makes a huge difference and the feedback I’ve got from different team members is that it has actually helped quite a lot and I’m quite happy with that.*

**Boundary spanning practices.** I also included a second order code around boundary spanning practices. Boundary-spanners such as shift or ward coordinators were commonly used in most multidisciplinary teams but case coordinators were not being used in the hospitals I carried out the interviews in, for example:

*We have on every shift a shift coordinator who on the weekday mornings is a clinical nurse specialist who’s the most senior nurse under the nurse unit manager. And then we have clinical nurses who are higher level nursing staff. But it’s usually always a very senior registered nurse or clinical nurse that
coordinates the shifts because they receive communication from the nurses under them, they receive communication from the allied health and they will communicate with allied health and medical staff.

**Communication and leadership training practices.** Several practices mentioned pertained to training for not only individual members but also for the team as a whole. For example, respondents described leadership and communication training. Both individual and team communication skills were unequivocally described as very important. Many emphasized the need for better communication training:

*Communication training is important. I think in general how to communicate is very important. If you know how to communicate then you can be in any team or the rules of communication like, you know, you are to listen, you are to acknowledge and not to blame anybody and build that team spirit.*

**Patient and clinician outcomes.** A final set of second order codes pertained to outcomes experienced and efforts to improvement them. For example, the second order code ‘patient outcomes’ captured quality of patient care provided by members of multidisciplinary teams, such as errors, bed capacity and patient readmission rates, as well as patient and clinician perception of patient care provided. These were all very frequently mentioned as an outcome of poor coordination. In addition, a few pointed out that there was little effort to improve on patient care, including serious flaws in the patient satisfaction surveys conducted:

*Well, there is a patient satisfaction survey. It has, as you'll know from research, it’s got such bad methodological problems that it’s pointless. It’s a voluntary survey and the hospital’s paid someone to do a voluntary survey which means that you have less than one per cent of people who come to the department will respond, many of them are quite upset and it would seem a very clear selection bias that people who are upset enough to want to respond are the ones that respond whereas people who’ve thought it was O.K. probably don’t. So I don’t know about that.*

As another example of a second order code, ‘clinician outcomes’ collated information regarding clinician satisfaction and group affect among the clinician teams. For example, the topic of clinician satisfaction came up in several interviews. A few at one hospital site indicated that a clinician satisfaction survey was conducted for the first time in their organisation but was more about satisfaction of clinicians with administration rather than their experience of working in multidisciplinary teams. Others indicated that such surveys are not really needed as most people understand the issues, even though actions were not being taken to address them:

*Look, I think we know what the issues are. We don’t need a survey to tell us what the issues are - the same issues keep coming up every time – so people feel not listened to, they don’t feel valued. And it’s little things, like having somewhere to go and have your lunch, all those sorts of things that really irk people and not having enough staff, having to do lots of overtime.*
**Theme Development**

In the final phase of the analysis, I derived three themes which integrate across the second order codes (see Table 2). Formally, a theme is defined as an implicit topic that organizes a group of repeating ideas that enables researchers to answer the research question (Ryan & Bernard, 2003). It contains codes that have a common point of reference and has a high degree of generality that unifies ideas regarding the subject of inquiry (Bradley, Curry, & Devers, 2007; Buetow, 2010). Theme development typically involves examining the codes and collating data to identify significant broader patterns of meaning within the data (Grbich, 2013).

Specifically the three major themes that I elaborate upon below in my findings section include: intrapersonal identity dynamics, interpersonal relationships, organisational and managerial points of leverage and work outcomes. The first theme on ‘intrapersonal identity dynamics’ collated second order codes of content of identity, intrapersonal identity conflicts, positive intrapersonal interactions and strength of team identity; thus all intraindividual multiple identity dynamics was included in this theme. The second theme related to ‘interpersonal relationships’ captured between-individuals identity dynamics and ways in which individuals navigate interpersonal conflicts, including the emergence of team identity conflict through the processes of convergence and compilation. The final theme included discussion of all organisational and departmental practices that could potentially lead to better relational coordination in the team and better outcomes, as well as the outcomes themselves. These themes help to provide answers to the initial research questions and in doing so extend theory. Each theme represents extensions of prior theoretical and empirical work. Below, I elaborate on the themes and their implications, and in doing so develop a theoretical model and propositions to guide future research and theory development.

**FINDINGS**

The analysis revealed important insights that create a nuanced understanding of multiple identity interactions in complex multidisciplinary teams. I derived three critical findings from our analysis, which I elaborate on here: (1) intrapersonal identity conflict represents the interplay between deep-structured and situated identities within the individual, (2) as interaction occurs, a team-level identity conflict emerges to characterize the team and conflict affects coordination, (3) coordination affects outcomes but is mitigated by practices that reveal and clarify priorities and roles in the team.
Intrapersonal Identity as Interplay Between Deep and Situated Identities

A novel finding derived from this analysis pertains to the content of the identities held and the nature of the interplay between them. I found that it is important to consider the qualitative meaning or ‘content’ of identities specific to the context in which they are invoked. In this context, the country in which a participant received their healthcare qualification was a more prevalent source of cultural identity and had a bigger impact on medical practice than country of birth. This was somewhat of a surprise given that cultural identity is usually taken to be synonymous with national identity. Yet the importance of country of qualification was expressed by nearly all of the respondents. Prior research does indicate that education and its primary components - curriculum, teaching and learning - are a major socio-cultural venue from which an individual’s experiences and identities are invented, racialized and remembered (Brock & Tulasiewicz, 2018). Because of the strong relationship between education and culture, it makes sense that an important element of cultural identity is the country where the individual received his/her education. Similarly, Kleinman et al. (1978) asserted that health care providers bring with them into the patient care setting their unique training within specific health care systems and there are negative consequences of ignoring these aspects of culture in provision of patient care.

Indeed, the overseas trained versus locally trained conflict came into play often in the hospitals I examined, suggesting that an important component of cultural identity is often defined by where qualification is obtained. This finding corroborates recommendations provided by Kirkman et al. (2017), in that they argued that researchers should not assume that culture equals country of birth, and should instead explore other ‘containers’ of culture besides country of birth. I extend this approach by providing empirical evidence that ‘country of birth’ is not always the best indicator of cultural identity and researchers should clarify the meaning of “cultural identity” in the specific context in which it is being investigated.

Related to this, I gathered insights regarding the content of team identity. Multidisciplinary teams represent ongoing and sustained relationships between different functions within a department, although the composition of the team changes according to the roster. This means that on a given day/shift, different doctors, nurses and allied healthcare professionals from a given department might come together for management of patients depending on the clinical roster. I found that respondents identified more with the daily rostered team rather than the whole department or multidisciplinary team, indicating that ‘team identity’ is based more on the degree of interaction, rather than the formal
designation of a “department”. This again reiterated the importance of understanding qualitative meaning of the identity under investigation in identity research.

With regard to professional identity, I found that this referred to the allegiance to the professional values, and that this is somewhat unique in the multidisciplinary context. For example, doctors often discussed the ‘sense of ownership’ they had around clinical governance and decision making process in the team and the pride they took in being in the medical profession. An often repeated explanation provided for having a strong sense of ownership around clinical governance issues was that the medical team, and particularly the consultant (senior most doctor on the shift), took all responsibility for patient outcomes in the team context. This was expressed by a consultant doctor in these words:

You take everybody’s opinion but if I am accountable for patient care then it has to be my decision. If for example you look at mortality then nobody is going to question the physiotherapist “Why is the mortality high?” or something or nobody is going to question the dietitian, so the final responsibility rests with the consultant doctor who I think should have the final say.

I found that organisational identity was often discussed in terms of hospital demands and the pressure respondents felt in adhering to the key performance indicators for the hospital. Most respondents, unless they were in administrative roles, discussed the impact of cultural, professional and team affiliations more frequently than their organisational affiliation. This indicated that most respondents did not have sufficient understanding of the big picture of healthcare and hospital demands but were more concentrated in their efforts as regard their professional and departmental affiliations.

In terms of the nature of the conflict among these identities within the individual, I found that health care professionals universally noted the conflict they experience among their different identities (cultural, organisational, professional and team identities) as they interact within multidisciplinary patient care teams in hospitals; the examples provided for positive identity interactions were few and far in between. This is in line with early evidence from multiple identity research that suggests that effects of conflict among identities are stronger than other types of relationships among identities (Gibson et al., 2016). The interview analysis reiterated these findings in the sense that respondents discussed the intrapersonal identity conflict in more concrete terms than positive identity interactions, providing examples of how they struggle to balance the demands of each allegiance within a multidisciplinary team context. Analysing examples provided for intrapersonal identity conflict, it becomes clear that such intrapersonal identity conflict arises when the norms associated with each of
the identities become salient at the same time and the individual experiences conflicting social norms. For example, one respondent noted:

_I sometimes feel a struggle between what is good for the organisation and for my team and for my profession. For example, the ICU has limited patient beds and we as intensivists have clear practice guidelines on who can be admitted in ICU or not. Sometimes when the hospital bed capacity is full, there is pressure to admit patients in ICU who may not be critically ill and can be easily managed on the ward. It is a difficult decision to take because if we admit such patients in ICU, we might not have a bed for a critically ill patient who arrives later who actually needs the ICU support more; moreover my team will be deskilled over a period of time if we keep accepting patients who are not critically ill, it is also a waste of the hospital resources. My training as a doctor and intensivist suggests that we should only take in patients who actually need ICU support and this practice will be good for the team as well but then I also understand the hospital constraints._

Here, the respondent is describing how organisational, team and professional identities are manifested at the same time and that they experience a conflict between these identities as they are making contradictory demands on the clinical decision making process.

Recent research integrating social identities with neurobiological science has established that individuals who primarily rely on a single identity have clearer normative guidelines to follow, while those with more complex identity structures are more likely to encounter conflicting social norms (Hirsh & Kang, 2015). My findings not only provide empirical evidence for such intrapersonal identity conflict in complex multicultural and multidisciplinary teams but also extend these theoretical understandings. Specifically, I found that the conflict often occurs as a result of the interplay between deep-structured and situated identities in a given context. Certain identities were chronic and context independent (for example, professional identity and cultural identity) whereas other identities were more transient and context specific (for example, organisational and team identities). Identity research does make a distinction between identities that are deep-structured and those that are situated (Horton et al., 2014; Rousseau 1998), defining deep-structured identities as fundamentally shaping one’s self definition, whereas situated identities are defined as dependent on the presence of situational cues (Horton et al., 2014). However, I am not aware of any empirical studies that investigate the interactions between deep-situated and surface identities in an organisational setting.

In the identity literature, identities that are not explicitly salient or situationally relevant are assumed to not have an impact on people or outcomes. In the examples provided by respondents, ‘professional identity’ and ‘cultural identity’ emerged as more deep-situated/chronic identities that manifested irrespective of the context, and yet organisational and team identities were also expressed
and influenced interactions. They became more salient with certain situational cues, but even when such cues were not prevalent, they were present none-the-less.

For example, although all clinicians talked about their strong allegiance to their profession, clinicians in management roles such as Nurse Unit Managers (NUMs) and Head of Departments (HoDs) were more likely to point out the discrepancies in the professional, organisational and team demands of patient care. As one Nurse Unit Manager explained:

_There are a lot of conflicts and in the nursing management role -- you're sort of in the middle. So you have the staff providing the care but then obviously you have the expectations of the hospital and then the organisation as a whole, you know, as in the region. So it's a balancing act every day, actually, because your (my) allegiance is with the nursing team and the care they provide because it's really important - they're the direct contact with the patients and the community – but unfortunately the expectations of the organisation and the KPIs around that make it quite challenging._

In the example above, it is evident that being in an administrative role as a NUM has made this person increasingly aware of the contradiction in hospital, team and professional demands within the multidisciplinary context. The respondent has a strong affiliation to the nursing profession (deep structured identity) but her role as a NUM has triggered her organisational affiliation (surface identity) as well in the multidisciplinary context.

Another respondent explained how it was a struggle to develop a team focus when people were always wearing their ‘professional hats’:

_Despite our professional education, each one of us is being paid to do the same job and that is to assess the needs of older people. You obviously bring your own clinical experience into that but we're all trying to do the same job. So I'm frustrated mainly by social worker or occupational therapists or nurses telling me "I look at it differently, though". Of course you do but you're still being paid to do the same job and when people tell me that that impacts on their productivity, that's when I find I've got a real challenge. Yes, just because you're a nurse or a social work or an OT, just because you're that doesn't mean that you shouldn't be able to have the same productivity as someone else. You can't hide behind your professional background as an excuse to not be as productive as the other members of the team and that's a real challenge I'm having at the moment. Some people can't take off their professional hat, you know. My challenge is to keep the team that I manage with the same focus and not be able to sort of use this idea that "I'm this or that profession and therefore I have to do things differently". You have to have a team perspective._

Again, this example demonstrates that professional identity remains in chronic salience and is therefore a deep-structured identity that impacts multidisciplinary team interactions in a significant way. In this sense, professional identity emerges as a focal identity in multidisciplinary team interactions
and is often in conflict with the organisational and team identities, and the interaction is made more complex when ‘cultural identity’ in terms of overseas or locally trained comes into interplay.

**Emergence of Team Level Identity Conflict and Effects on Coordination**

Respondents provided rich narratives of how interpersonal identity conflict is ubiquitous and widely experienced by team members. I found that difficulties in patient care coordination arose due to differences in norms associated with different identities that the care providers hold. For example, respondents reported that ‘cultural identity’ might influence the team affiliation of team members and when everyone had a different conceptualization and understanding of multidisciplinary team function based on that cultural identity, it led to confusion and misunderstanding between members in multidisciplinary interactions. Said one respondent:

*I guess one of the points I’m aware of (in terms of interpersonal conflict), is that my view of how the multidisciplinary team works may be completely different to other members of the team and that may be because I have a completely different perception of it and that might be part of the problem.*

The same respondent continues,

*A specific example I can think of would be doctors who were trained in a medical culture that is less egalitarian than an Australian culture and where there’s very much a male-dominant society and I have seen occasions in this hospital where that doctor, a male, has been the leader of a multidisciplinary team as a doctor and many of the allied health staff are female and there’s already a potential, some divide there and it’s caused, I think, friction in the way that people have interacted in terms of how people are treated, how people feel they are valued in a multidisciplinary team.*

Similarly, respondents mentioned that interpersonal conflict was often a result of different norms and priorities associated with each profession, which resulted in a silo effect across different professional teams within the multidisciplinary team. Indeed, one of the most common reasons for lack of relational coordination or interpersonal conflict was cited to be the centrality or permanent salience of professional identity of members across all situations. One respondent noted:

*I think there needs to be increased realisation and coordination across the discipline. I still believe there is a fragmentation of communities within the multidisciplinary team. I think the medical community to my unit still is slightly cut off from the nursing community, which might be cut off from the allied health community.*

Analysis indicated that these identity conflicts were often evident in the hand-offs among care providers, and achieving consistency and high quality care is a critical challenge in the face of lack of adequate communication and patient care coordination efforts. Part of the key to addressing this is
likely recognizing the emergence of a team-level sense of identity conflict that comes to characterize the team.

Team-level identity conflict is a novel construct that has not been explored in identity literature. As mentioned previously, this analysis indicates that this team-level identity conflict arises due to both convergence and compilation phenomena. That is, in some teams, I witnessed the emergence of similarity in level of individual members’ intrapersonal conflict pattern, but in other teams the team-level conflict that arises may be different from the additive aggregate effect.

Researchers investigating emergence of collective entities in social systems have discussed the various ways by which such entities emerge in groups and organisations. For example, Klein and Kozlowski (2000) developed a typology for understanding different forms of emergence in social systems, ranging from composition to compilation. In composition forms, emergent processes, such as interactions and interdependencies, allow individuals’ perceptions, feelings, and behaviours to become similar to one another. The end result of the emergent process in composition forms is assumed to be low variance or consensus of individual-level elements (Chan, 1998; Hazy & Ashley, 2011).

In contrast, compilation is based on the notion that a particular configuration or pattern of individual elements manifests as the emergent property. There is variability across the individual elements, but they combine in such a way that complement and fit with one another. The interviews provide preliminary evidence that, in addition to a composition process, there is a compilation form of team-level conflict that emerges in the multidisciplinary team.

**Effects of Identity Conflict are Mitigated by Practices that Reveal and Clarify Priorities and Roles in the Team**

For my final theme, I found that negative consequences of identity conflicts can be alleviated by organisational practices that reveal and clarify priorities and roles of each function within the multidisciplinary team. These practices help to reduce in-group and out-group distinctions, promoting and emphasizing the accomplishment of shared organizational priorities, while also acknowledging the variety of identities members bring to the team. This latter feature of such practices is particularly important given the conflict that often arises is due to the difficulty in navigating multiple identities.
Respondents identified and discussed several practices such as multidisciplinary team training, multidisciplinary meetings, use of boundary spanning positions, communication training, leadership training, and organising social events that could potentially improve relational coordination between team members and lead to better patient care outcomes. I found that team members not only need to have a holistic vision of working together to achieve team and organisational goals, but also need clear understanding of the roles and priorities of each professional group within the team. Such roles and priorities help to preserve the multiple identities, therefore reducing the consternation members might feel in juggling them. Respondents often provided examples of how lack of clarity around roles and priorities can be problematic in team functioning and also stressed the importance of practices that could help to resolve the ambiguity:

*When I first started here within a health setting, I think I had the understanding and the knowledge of teams and groups and how they work. What I probably didn’t have was a really good understanding of the roles and responsibilities of other disciplines and I’m sure that that’s the same for people when they look at social work. They’re not really sure how you refer to a social worker, “How do you do that, how do I contact you, what do you do, what won’t you do? What are physiotherapists’ role, what do they do?” So I think within that team setting, I think part of an orientation or training process around developing an understanding of the roles and responsibilities of other disciplines within that team may have made it easier and more beneficial. I think if everyone within a team knows what everyone else should be doing, then the team should function better. So if we’ve got new players into that team not really understanding what an occupational therapist really does, well, if you did understand that, then you probably should be better at doing your job because you know clearly what other disciplines will and won’t do.*

**DISCUSSION**

My findings add to the identity and team literature. I begin by examining what was consistent with existing research, key points of difference, and their implications for multiple identities and team literature. Next, I discuss implications for the research model that was proposed in Chapter 2, as well as the implications for methods and measurement. I also provide important recommendations for future research and practice improvement.

**Implications for Theory Development**

**Content of identities.** Social identity theory highlights the potential importance of identity content (Turner, 1999). For example, Self-categorization theory postulates that when an individual sees oneself as a category member, s/he takes on the norms and values associated with that category and behaves according to the ‘normative content’ of the category in question (Livingstone & Haslam, 2008; Postmes, Spears, & Lea, 1998). Therefore, understanding the context and the meaning of the identity
specific to that context becomes pertinent. However, identity scholars have often noted that identity research tends to downplay identity content and focuses on more generic constructs such as categorization or identification (Hewstone & Cairns, 2001; Lalonde, 2002; Livingstone & Haslam, 2008; Turner, 1999). Many studies have looked at relationships such as conflict and synergy without specifying the content of identities (Brook et al., 2008; Heere & James, 2007; Settles, 2004; Thoits, 1983).

For example, Brook et al. (2008) proposed that the effects of multiple identities on psychological well-being depend on the number of identities, importance of those identities, and relationship between them but did not consider identity content in their research model. Similarly, Settles (2004) examined the role of identity centrality in identity conflict without taking identity content in consideration. In a recent study, Steffens, Gocłowska, Cruwys, & Galinsky (2016) focused on a general association between multiple identities and enhanced creativity without investigating the content of identities.

Some studies have examined the role of social identity content in identity research. One notable study is by Livingstone and Haslam (2008) conducted with students in Ireland to investigate the relationship between social identity content and intergroup relations. Their findings demonstrate the importance of appreciating the content and meaning of social identities when theorizing about intergroup relations and developing conflict management interventions. Similarly, Reicher (1984) highlights how the riot in Bristol, England in 1980 was characterized not only by the existence of a shared identity among participants, but also by the specific content and meaning of that identity. However, empirical studies in work organizations, on identity content and identity relationships and their impact on outcomes, are still very limited.

Identity content may be more important than relationships among identities for certain outcomes. Ramarajan (2014) suggested that identity relationships may be more important for general tendencies or outcomes such as psychological well-being, whereas the content of identities and their relationships may be more important for specific task outcomes (such as performance). This indicates the relevance of understanding the research questions and specific outcomes of interest, in order to clarify when and why content and context of identities should be considered, in addition to the relationship between identities. My findings provide empirical evidence on how identity content, in addition to the identity relationships, can impact work outcomes.
Emergence processes. Since organisations are social systems, scholars are increasingly paying attention to higher-order social interactive properties that cannot be reduced to an aggregation of the attributes or perceptions of the individuals within the unit or organization (Chan, 1998; Fulmer & Ostroff, 2016; Klein & Kozlowski, 2000; Morgeson & Hofmann, 1999). Scholars agree that social context is anchored in the cognitions, emotions, and normative behaviours of individuals (Klein & Kozlowski, 2000) and a degree of convergence or consensus across individuals creates a higher-level property transcending individuals (Chan, 1998).

Many researchers (e.g., Chan, 1998; Fulmer & Ostroff, 2016; Morgeson & Hofmann, 1999) have emphasized the importance of understanding the structure and the function of the emergent collective construct as also the developmental aspects of the emergence of such collective constructs. Theory and research has begun to investigate emergence of collective constructs such as team learning, team efficacy and organisational climate (Bell & Kozlowski, 2008; DeRue, Hollenbeck, Ilgen, & Feltz, 2010; Zohar, Luria, & Zedeck, 2004). However, this is seldom done in identity research. For example, extant literature does not discuss emergence of collective constructs such as team identity conflict or the developmental mechanism by which team identity conflict might arise. Exploring dynamics of such emergent phenomena is an exciting avenue of identity research that will add to our current understanding of identity interactions.

Outcomes of identity processes. Extant literature provides insights into how identity conflict within an individual could lead to negative consequences. For example, it is widely accepted that emotions at work affect employee attitudes, cognitions, and behaviours (Davies, 2015; Mason & Griffin, 2003). Emotions are an important element of identity conflict (Barsade, 2002; Horton et al., 2014). They define individuals' subjective interpretation of reality and reactions to current situations. Conflict is often associated with stress and threat, which increase emotional responses and negative arousal (Thomas, 1992).

Research in neuropsychology of behavioural conflict has demonstrated that identity conflicts involve activity in the Behavioural Inhibition System (BIS), a neural system which impacts stress, health, and anxiety (Hirsh & Kang, 2015). Whereas individuals who primarily rely on a single identity have clearer normative guidelines to follow, those with more complex identity structures are more likely to
encounter conflicting social norms (Hirsh & Kang, 2015). Whenever behavioural conflicts are detected, the BIS tends to slow or stop ongoing goal directed behaviour. In social situations, this is often manifested as social inhibition, in which an individual worries about experiencing negative feedback and is thus reluctant to express his or her thoughts and feelings (Rubin & Asendorpf, 1992).

Prior research also demonstrates that emotions can be shared such that group affect develops (Smith, Seger, Mackie, & Dovidio, 2007). Team affective tone has been proposed as a valid construct to capture such collective affect (George, 1990), and it has been argued that team affective tone influences team dynamics and team effectiveness (George, 1995; Mason & Griffin, 2003). Prior research has suggested various mechanisms to explain the emergence of affective similarity in work groups and emotional contagion seems to be particularly relevant. Here, I show evidence that it emerges due to identity conflicts and the coordination difficulties caused by these identity-based interactions. This could be construed as an antecedent to emotional contagion, the process in which a person or group influences the emotions, or behaviour of another person or group through the conscious or unconscious induction of emotion states and behavioural attitudes (Barsade, 2002; Barsade & Gibson, 2012). Overall, unpleasant emotions are likely to lead to greater emotional contagion than pleasant emotions. My qualitative study provides preliminary evidence to support this mechanism and this will be investigated further in the quantitative phase. Moreover, research on organisational practices that can mitigate the negative consequences of intrapersonal identity conflict on relational coordination and work outcomes is practically non-existent. I extend identity and team research by investigating such effects.

**Implications for Model Development**

In Chapter 2, a preliminary model encompassing the process by which intra-individual identity conflict among identities such as cultural, organisational, professional and team identities, influences relational coordination, which subsequently influences patient outcomes was presented. Moderators of the relationship between intra-individual identity conflict and relational coordination, such as use of multidisciplinary training, multidisciplinary meetings and boundary spanning positions, were presented, such that these practices reduced the negative consequences of identity conflict for relational coordination. My model also suggested that multidisciplinary team training, multidisciplinary team meetings and use of boundary spanning positions is positively related to strength of team identity. Six preliminary propositions were developed (see Figure 2 and Table 3).
Table 3: Preliminary Research Propositions

<table>
<thead>
<tr>
<th>Proposition</th>
<th>Description</th>
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<tbody>
<tr>
<td>P1</td>
<td>The mean level of conflict among cultural, organisational, professional and team identities in multidisciplinary patient care teams is negatively related to quality of patient care provided; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better work outcomes.</td>
</tr>
<tr>
<td>P2</td>
<td>Team identity is positively related to relational coordination.</td>
</tr>
<tr>
<td>P3</td>
<td>Multidisciplinary team training moderates the relationship between the mean identity conflict in multidisciplinary teams and relational coordination, such that multidisciplinary training reduces the negative consequences of identity conflict for relational coordination.</td>
</tr>
<tr>
<td>P4</td>
<td>Multidisciplinary team meetings moderate the relationship between the mean identity conflict in multidisciplinary teams and relational coordination, such that frequent multidisciplinary meetings reduce the negative consequences of identity conflict for relational coordination.</td>
</tr>
<tr>
<td>P5</td>
<td>Multidisciplinary boundary spanners moderate the relationship between mean identity conflict in multidisciplinary team and relational coordination, such that their presence reduces the negative consequences of identity conflict for relational coordination.</td>
</tr>
<tr>
<td>P6</td>
<td>Multidisciplinary training, multidisciplinary meetings and use of boundary spanning positions in multidisciplinary teams are positively related to strength of team identity, such that more prevalent is the use of such organisational/managerial techniques, the stronger the team identity.</td>
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Preliminary Research Model (as shown in Figure 2)

Modifications to this model based on the qualitative analysis presented in this chapter include additional variables and relationships, which are developed here. The revised model and formal hypotheses to be tested in subsequent phase of this research are depicted as Table 4 and Figure 3 respectively.
### Table 4: Revised Research Hypotheses

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Description</th>
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<tr>
<td>H1</td>
<td>Team-level identity conflict emerges through processes of interaction in teams; this team-level construct predicts variance in relational coordination beyond the mean level of intrapersonal identity conflict of team members.</td>
</tr>
<tr>
<td>H2a</td>
<td>Mean intrapersonal identity conflict among cultural, organisational, professional and team identities in multidisciplinary patient care teams is negatively related to quality of patient care provided; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better work outcomes.</td>
</tr>
<tr>
<td>H2b</td>
<td>Mean intrapersonal identity conflict among cultural, organisational, professional and team identities in multidisciplinary teams is negatively related to clinician job satisfaction; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better clinician job satisfaction.</td>
</tr>
<tr>
<td>H2c</td>
<td>Mean intrapersonal identity conflict among cultural, organisational, professional and team identities in teams increases negative group affect; this relationship is mediated by relational coordination such that more identity conflict, the less relational coordination, and the more negative group affect.</td>
</tr>
<tr>
<td>H3</td>
<td>Strength of team identity is positively related to relational coordination.</td>
</tr>
<tr>
<td>H4a-f</td>
<td>The relationship between mean intrapersonal identity conflict and relational coordination is moderated by (a) multidisciplinary team training, (b) multidisciplinary team meetings, (c) multidisciplinary boundary spanners, (d) leadership training (e) communication training, (f), and use of informal (social) events such that they reduce the negative consequences of identity conflict for relational coordination.</td>
</tr>
<tr>
<td>H5a-f</td>
<td>The relationship between (a) Multidisciplinary team training, (b) multidisciplinary team meetings, (c) use of boundary spanning positions, (d) leadership training, (e) communication training, and (f) use of social events in complex teams and strength of team identity is positive, such that more prevalent is the use of such techniques, the stronger the team identity.</td>
</tr>
</tbody>
</table>
First, the most important finding from my analysis indicates emergence of a team level identity conflict in multidisciplinary teams. I found that social processes and communication mechanisms that develop within a multidisciplinary team promote collective sense making, shared knowledge and perceptions, thus leading to development of a team-level sense of identity conflict which characterizes the team. I predict that this will account for additional variance beyond the mean level of intrapersonal identity conflict experienced by each member individually. To reflect this, I introduce a new hypothesis regarding emergence of team level identity conflict in our revised model:

$H1$: Team-level identity conflict emerges through processes of interaction in teams; this team-level construct predicts variance in relational coordination beyond the mean level of intrapersonal identity conflict of team members.

A second implication for the model is that the findings suggest that leadership training, communication training, and the use of informal (social) events, mitigate the negative consequences of
intra-individual identity conflict for relational coordination, alongside the moderators presented in the preliminary model. These practices are targeted at not only individual members, but also the team itself, and so an interesting issue I will investigate in Chapter 4 using quantitative modelling is which practices (individual or team) have lesser, equal or greater influence on outcomes of multidisciplinary teams. It may be that the team-focused practices are particularly impactful, given the recognizable patterns of interdependent actions involving multiple participants (Feldman & Pentland, 2003; Pentland & Feldman, 2008). Team focused practices have been identified in team literature as playing an overlooked but central role in helping organizational/departmental members reflect on, and make sense of, the distinctive characteristics of the organization and team (Ravasi & Schultz, 2006).

An important type of member training that the interviewees recommended was communication training. Research has shown that when communication about tasks and responsibilities is done well, there is significant reduction in clinician turnover and improved job satisfaction (Lein & Wills, 2007) because it facilitates a culture of mutual support. In an interesting study, Kirschbaum & Fortner (2012) demonstrated that miscommunication among providers more frequently contributes to medical error than lack of skill or knowledge. Thus, importance of communication training among care providers cannot be overemphasized. Yet, although there is significant research work that has investigated the role of communication training in clinician-patient interactions, the importance of communication skills training for clinicians in clarifying roles and priorities remains under researched. Team-focused communication training of members of multidisciplinary teams seems very promising in this context.

As another example, leadership skills in health services are critical to the effectiveness and efficiency of team functioning and also to the capacity of teams to sustain themselves in the longer term (MacPhail, Young, & Ibrahim, 2015; McAlearney, Ramanujam, & Rousseau, 2006; Pihlainen, Kivinen, & Lammintakanen, 2015). This is well summarised by Onyett when he wrote:

*Leadership is enacted strategically in the sense of being clear about what the whole local system of care should be achieving; operationally in terms of how this particular team contributes to that enterprise; and professionally in terms of how best to enable staff to make their optimal contribution to the work of the team* (Onyett, 1997, p. 314).

Transforming health-care systems to improve patient safety and quality of care requires engagement and leadership on the part of all clinical staff (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014; Davidson, Elliot, & Daly, 2006; Ezziane, 2012; Fulop & Day, 2010; Künzle, Kolbe, & Grote, 2010; McKimm & Swanwick, 2011). Effective leadership has been demonstrated to lead to better
patient care outcomes by providing a composite picture of the team/ organisational goals (McAlearney et al., 2006).

Education and training have been increasingly emphasised to develop the knowledge and skills of clinical leadership (Long et al., 2013). Evidence of the effectiveness of leadership training in healthcare mainly derives from research with medical and other clinical leaders. These populations, due to their non-managerial background and strong technical expertise, are often reluctant or ill-prepared to take up leadership positions and thus require high levels of support compared with leaders in other organisations (Curtis, de Vries, & Sheerin, 2011; Heller et al., 2004; Levenson, Atkinson, & Shepherd, 2010; McKimm, Rankin, Poole, Swanwick, & Barrow, 2009). However, leadership training is not yet a routine component of the graduate health professional’s curricula in Australia or other modern health systems (MacPhail, Young, & Ibrahim, 2015). In particular, there is limited research that has investigated the role of ‘leadership training’ in the context of multidisciplinary teams. Research also shows that one-off programmes do not provide the sustained support and continual improvement in leadership training likely to be necessary to ensure impact on key outcomes, such as quality of care.

My analysis indicates that understanding the identity dynamics of team members could be a crucial component in managing interpersonal conflict, and effective leadership training could foster skills in not only identifying intractable identity conflicts in teams but also managing such conflicts. For example, respondents in my interview study universally noted the importance of leadership training in managing relational coordination and improving patient care outcomes.

Finally, along with formal practices and routines like scheduled multidisciplinary training and meetings, organising social or informal events could potentially play an important role in acting as a buffer against negative consequences of intrapersonal conflict on relational coordination within the team. As noted often by respondents, organising informal events can play a significant role in sharing information and clarifying roles and priorities of different functions within the team. Research has shown that organising social events can help employees know each other better (Morton, Igantowicz, Gnani, Majeed, & Greenfield, 2016; West & Lyubovnikova, 2013) and foster team cohesion and professional connections (Morton et al., 2016). Yet, there is some research that has shown that such events do not have any conclusive positive effects for the individuals, teams and organisations. For example, Ammeter & Dukerich (2002) investigated factors that led to high levels of team performance in engineering and construction project teams and found that team building social events (both formal and informal) did not have a significant effect on project performance. In light of such mixed results, it is
important to investigate the role of social (informal) events in enhancing relational coordination and patient care outcomes in multidisciplinary teams.

Based on these findings, I modify my hypothesis as follows:

H4(a-f): The relationship between team identity conflict and relational coordination is moderated by (a) multidisciplinary team training, (b) multidisciplinary team meetings, (c) multidisciplinary boundary spanners, (d) leadership training (e) communication training, and (f) use of informal (social) events, such that they reduce the negative consequences of identity conflict for relational coordination.

The findings also suggest that the three practices described above may serve to increase strength of team identity. Testing this relationship would be a novel contribution to the literature, because it links both individual and team practices to a team outcome. There is some tangential evidence that this may be the case. For example, West et al., (2003) analysed ratings of leadership in health care teams and found that leadership clarity was associated with clear team objectives, high levels of participation, commitment to excellence, and support for innovation. Effective ‘leadership training’ is thus likely to strengthen team identity.

Similarly, communication skills training and use of social events are likely to lead to a strong sense of team identity. Communication skills training can facilitate better utilization of unique skills in teams, which might then result in members have a greater sense of identification with the team. Social events help to energize members and help them get to know each other on a more personal basis, which might then result in greater interaction within the team (Lein & Wills, 2007; Ibaum, Rask, Brennan, Phelan, & Fortner, 2012; Morton et al., 2016), which may in turn, lead to the strength of team identity. I therefore modify the proposition in my preliminary model to include these new practices, suggesting the following modified hypothesis:

H5 (a-f): (a) Multidisciplinary team training, (b) multidisciplinary team meetings, (c) use of boundary spanning positions, (d) leadership training, (e) communication training, and (f) use of social events in teams are positively related to strength of team identity, such that more prevalent is the use of such techniques, the stronger the team identity.

Finally, the findings indicated several additional outcomes of identity conflict, as mediated by relational coordination, which were not originally proposed in the preliminary model. First, identity conflict and its impact on relational coordination, appears to result in emergence of group affect in multicultural multidisciplinary teams, such that greater conflict results in poor relational coordination and negative group affect, while less conflict results in better relational coordination and more positive group affect. Group affect, as a shared perception of negative moods and homogeneous emotional
states within a team (Shin, 2014), is an aggregate of the moods of the team members (Sy et al., 2005) and is argued to influence team dynamics and team effectiveness (George, 1990, 1995; Mason & Griffin, 2003). The following hypothesis reflects this:

**H2b**: Team identity conflict among cultural, organisational, professional and team identities in teams increases negative group affect; this relationship is mediated by relational coordination such that more identity conflict, the less relational coordination, and the more negative group affect.

The analysis indicates that not only patient outcomes but also clinician outcomes are impacted by identity conflict; many respondents reported a decrease in job satisfaction because of intrapersonal and interpersonal identity conflicts. For example, many respondents discussed how the conflicting demands of their organisational and professional identity around effective patient bed management led to feelings of dissatisfaction with the job as also creating stress and frustration. Research also has shown that identity conflicts can alter members’ attributions of behaviour and distort communication (Bar-Tal, 1998; Friedman & Davidson, 2001), which can lead to decreased job satisfaction and increased turnover (Faircloth, 2012; Humphreys & Brown, 2002; Veldman et al., 2017). For example, Veldman et al., (2017) reported lower job satisfaction arising due to gender role conflict in female police officers. However, empirical research looking at the impact of multiple identities within complex multicultural multidisciplinary teams is still scarce. I introduce a new hypothesis to investigate the impact of intrapersonal dynamics on clinician job satisfaction.

**H2c**: Team identity conflict among cultural, organisational, professional and team identities in teams is negatively related to clinician job satisfaction; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better clinician job satisfaction.

**Implications for Methods and Measurement**

The introduction of new research hypotheses has important implications for survey development. First, as I detail in Chapter 4, I developed and validated a new scale that captures team-level identity conflict, which uses the team as the referent. I administered this scale in addition to items which assess each individual team members’ level of intrapersonal identity conflict.

In the context of knowledge sharing teams, Ostroff, Kinicki and Muhammad (2012: 660) stated that “Elemental content is the raw material of emergence and refers to the conditions, affect, perceptions or mental representations; interaction denotes the process of emergence (e.g., how the elemental content becomes shared) through communication and information exchange, sharing of ideas, and exchanging of work products.” Based on this conceptualization, the new scale of team-level
identity conflict had items to capture how the individual identity conflict patterns (elemental content) become a distinct entity/pattern during the emergence process through communication and information exchange and sharing of ideas in multidisciplinary teams. Since healthcare teams are service teams, the new scale also had items on how the new team level conflict construct arises due to challenges in combining actions and jointly delivering a service.

In addition, I also investigated the new dependent variable, group affect by using the validated Positive and Negative Affective Schedule (PANAS) (Watson, Clark, & Tellegen, 1988). The PANAS is a 20-item scale with 10 items measuring positive affect such as ‘excited’ and 10 items measuring negative affect, such as “stressed”. Participants indicated how they felt at work in the daily rostered multidisciplinary team on a 5-point Likert scale ranging from 1 (very slightly or not at all) to 5 (very much). As I elaborate in Chapter 4, I first measured individual negative affect and once the affective consistency among group members was confirmed through the \( r_{wg} \) index (George 1990), individual affect was aggregated to yield the group affect construct.

Finally, the refined survey also had new scales and items to measure the prevalence, utility and content of practices, such as leadership training, communication training, and use of social events.

**Conclusion**

This first phase extended the theoretical understanding of multiple identities, demonstrating important points of reinforcement and differentiation from the existing literature. Empirical research on multiple identities in organisational studies is still sparse and mostly confined to the study of multiple racial identities or the intersection between two identities (Kang & Bodenhausen, 2015). Scholars attribute lack of momentum in tackling multiple identities to the fact that there is no overarching framework/model to investigate the impact of multiple identities. This research is an attempt to address the abovementioned limitations in multiple identity research.
Chapter 4
Phase 2: Quantitative Study

The second phase of this research included a quantitative survey study to understand the relationship between intrapersonal identity conflict, relational coordination and outcome of quality of patient care, clinician job satisfaction, and emergence of group affect, as moderated by the points of leverage identified in Phase 1. Goldman, Aliaga and Gunderson (1998) define quantitative research as the process of explaining phenomena by collecting numerical data that are analysed using mathematically based methods (in particular statistics). Little research thus far has investigated structures and patterns of identities through surveys or other quantitative techniques, particularly in real life organisations.

The limited research using quantitative methods to measure identities most often uses surveys to ask participants about the number, strength, importance, and relationships between specific identity pairs (e.g. Cheng et al., 2008; Jones & Hynie, 2017; Ramarajan, Berger, & Greenspan, 2017; Ramarajan, Rothbard, & Wilk, 2017). For example, Cheng et al. (2008) experimentally primed specific pairs of identities and measured individual differences in how the two identities are related (e.g. conflict or integration) by using survey techniques. Similarly, Jones and Hynie (2017) examined the experience and management of conflict between different pairs of role, relationship and social identities but restricted themselves to a pair of identities at a time and used a university student sample in the laboratory. Few studies have been carried out in organisations.

As a notable exception, Ramarajan, Rothbard & Wilk (2017) examined the impact of identity conflict and identity enhancement on sales performance in employee-customer interactions and found independent effects for identity conflict and identity enhancement. However, the study examined conflict between only two identities.

Further, what scant research does examine more than a pair of identities exemplifies just how complex these relationships can be. For example, in the Ramarajan, Berger & Greenspan (2017) paper mentioned earlier, which involved charity sport events, student teams, and two experiments, the authors found that generally experiencing identities as enhancing, rather than conflicting resulted in prosocial outcomes. However, mutually enhancing, mutually conflicting, and independent identities were not significantly different from one another in their relationships with outcomes. This suggests that the intrapersonal impacts of identity conflict across three or more identities is not well understood.
To address these complexities, and building on the main themes that emerged from analysis of exploratory Phase 1, I used quantitative survey techniques not only to glean deeper understanding of each identity under investigation, but also the conflict between different identities, and the strength of each identity within an individual. I examined the impact of intrapersonal and interpersonal interactions on relational coordination and the distal outcome of quality of patient care, clinician job satisfaction and emergence of group affect. The survey also investigated the prevalence and utility of organisational practices such as use of multidisciplinary team training, multidisciplinary team meetings, leadership training, communication training, organising social events and use of boundary-spanning positions within a healthcare team. Also, this survey study was carried out on on-going teams in organisations and thus contributed to our understanding of multiple identity interactions in real world settings.

Participants

Participants in this study were members of healthcare teams (doctors, nurses, allied healthcare staff and healthcare administrators) across five departments (Medicine, Surgery, Emergency, Intensive Care Unit and Geriatrics) in four Western Australian public sector hospitals, two small regional hospitals (Hospital A and Hospital B) and two large metropolitan hospitals, namely, Hospital C and hospital D. A total of 37 teams were included in this study from four hospitals. Table 5 provides a summary of the demographic characteristics of the study sample.

Table 5: Demographic Properties of the Matched Sample of Healthcare Professionals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Teams</th>
<th>Mean Age Range</th>
<th>% Female</th>
<th>Mean Org. Tenure in years (SD)</th>
<th>% born overseas</th>
<th>% with overseas qualifications</th>
<th>% Doctors</th>
<th>% Nurses</th>
<th>% AHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>22</td>
<td>35-44</td>
<td>61.5</td>
<td>5.08 (5.00)</td>
<td>63.1</td>
<td>56.9</td>
<td>44.6</td>
<td>40.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Hospital B</td>
<td>7</td>
<td>35-44</td>
<td>63.6</td>
<td>5.03 (4.45)</td>
<td>72.7</td>
<td>54.5</td>
<td>31.8</td>
<td>27.3</td>
<td>40.9</td>
</tr>
<tr>
<td>Hospital C</td>
<td>8</td>
<td>35-44</td>
<td>66.7</td>
<td>3.93 (2.49)</td>
<td>58.3</td>
<td>50.0</td>
<td>29.2</td>
<td>33.3</td>
<td>37.5</td>
</tr>
<tr>
<td>Hospital D</td>
<td>0</td>
<td>No matched data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>37 teams (121 individual respondents)</td>
<td>39.5 (SD=10.1)</td>
<td>62.8</td>
<td>4.75 (4.33)</td>
<td>66.1</td>
<td>57.0</td>
<td>38.7</td>
<td>36.0</td>
<td>25.2</td>
</tr>
</tbody>
</table>

Note. The matched sample refers to the individuals who completed both the online and onsite clinician surveys. A unique identifying code helped in matching the online and onsite surveys.
A total of 300 healthcare professionals were invited to participate and 121 responded, for a response rate of 40.33%. Those that did not respond failed to do so because they were ill, on leave, or had been re-assigned to a different hospital or unit that was not participating during the time of the study. Non-respondents did not differ from respondents on any demographic characteristics. The 121 respondents were healthcare professionals (doctors 38.8%, nurses 38% and allied healthcare professionals 23.1%) ranging in age from 25 to 55 years, with a mean age of 39.5 (s.d. =10.1) and organizational tenure of 4.75 years (s.d. =4.43). Participants were 62.8 percent female and 37.2% male. A total of 33.9 percent of the participants were born in Australia, as compared to 66.1 percent born overseas. The percent of the participants with local (Australian) medical/healthcare qualifications was 43% whereas 57% had overseas medical/healthcare qualification (from India, Pakistan, England, South Africa, Scotland, Ireland, USA, Switzerland, Netherlands, Iraq, Malaysia, Philippines, Germany and Argentina).

I also conducted an independent patient satisfaction survey for each of the 37 teams to assess the work outcomes for the study at all four hospitals, including a total of 85 patients with a mean age of 63.68 (s.d. =16.06). 47.1% percent participants were female and 52.9 percent of the participants were male. 83.5 percent of the participants were Australian, 6.7 percent were English, 3.5 percent from New Zealand and 1.2 percent each from Scotland and South Africa. The demographic details of the patient data are included in Table 6.

**Table 6: Demographic Properties of the Patient Sample**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Responses</th>
<th>Teams</th>
<th>Mean Age in years (SD)</th>
<th>% Male</th>
<th>% Female</th>
<th>% Australian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>56</td>
<td>22</td>
<td>64.44 (16.78)</td>
<td>46.4</td>
<td>53.6</td>
<td>78.6</td>
</tr>
<tr>
<td>Hospital B</td>
<td>15</td>
<td>7</td>
<td>64.54 (16.17)</td>
<td>53.3</td>
<td>46.7</td>
<td>86.7</td>
</tr>
<tr>
<td>Hospital C</td>
<td>14</td>
<td>8</td>
<td>59.00 (13.05)</td>
<td>78.6</td>
<td>21.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Hospital D</td>
<td>No matched data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>37</td>
<td>63.68 (16.06)</td>
<td>52.9</td>
<td>47.1</td>
<td>83.5</td>
</tr>
</tbody>
</table>
Procedure

Data were collected from members of healthcare teams across four hospitals via two surveys: an online survey that was administered via email and an onsite survey for the teams. The online survey contained questions regarding data that was not time-sensitive and not related to shift work, such as intrapersonal identity relationships, strength of identities under investigation, and prevalence and utility of organisational practices such as multidisciplinary training, multidisciplinary meetings, use of boundary spanners, leadership training, communication training and organising social events.

The Phase 1 interviews indicated that healthcare workers in these settings considered the team that they worked with on their shift as their work team. Thus, the onsite survey was a brief paper and pencil survey that was related to staff members of teams rostered together for a given shift (doctors, nurses, allied healthcare staff and healthcare administrators). This onsite survey had questions pertaining to relational dynamics between members working as a team, questions related to emergence of group affect, clinician perception of patient care outcomes, and satisfaction with the team. To administer these, I was on site for 20-25 days per hospital.

In addition, an onsite paper and pencil ‘patient survey’ was conducted for each team on the same day when onsite data was collected from clinicians to assess work outcomes for each team. This survey contained questions regarding the quality of patient care, including patient’s satisfaction with the overall communication and coordination of the team members providing care to the patient on the day and overall satisfaction with the service received on the day.

Although data collection was undertaken via anonymous surveys, clinicians were asked to construct a unique identifying code and provide it on both online and onsite surveys to facilitate the matching of responses (Schnell, Bachteler, & Reiher, 2010). Respondents were retained only if online and onsite survey data could be matched up using this code, and only if the team was represented by at least two members responding (i.e., teams with only one respondent at a given time point were removed from all analyses). Table 7 provides details of the data collection from all hospitals.
Table 7: Total Survey Statistics

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Online surveys</th>
<th>Onsite surveys (teams)</th>
<th>Patient surveys (teams)</th>
<th>Matched teams (onsite, online &amp; patient data)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete responses (excluding partial responses)</td>
<td>Total responses (complete + partial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital A</td>
<td>57</td>
<td>103</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Hospital B</td>
<td>26</td>
<td>64</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Hospital C</td>
<td>32</td>
<td>32</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Hospital D</td>
<td>23</td>
<td>23</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>222</td>
<td>94</td>
<td>94</td>
</tr>
</tbody>
</table>

Measures

**Identification.** The strength of identification across four reference groups (culture, organization, profession and team) was measured in the online survey, based on the Phase I interviews which indicated the relevance of these specific groups. Following Mael and Ashforth (1992) participants were asked to report on the extent to which they identified with the four reference groups by responding to the following set of three items for each of the reference groups (i.e., 12 items in total): “[When I talk about [reference group], I usually say ‘we’ rather than ‘they’.”, “I am interested in what others think of [reference group].”, and “I view [reference group’s] successes as my successes.” Participants responded on a 5-point scale where 1= Strongly Disagree and 5=Strongly Agree. The reliability (Cronbach’s alphas) for these four identification subscales ranged from .657 (professional identification) to .786 (team identification).

The mean and standard deviations for strength of team identity are (4.13, .29), professional identity (4.04, .37), organisational identity (3.72, .32) and cultural identity (3.54, .40).

**Intra-individual identity conflict.** Survey items for conflict among identities were based upon the theoretical definition of the construct, analysis of the interviews conducted in Phase 1 as well as adaptation from measures currently used in the literature (e.g., Gibson et al., 2016). Respondents were asked to fill in a 4×4 matrix for the four identities (cultural, organisational, professional and team...
identities) with the ‘individual’ as the referent and score the conflict between each pair of identity (cultural vs organisational identity, cultural versus professional identity, cultural versus team identity, organisational versus professional identity, organisational versus team identity and professional versus team identity) on a scale of 1 to 5 where 1 indicated no conflict and 5 indicated maximum conflict. The respondents were instructed to not score relationship between the same pair of identity (for e.g. cultural identity versus cultural identity), thus I obtained scores for 12 interactions and then took the average for the same pair (e.g. cultural versus organisational identity) irrespective of the ordering of identity (e.g. cultural identity versus organisational identity and organisational identity versus cultural identity) to get a total of 6 interactions. Thus, the scores across each identity pair were averaged for each individual to calculate an overall identity conflict score, and in this manner, Cronbach’s alpha was .891. I then calculated the ‘mean intrapersonal conflict’ among identities by taking the arithmetic mean across individuals in the team on their degree of intrapersonal conflict among identities. This reflects the central tendency in the team for members to experience intrapersonal identity conflict. I discuss aggregation statistics below.

**Team identity Conflict.** The qualitative analysis indicated that social processes and communication mechanisms that develop within a multidisciplinary team promote collective sense making, shared knowledge and perceptions, thus leading to development of a team-level sense of identity conflict which characterizes the team. In terms of how this team-level construct emerges, I found evidence of both convergence and compilation phenomena. I predicted that this will account for additional variance beyond the team’s mean level of intrapersonal identity conflict experienced by each member individually. To measure this construct, I developed and validated a new 6-item scale where the referent for the individual respondent was the ‘team’.

I developed the new scale based on Gibson et al. (2016) scale and piloted it on a small sample of 30 healthcare practitioners. The pilot respondents were then interviewed to clarify if they understood the survey questions clearly and the survey questions were then revised based on recommendations from respondents. I checked for reliability and factor structure in the pilot sample, and then included the revised scale for purpose of dissertation data.

Response were on a 5-point scale, where 1= Not at all, and 5 = A great deal. Example items include “to what extent do team members’ affiliations with different groups (culture, organisation,
profession and team) dictate different ways of doing things” and “to what extent do team members’ affiliations with different groups result in conflicting priorities for the team”. Cronbach’s alpha for this scale was .807.

**Relational coordination (RC).** RC was assessed via the 7-item scale developed by Gittell (2006), who defined RC as “a mutually reinforcing web of communication and relationships carried out for the purpose of task integration” (Gittell, 2002b, p.300). Items assess the frequency of communication among care providers; the timeliness and accuracy of communication; the problem-solving nature of communication; and the degree to which relationships are characterized by shared goals, shared knowledge and mutual respect. The scale used ‘team’ as the referent for all items. Respondents answered on a 5-point scale where 1=Never and 5=Always. Cronbach’s alpha for this scale was .851.

**Patient care outcomes.** To measure patient outcomes, a 7-item quality of care survey was adapted from a validated instrument that is widely used to assess the quality of care in health care settings (Pearse, 2005). All items included ‘team’ as the referent. Example items include “how would you rate the quality of care you received by the team members (doctors, nurses and allied healthcare staff”). Participants responded to these on a 5-point scale where 1=Poor and 5=Excellent. Cronbach’s alpha for this scale was .921.

Patient care outcomes were also assessed with a 4-item scale with ‘team’ as the referent and completed by the clinicians who provided the care, using a 5-point scale where 1= strongly disagree and 5 = strongly agree. Example items include “the work team meets its patient care goals” and “the work team communicates in an efficient way to deliver patient care outcomes”. Cronbach’s alpha for this scale was .641.

**Negative group affect.** I measured group affect by adapting the items capturing negative affect from the validated Positive and Negative Affective Schedule (PANAS) (Watson, Clark, & Tellegen, 1988), given that my preliminary interviews indicated that negative affect was most impacted by identity conflict. The 5-item scale included items such as ‘angry, anxious, frustrated, irritated and fatigued’. Participants indicated how the team felt during the team interaction on a 5-point Likert scale ranging from 1= not at all to 5 = very much. Cronbach’s alpha for this scale was .746.
Clinician job satisfaction. I measured clinician job satisfaction with a 5-item scale adapted from Shortell et al. (1994) scale that included items such as “you are satisfied with working in this multidisciplinary team” and “overall, you are satisfied with your job”. The individual was the referent for all items in this scale. Participants responded to these on a 5-point scale where 1 = strongly disagree and 5 = strongly agree. Cronbach’s alpha for this scale was .780.

Organisational practices (moderators). Measures of the organisational practices that emerged in interviews (such as the use of multidisciplinary training, multidisciplinary team meetings, leadership training, communication training, organising social events and use of boundary spanning roles) were identified following the Phase I interview analysis. Respondents indicated the frequency and the extent to which each practice had utility (e.g. please indicate the usefulness of the organisational practice for team outcomes) using a 5-point scale where 1= extremely useless and 5= extremely useful.

Control variables. Control variables for this study included psychological safety and intragroup conflict as these concepts can be viewed as alternative explanations for findings of the proposed model. Demographic variables such as professional experience after gaining healthcare qualification (in years) and experience in Australian healthcare organisations (in years) were also included as control variables as past studies (Gittel et al., 2010; Havens et al., 2010) have established that these can impact the team outcomes.

Psychological Safety. Psychological safety refers to a shared belief held by team members that the team is safe for interpersonal risk taking and captures a “sense of confidence that the team will not embarrass, reject, or punish someone for speaking up” (Edmondson, 1999, p.354). Psychological Safety scale was captured with a 7-item scale adapted from Edmondson (1999); example items include “I am able to bring up problems and tough issues in the team” and “If I make a mistake in this team, it is often held against me (reverse scored)”. Participants responded to these on a 5-point ‘Strongly Disagree — Strongly Agree’ scale. Cronbach’s alpha for this scale was .752.

Intra-group conflict. Intra-group conflict refers to “perceived incompatibilities or perceptions by the parties involved that they hold discrepant views or have interpersonal incompatibilities” (Jehn, 1995, p. 256). The conflict literature distinguishes between two types of intragroup conflict, namely, relationship conflict and task conflict (Jehn, 1995, 1997; McCarter et al., 2018). Relationship conflict includes interpersonal incompatibilities or personality clashes which typically include tension, animosity and annoyance among members within a group, and has been associated with negative outcomes such
as dissatisfaction and decreased performance (De Wit, Greer, Jehn, & Kozlowski, 2012; McCarter et al., 2018). Task conflict exists when there are disagreements among group members about the content of the task being performed, including differences in viewpoints, ideas and opinions (De Dreu & Weingard, 2003; Rispens, Greer, & Jehn, 2007). Although task conflict can enhance performance through discussions and debates, many reviews and meta-analysis (e.g., McCarter et al., 2018) have associated both relationship and task conflict with negative outcomes. I measured intragroup conflict with Jehn’s (1995) 9-item scale, where 1=Not at all and 5=A great deal. Four items assessed relationship conflict (e.g. How much relationship/emotional conflict is there in your team?) and five items related to task conflict (e.g. “how often are there disagreements about who should do what in your team”). Cronbach’s alpha for this scale was .890.

Aggregation

All variables were aggregated to the team level using either a referent-shift model (team identity conflict, relational coordination, team affect, patient ratings of team quality of care, and the six organizational practices) or summary index composition model (mean intrapersonal identity conflict and clinician job satisfaction) (Chen, Bliese, & Mathieu, 2004). Thus, the team-level construct was operationalized as the mean of the responses from the individual team members.

The referents-shift variables were rated by individual team members on the extent to which they perceived these characteristics and behaviours in their team. For these variables, referent-shift composition models were specified (the team was the referent), as I anticipated that team members would perceive these team-level constructs similarly. Specifically, constructs were operationalized for each team as the mean of the corresponding responses from the teams’ members (Chan, 1998; Chen et al., 2004), and I then sought to demonstrate that the team members were providing ratings of the phenomena that are in agreement with one another (Bliese, 2000).

To assess the degree of agreement, I first calculated the $r_{WG}$ indices of each construct, for each team (LeBreton & Senter, 2008); these are shown in Table 8. $r_{WG}$ indices is arguably the most popular estimate of interrater agreement (IRA) (James, Demaree, & Wolf’s 1984, 1993). The use of $r_{WG}$ is predicated on the assumption that each target has a single true score on the construct being assessed (O’Neill, 2017). Consequently, any variance in judges’ ratings is assumed to be error variance. Thus, it is possible to index agreement among judges by comparing the observed variance to the variance expected when judges respond randomly. Basically, when all judges are in perfect agreement, they
assign the same rating to the target, the observed variance among judges is 0, and \( r_{WG} = 1.0 \) (Le Breton & Senter 2008). In contrast, when judges are in total lack of agreement, the observed variance will asymptotically approach the error variance obtained from the theoretical null distribution as the number of judges increases (Le Breton & Senter 2008). This leads \( r_{WG} \) to approach 0.0. In the present case, the observed median \( r_{WG} \) indices of all constructs was well within the range (please refer to Table 8).

I also calculated intra-class correlation coefficients ICC (1) and ICC (2) (Chen et al., 2004) for these variables. ICC(1) provides the proportion of the total variation in individual-level ratings of a phenomenon that is attributable to team membership (Trevethan, 2017). In the absence of any within group agreement, ICC(1) will be zero, though a low ICC(1) does not necessarily imply a lack of agreement; it could simply reflect a lack of meaningful variation across the groups on the phenomenon of interest. ICC(2) indicates the extent to which the observed means can be considered reliable. ICC (1) is typically interpreted as a measure of effect size (Bliese, 2000; Bryk & Raudenbush, 2002; Le Breton & Senter, 2008), revealing the extent to which individual ratings are attributable to group membership. Thus, when interpreting values for ICC(1), Le Breton and Senter (2008) encourage researchers to adopt traditional conventions used when interpreting effect sizes (i.e., percentage of variance explained). Specifically, a value of .01 might be considered a “small” effect, a value of .10 might be considered a “medium” effect, and a value of .25 might be considered a “large” effect (see Murphy & Myors, 1998, p. 47). For example, an ICC(1) = .05 represents a small to medium effect, suggesting that group membership (e.g., the team) influenced judges’ ratings (e.g., employees responses to questions about the team). Thus, values as small as .05 may provide prima facie evidence of a group effect. Such a finding would warrant additional investigations concerning the viability of aggregating scores within groups (e.g., estimating within-group agreement via \( r_{WG} \)) (Le Breton & Senter, 2008).

Table 8 shows the scores obtained on these indices. Taken together, these aggregation statistics indicate that members agree very strongly with each other in their assessments of all but two of the referent-shift variables, and there is a moderate level of variability across teams. There were two practices which demonstrated an insufficient group effect: team meetings and boundary spanning. As a result, these were eliminated from the analysis below.
Table 8: Means and Standard Deviations of, \( r_{WG} \) and ICC (1) for All Referent Shift Team Level Study Variables

<table>
<thead>
<tr>
<th>Scale/variable</th>
<th>Mean</th>
<th>SD</th>
<th>Median rWG</th>
<th>ICC (1)</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team-level identity conflict (new scale)</td>
<td>2.65</td>
<td>.38</td>
<td>0.966</td>
<td>.025</td>
<td>1.052</td>
<td>0.416</td>
</tr>
<tr>
<td>Relational coordination</td>
<td>3.66</td>
<td>.41</td>
<td>0.987</td>
<td>.182</td>
<td>1.447</td>
<td>0.091</td>
</tr>
<tr>
<td>Patient Ratings of Quality of Care</td>
<td>3.80</td>
<td>.73</td>
<td>0.989</td>
<td>.531</td>
<td>3.266</td>
<td>.000</td>
</tr>
<tr>
<td>Negative affect</td>
<td>1.92</td>
<td>.39</td>
<td>0.987</td>
<td>.439</td>
<td>2.554</td>
<td>.000</td>
</tr>
<tr>
<td>Multidisciplinary training</td>
<td>3.99</td>
<td>.37</td>
<td>0.769</td>
<td>.052</td>
<td>1.110</td>
<td>.346</td>
</tr>
<tr>
<td>Leadership training</td>
<td>3.56</td>
<td>.49</td>
<td>0.750</td>
<td>.106</td>
<td>.787</td>
<td>.784</td>
</tr>
<tr>
<td>Multidisciplinary meetings</td>
<td>3.88</td>
<td>.62</td>
<td>0.750</td>
<td>-.034</td>
<td>.934</td>
<td>.580</td>
</tr>
<tr>
<td>Communications training</td>
<td>3.84</td>
<td>.52</td>
<td>0.750</td>
<td>.450</td>
<td>2.639</td>
<td>.000</td>
</tr>
<tr>
<td>Social events</td>
<td>3.29</td>
<td>.59</td>
<td>0.857</td>
<td>0.245</td>
<td>1.647</td>
<td>.036</td>
</tr>
<tr>
<td>Boundary spanning</td>
<td>3.992</td>
<td>.439</td>
<td>0.857</td>
<td>-.125</td>
<td>.779</td>
<td>.794</td>
</tr>
</tbody>
</table>

In contrast to the above, the mean intra-personal identity conflict and clinician job satisfaction were considered using a summary-index composition model, in which the concept was thought to manifest at the individual level, but the team's score equal to the mean of the individual members' scores was calculated, to enable analysis with this variable at the team level (Chen et al., 2004). I do not argue here that these variables represent a team level construct *per se*, however I wished to investigate whether the central tendency in the team would affect team outcomes. With Summary Index composition models, there is no requirement that the experiences of team members be shared, nor a consensus be made amongst team members, and as such, strong inter-rater agreement is not required to justify the calculation of a summary statistic.

Analysis & Results

Means, standard deviations and inter-correlations among all of the variables in the study are depicted in Table 9. In the next section, I document the analysis and results for quantitative tests conducted for the five hypotheses to delineate the extent of support for the model in Figure 3 (see page 65). By way of overview, Analysis of Variance (ANOVA) and Multiple Regression Analysis, including
mediation and moderation analysis (Hayes 2012) were used to test the hypotheses, with analyses being conducted in SPSS v25.

Table 9: Means and Standard Deviations of, $r_{WG}$ and ICC (1) for All Referent Shift Team Level Study Variables

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intrapersonal identity Conflict</td>
<td>1.93</td>
<td>.37</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Relational coordination</td>
<td>3.66</td>
<td>.41</td>
<td>.26</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient perception of care outcomes</td>
<td>3.80</td>
<td>.73</td>
<td>-18</td>
<td>.49**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Clinician perception of care outcomes</td>
<td>3.41</td>
<td>.25</td>
<td>-28</td>
<td>.50**</td>
<td>.24</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Clinician satisfaction</td>
<td>2.61</td>
<td>.50</td>
<td>-25</td>
<td>.66**</td>
<td>.37*</td>
<td>.64**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Negative affect</td>
<td>1.92</td>
<td>.39</td>
<td>.31</td>
<td>- .57**</td>
<td>- .35*</td>
<td>- .56**</td>
<td>- .56**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Multidisciplinary training</td>
<td>3.99</td>
<td>.37</td>
<td>.16</td>
<td>.16</td>
<td>.01</td>
<td>.08</td>
<td>.07</td>
<td>- .12</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Leadership training</td>
<td>3.56</td>
<td>.49</td>
<td>- .03</td>
<td>.19</td>
<td>.12</td>
<td>.13</td>
<td>- .02</td>
<td>- .06</td>
<td>.36*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Communication training</td>
<td>3.84</td>
<td>.52</td>
<td>- .14</td>
<td>.29</td>
<td>.10</td>
<td>.33*</td>
<td>.10</td>
<td>- .11</td>
<td>.15</td>
<td>.61**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Social events</td>
<td>3.29</td>
<td>.59</td>
<td>- .19</td>
<td>.21</td>
<td>.18</td>
<td>.25</td>
<td>.09</td>
<td>- .07</td>
<td>.03</td>
<td>.62**</td>
<td>.59**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Strength of team identity</td>
<td>4.13</td>
<td>.29</td>
<td>- .08</td>
<td>.20</td>
<td>.14</td>
<td>.01</td>
<td>- .04</td>
<td>.13</td>
<td>.30</td>
<td>.37*</td>
<td>.47**</td>
<td>.18</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Psychological safety</td>
<td>3.45</td>
<td>.26</td>
<td>- .14</td>
<td>.01</td>
<td>.02</td>
<td>.04</td>
<td>- .01</td>
<td>.01</td>
<td>.06</td>
<td>.05</td>
<td>.27</td>
<td>.35*</td>
<td>.28</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>13. Intragroup conflict</td>
<td>2.32</td>
<td>.31</td>
<td>.53</td>
<td>- .22</td>
<td>- .06</td>
<td>- .05</td>
<td>- .30</td>
<td>.11</td>
<td>.00</td>
<td>-1.19</td>
<td>- .14</td>
<td>- .39*</td>
<td>- .00</td>
<td>- .64**</td>
<td>1</td>
</tr>
<tr>
<td>14. Team Identity conflict</td>
<td>2.53</td>
<td>.41</td>
<td>.52**</td>
<td>- .16</td>
<td>.07</td>
<td>- .12</td>
<td>- .14</td>
<td>.31</td>
<td>.10</td>
<td>- .02</td>
<td>- .08</td>
<td>- .11</td>
<td>.25</td>
<td>.16</td>
<td>.57**</td>
</tr>
</tbody>
</table>

Hypothesis 1 - Team-Level Identity Conflict

Hypothesis 1 stated that team-level identity conflict emerges through processes of interaction in teams; this team-level construct predicts variance in relational coordination beyond the mean level of intrapersonal identity conflict of team members. To test this hypothesis, hierarchical multiple regression analysis (MRA) was employed, with relational coordination (RC) as the dependent variable (DV) and the ‘mean intrapersonal identity conflict’ and ‘team identity conflict’ as the independent variables (IV).

Before interpreting the results of the MRA, a number of assumptions were tested, and checks were performed. First, stem-and-leaf plots and boxplots indicated that each variable in the regression was normally distributed and free from univariate outliers. Second, an inspection of the normal probability plot of standardized residuals and the scatterplot of standardized residuals against standardized predictive values indicated that the assumption of normality, linearity and
homoscedasticity of residuals were met. Third, Mahalanobis distance did not exceed the critical $\chi^2$ for df =2 (at $p=.01$) of 9.21 for any cases in the data file, indicating that the multivariate outliers were not of concern. Finally, relatively high tolerance for the two predictors in the final regression model indicated that multicollinearity would not interfere with the interpretation of the outcome of the MRA.

In the first step of analysis, the team’s mean intrapersonal identity conflict accounted for 8.7% of the variance in relational coordination, $R^2=.087$, $F$ (1, 35) =3.33, $p=.076$. On step 2, the team-level emergent construct, team identity conflict, was added to the regression equation and accounted for an additional 0.10% of the variance in relational coordination, $R^2$ change=.10, $F$ change (1, 34) =.056, $p=.815$. In combination, the two predictor variables accounted for a statistically non-significant variance in relational coordination, $R^2=.09$, $F$ (2, 34) =1.65, $p=.207$. The results are reported in Table 10.

These results fail to support H1 that team-level identity conflict emerges through processes of interaction in teams and that this team-level construct predicts variance in relational coordination beyond the mean level of intrapersonal identity conflict of team members. As a result of these analyses, I utilize the mean level of intrapersonal identity conflict in the remainder of this thesis. I discuss this approach in the Discussion Section, including suggestions for how future research might extend this research to investigate emergence of a team level of identity conflict.

Table 10: Regression Table for Hypothesis H1: Regression of Relational Coordination on ‘Mean Intrapersonal Conflict among Identities‘ and ‘Team Identity Conflict’

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Dependent variable=Relational Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1</td>
</tr>
<tr>
<td>Mean Intrapersonal identity conflict</td>
<td>-.295</td>
</tr>
<tr>
<td>Team Identity conflict</td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.087</td>
</tr>
<tr>
<td>$\Delta R^2$</td>
<td>.001</td>
</tr>
</tbody>
</table>

Note. *$p < .05$, **$p <.01$. N = 37. Unless specified otherwise, values in cells are standardized regression coefficients.
**Hypotheses 2a-2c: Mediation Analysis**

To test the mediation hypotheses (H2a-H2c), I used the bootstrapping procedure (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002; Preacher & Hayes, 2004). This method is preferred for group-level analysis because other approaches, such as the Baron and Kenny (1986) method, may lack statistical power (MacKinnon et al., 2002), and bootstrapping is recommended to examine mediation in small sample sizes (Shrout & Bolger, 2002). In general, bootstrap methods offer an empirical method of determining the significance of statistical estimates, and involves repeated random sampling observations with replacement from the data and calculating the statistic of interest in each resample (Efron & Tibshirani, 1993). Over many bootstrap samples, an empirical approximation of the sampling distribution of the statistic can be generated and used for hypothesis testing. I used the bootstrapping procedure through Hayes’ 2013 PROCESS add-on for SPSS (Hayes, 2013).

For all mediation hypotheses, the statistical significance of parameters were judged using bias-corrected 95% confidence intervals from 5000 bootstrapped samples (Hayes, 2013). All mediation analyses were conducted with 4 controls (psychological safety climate, intragroup conflict, years of professional experience after gaining healthcare qualification, and years of experience with the Australian healthcare system).

**Hypothesis 2a: The Relationship between ‘Intrapersonal Identity Conflict’ and Patient Care Outcomes.** Hypothesis 2a stated that mean intrapersonal identity conflict among cultural, organisational, professional and team identities in patient care teams is negatively related to quality of patient care provided; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better work outcomes. I tested this hypothesis twice using both patient and clinician perceptions of care outcomes.

*Patient perception of care outcomes.* The indirect effect of mean intrapersonal identity conflict on patient perception of care outcomes, through relational coordination, was -.265 (95% CI: -.759, -.011). The total effect of mean intrapersonal identity conflict on patient perception of care outcomes was -.220 (95% CI: -.117, .677) and direct effect of mean intrapersonal identity conflict on patient perception of care outcomes was -.021 (.802, .706); but the confidence intervals around these estimates crossed zero. The results are graphically depicted in figure 4.
Current consensus on mediation analysis (Hayes & Rockwood, 2017; Rucker, Preacher, Tormala, & Petty, 2011; Zhao, Lynch & Chen, 2010) suggests that mediation is supported by the magnitude and significance of the indirect effect (i.e. if there are theoretical reasons to predict the presence of an indirect effect, researchers should explore these effects regardless of the significance of the total or direct effect). The indirect effect is in the direction predicted and statistically significant for this analysis, and thus Hypothesis H2a is supported with the patient assessments of quality of care.

Figure 4: Model of Mean Intrapersonal Identity Conflict as a Predictor of Patient Perception of Care Outcomes, Mediated by Relational Coordination.

Clinical perception of care outcomes. The indirect effect of mean intrapersonal identity conflict on clinician perception of care outcomes, through relational coordination, was -.081 (-.222, -.004). The total effect of mean intrapersonal identity conflict on clinician perception of care outcomes was -.302 (95% CI: -.606, .003) and direct effect of mean intrapersonal identity conflict on clinician perception of care outcomes was -.241 (95% CI: -.515, .034); the confidence intervals around these estimates crossed zero. However, as noted above, given the indirect effect was in the direction predicted and statistically significant for this analysis, Hypothesis H2a was also supported with clinician assessments of quality of patient care. The results are graphically depicted in Figure 5.
Hypothesis 2b: The Relationship between Intrapersonal Identity Conflict and Clinician Job Satisfaction. Hypothesis H2b stated that the mean intrapersonal identity conflict among cultural, organisational, professional and team identities in teams is negatively related to clinician job satisfaction, and that this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better clinician job satisfaction. The indirect effect of mean intrapersonal identity conflict on clinician job satisfaction, through relational coordination, was -0.213 (-0.504, -0.003). The total effect of mean intrapersonal identity conflict on clinician job satisfaction was -0.27 (95% CI: -0.639, 0.586) and direct effect of mean intrapersonal identity conflict on clinician job satisfaction was 0.133 (-0.357, 0.624), however the confidence intervals around these estimates crossed zero. The indirect effect was in the direction predicted and statistically significant for this analysis, hence Hypothesis H2b was supported with clinician job satisfaction. The results are graphically depicted in Figure 6.
Hypothesis 2c: The Relationship between Intrapersonal Identity Conflict and Negative Affect. Finally, hypothesis H2c stated that the mean intrapersonal identity conflict among cultural, organisational, professional and team identities in multidisciplinary teams increases negative group affect, and this relationship is mediated by relational coordination such that more identity conflict, the less relational coordination, and the more negative the group affect. The indirect effect of mean intrapersonal identity conflict on negative affect, through relational coordination, was .148 (95% CI: .008, .392). The total effect of mean intrapersonal identity conflict on negative affect was .336 (95% CI: -.147, .819) and direct effect of mean intrapersonal identity conflict on negative affect was .225 (95% CI: -.189, .638), however the confidence intervals around these estimates crossed zero. The indirect effect was in the direction predicted and statistically significant for this analysis, and thus Hypothesis H2c was supported in the analysis. The results are graphically depicted in Figure 7.
Figure 7: Model of Mean Intrapersonal Identity Conflict as a Predictor of Negative Group Affect, Mediated by Relational Coordination.

The summary of results for hypotheses H2a-c are included in Table 11.

Table 11: Regression Table for Hypothesis H2a-c: Indirect Effect of X (Average Intrapersonal Identity Conflict among Cultural, Organisational, Professional and Team identities) on Y via Relational Coordination (M).

<table>
<thead>
<tr>
<th>Y (dependent variable)</th>
<th>Indirect Effect</th>
<th>Boot SE</th>
<th>Boot LL CI</th>
<th>Boot ULC I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient perception of care outcomes</td>
<td>-.265</td>
<td>.181</td>
<td>-.759</td>
<td>-.011</td>
</tr>
<tr>
<td>Clinician perception of care outcomes</td>
<td>-.081</td>
<td>.055</td>
<td>-.222</td>
<td>-.004</td>
</tr>
<tr>
<td>Clinician satisfaction</td>
<td>-.213</td>
<td>.125</td>
<td>-.504</td>
<td>-.003</td>
</tr>
<tr>
<td>Negative affect</td>
<td>.148</td>
<td>.095</td>
<td>.008</td>
<td>.392</td>
</tr>
</tbody>
</table>

Note: Bias-corrected 95% confidence intervals from 5000 bootstrapped samples
N=37
Hypothesis 3: Strength of Team Identity is Positively Related to Relational Coordination

To test the proportion of variance in relational coordination that can be accounted for by the strength of team identity, beyond that already accounted for by the control variables (psychological safety, intragroup conflict, professional experience and experience with Australian Healthcare System), a hierarchical multiple regression analysis (MRA) was performed with strength of team identity as independent variable (IV) and relational coordination (RC) as dependent variable (DV).

Before interpreting the results of the MRA, a number of assumptions were tested, and checks were performed. First, stem-and-leaf plots and boxplots indicated that each variable in the regression was normally distributed and free from univariate outliers. Second, an inspection of the normal probability plot of standardized residuals and the scatterplot of standardized residuals against standardized predictive values indicated that the assumption of normality, linearity and homoscedasticity of residuals were met. Third, Mahalanobis distance did not exceed the critical \( \chi^2 \) for df = 5 (at \( p = .01 \)) of 15.09 for any cases in the data file, indicating that the multivariate outliers were not of concern. Finally, relatively high tolerance for the two predictors in the final regression model indicated that multicollinearity would not interfere with the interpretation of the outcome of the MRA.

On step 1 of the hierarchical MRA, the four controls accounted for a non-significant 7.9% of the variance in relational coordination, \( R^2 = .079, F (4, 32) = 6.91 \). \( p = .604 \). On step 2, strength of team identity was added to the regression equation, and accounted for an additional 8.7% variance in relational coordination (\( \Delta R^2 = .087, \Delta F = 3.21, p = .083 \)). In combination, the control variables and strength of team identity explained 16.6% variance in relational coordination, \( R^2 = .166, F (5, 31) = 1.23, p = .317 \). These results fail to support the hypothesis that strength of team identity is positively related to relational coordination. The results are reported in
Table 12.
Table 12: Regression Table for Hypothesis H3: Hierarchical Regression Analysis Predicting Relational Coordination from Strength of Team Identity.

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Dependent variable=Relational Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 1</td>
</tr>
<tr>
<td>Psychological safety</td>
<td>-.238</td>
</tr>
<tr>
<td>Intragroup Conflict</td>
<td>-.358</td>
</tr>
<tr>
<td>Professional Experience</td>
<td>-.064</td>
</tr>
<tr>
<td>Experience with Australian Healthcare System</td>
<td>.029</td>
</tr>
<tr>
<td>Strength of Team Identity</td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.079</td>
</tr>
<tr>
<td>$\Delta R^2$</td>
<td></td>
</tr>
</tbody>
</table>

Note. *$p < .05$, **$p < .01$. $N = 137$. Unless specified otherwise, values are standardized regression coefficients.

Hypotheses 4a-f: The Moderating Effect of Organizational Practices on the Relationship Between Intrapersonal Identity Conflict and Relational Coordination

Hypothesis 4 stated that the relationship between ‘mean intrapersonal identity conflict’ and relational coordination is moderated by (a) multidisciplinary training, (b) multidisciplinary meetings, (c) multidisciplinary boundary spanners, (d) leadership training (e) communication training, (f), and use of informal (social) events such that they reduce the negative consequences of identity conflict for relational coordination. However, as reported above, insufficient aggregation indices meant that I was unable to test H4b regrading team meetings and H4c regrading boundary spanners. Hence I report the results of H4a, H4d, H4e and H4f here.

Moderated regression analyses were undertaken using Hayes’ (2013) PROCESS add-on for SPSS. The control variables for the moderation analyses were intragroup conflict, psychological safety, years of professional experience after gaining healthcare qualification and years of experience with the Australian healthcare system. As reported in Table 13 to Table 16, there was no support for the four hypotheses. In each case, the overall model failed to account for a significant portion of the variance in relational coordination, and the interaction term did not result in a significant change in $r$-square. For H4a regarding multidisciplinary team training the overall model $R^2 = .17$, $F (7, 29) = .63$, $p = .726$ (n.s) and interaction term accounted for 2.9% of variance in relational coordination, $F (1, 29) = .816$, $p = .374$. For H4d regarding leadership training the overall model $R^2 = .19$, $F (7, 29) = .58$, $p = .765$ (n.s) and the
interaction term accounted for a non-significant 7.6% of variance in relational coordination, F (1, 29) =1.443, p=.239. For H4e regarding communication training the overall model $R^2 = .19$, F (7, 29) = .57, p= .775 (n.s) and the interaction term accounted for a non-significant 0.4% variance in relational coordination, F (1, 29) = .114, p=.738. And finally for H4f regarding social events the overall $R^2 = .12$, F (7, 29) = .55, p= .793 (n.s), and the interaction term accounted for a 0% of variance in relational coordination, F (1, 29) = .006, p=.940.

Table 13: Moderation table for Hypothesis H4a: Moderation of Organisational Practice of Multidisciplinary Team Training on ‘Mean Intrapersonal Identity Conflict among Cultural, Organisational, Professional and Team Identities’ and Relational Coordination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B (95% CI)</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>5.39 (1.46, 9.32)</td>
<td>1.922</td>
<td>2.80</td>
<td>p=0.009</td>
</tr>
<tr>
<td>Intrapersonal identity conflict (IIC)</td>
<td>-0.31 (-0.88, 0.26)</td>
<td>0.278</td>
<td>-1.12</td>
<td>p=0.270</td>
</tr>
<tr>
<td>Multidisciplinary team training (MDT)</td>
<td>0.26 (-0.16, 0.67)</td>
<td>0.203</td>
<td>1.26</td>
<td>p=0.218</td>
</tr>
<tr>
<td>IIC* MDT (interaction)</td>
<td>0.55 (-0.69, 1.79)</td>
<td>0.608</td>
<td>0.90</td>
<td>p=0.374</td>
</tr>
</tbody>
</table>

$R^2 = .169$
$\Delta R^2 = .029$

Table 14: Moderation Table for Hypothesis H4c: Moderation of Organisational Practice of Leadership Training on ‘Mean Intrapersonal Identity Conflict among Cultural, Organisational, Professional and Team identities’ and Relational Coordination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B (95% CI)</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>5.24 (1.51, 8.95)</td>
<td>1.820</td>
<td>2.89</td>
<td>p=0.007</td>
</tr>
<tr>
<td>Intrapersonal identity conflict (IIC)</td>
<td>-0.17 (-0.71, 0.37)</td>
<td>0.263</td>
<td>-0.65</td>
<td>p=0.520</td>
</tr>
<tr>
<td>Leadership training</td>
<td>0.15 (-2.13, 0.51)</td>
<td>0.178</td>
<td>0.84</td>
<td>p=0.405</td>
</tr>
<tr>
<td>IIC*LT (interaction)</td>
<td>0.87 (-0.61, 2.34)</td>
<td>0.720</td>
<td>1.20</td>
<td>p=0.239</td>
</tr>
</tbody>
</table>

$R^2 = .193$
$\Delta R^2 = .076$
Table 15: Moderation Table for Hypothesis H4d: Moderation of Organisational Practice of Communication Training on ‘Mean Intrapersonal Identity Conflict among Cultural, Organisational, Professional and Team Identities’ and Relational Coordination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B (95% CI)</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>6.07 (2.38, 9.75)</td>
<td>1.802</td>
<td>3.37</td>
<td>p=0.002</td>
</tr>
<tr>
<td>Intrapersonal identity conflict (IIC)</td>
<td>-0.12 (-0.68, 0.46)</td>
<td>0.276</td>
<td>-0.43</td>
<td>p=0.669</td>
</tr>
<tr>
<td>Communication training (CT)</td>
<td>0.23 (-0.11, 0.57)</td>
<td>0.166</td>
<td>1.41</td>
<td>p=0.169</td>
</tr>
<tr>
<td>IIC*CT (interaction)</td>
<td>0.16 (-0.83, 1.18)</td>
<td>0.481</td>
<td>0.34</td>
<td>p=0.738</td>
</tr>
</tbody>
</table>

$R^2 = .188$
$\Delta R^2 = .004$

Table 16: Moderation Table for Hypothesis H4e: Moderation of Organisational Practice of ‘Organising Social Events’ on ‘Mean Intrapersonal Identity Conflict among Cultural, Organisational, Professional and Team Identities’ and Relational Coordination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B (95% CI)</th>
<th>SE</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>5.40 (1.77, 9.04)</td>
<td>1.776</td>
<td>3.04</td>
<td>p=0.005</td>
</tr>
<tr>
<td>Intrapersonal identity conflict (IIC)</td>
<td>-0.20 (-0.80, 0.40)</td>
<td>0.295</td>
<td>-0.68</td>
<td>p=0.501</td>
</tr>
<tr>
<td>Social events (SE)</td>
<td>0.13 (-0.21, 0.46)</td>
<td>0.161</td>
<td>0.78</td>
<td>p=0.443</td>
</tr>
<tr>
<td>IIC*SE (interaction)</td>
<td>0.042 (-0.91, 0.63)</td>
<td>0.547</td>
<td>0.08</td>
<td>p=0.940</td>
</tr>
</tbody>
</table>

$R^2 = .123$
$\Delta R^2 = .000$
Hypothesis H5a-f: The Relationship Between Organizational Practices and Strength of Team Identity

Hypothesis H5 stated that the relationship between (a) multidisciplinary training, (b) multidisciplinary meetings, (c) use of boundary spanning positions, (d) leadership training, (e) communication training, and (f) use of social events in complex teams and strength of team identity is positive, such that more prevalent is the use of such techniques, the stronger the team identity.

To test this hypothesis, a standard multiple regression analysis (MRA) was performed with strength of team identity as the dependent variable and multidisciplinary training, leadership training, communication training and use of social events, entered together, as independent variables. Two organisational practices, multidisciplinary meetings and use of boundary spanning positions, were not included in the regression model due to poor aggregation statistics.

Before interpreting the results of the MRA, a number of assumptions were tested, and checks were performed. First, stem-and-leaf plots and boxplots indicated that each variable in the regression was normally distributed and free from univariate outliers. Second, an inspection of the normal probability plot of standardized residuals and the scatterplot of standardized residuals against standardized predictive values indicated that the assumption of normality, linearity and homoscedasticity of residuals were met. Third, Mahalanobis distance did not exceed the critical $\chi^2$ for $df=4$ (at $p=.01$) of 13.28 for any cases in the data file, indicating that the multivariate outliers were not of concern. Finally, relatively high tolerance for the four predictors in the final regression model indicated that multicollinearity would not interfere with the interpretation of the outcome of the MRA.

In combination, the four organisational practices of multidisciplinary team training, leadership training, communication training and use of social events predicted a significant portion of variance in strength of team identity, $R^2=0.29$, $F (4, 32) =3.33$, $p<.05$. Among the four practices, communication training was the only significant predictor of strength of team identity ($b=0.26$, $t=2.38$, $p<0.05$). Organisational practices of multidisciplinary training, leadership training and use of social events did not contribute significantly to the strength of team identity. The results for H5a-f are included in Table 17.
**Table 17**: Regression table for Hypothesis H5a-f: Unstandardised (B) and Standardized (β) Regression Coefficients, and Squared Semi-partial (or ‘part’) Correlations (sr²) in the Regression Model Predicting Strength of Team Identity (N=37).

<table>
<thead>
<tr>
<th>Variable</th>
<th>B [95% CI]</th>
<th>β</th>
<th>sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary training</td>
<td>0.14 [-0.12, 0.41]</td>
<td>0.19</td>
<td>.03</td>
</tr>
<tr>
<td>Leadership training</td>
<td>0.08 [-0.19, 0.34]</td>
<td>0.13</td>
<td>.01</td>
</tr>
<tr>
<td>Communication training</td>
<td>0.26 [0.04, 0.49]</td>
<td>0.48* .12</td>
<td></td>
</tr>
<tr>
<td>Social events</td>
<td>-0.09 [-0.30, 0.12]</td>
<td>-0.19</td>
<td>.02</td>
</tr>
</tbody>
</table>

*Note. CI=confidence interval
**p<.001, *p<.05

**Model summary**

<table>
<thead>
<tr>
<th>R</th>
<th>R Square</th>
<th>Std. Error of the Estimate</th>
<th>Change Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>.542*</td>
<td>.294</td>
<td>.255</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>R Square Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.294</td>
</tr>
</tbody>
</table>

As a post hoc analyses, I explored whether the practices predicted other phenomenon in our model. Substituting the dependent variable strength of team identity with other dependent variables, I found no effect of the four practices on mean intraindividual identity conflict (R²=.07, F=.586, p=.675) or relational coordination (R²=.09, F=.768, p=.554). I also explored effects on outcomes, finding no effect of the practices on outcomes of patient care including patient perception (R²=.034, F=.285, p=.886) and clinician perception (R²=.136, F=1.256, p=.307) of care outcomes, job satisfaction (R²=.043, F=.363, p=.833) and group affect (R²=.027, F=.220, p=.926).
DISCUSSION OF PHASE 2

The quantitative study complemented the qualitative study in investigating the impact of conflictual identity interactions on organizationally relevant outcomes in a team setting. Specifically, the study found support for the negative impact of conflict among four identities (cultural, organizational, professional and team identities) on outcomes of quality of performance, clinician job satisfaction and emergence of group affect. Most importantly, the role of relational coordination in mediating the negative effect of identity conflict on work outcomes was confirmed. I also found that the organizational practice of communication training is a powerful predictor of strength of team identity. Given prior research indicates the importance of a strong team identity for team effectiveness, this finding suggests a possible avenue for increasing the effectiveness of teams in a healthcare setting. The overall results for all hypotheses are summarized in Table 18.

Table 18: Summary of Results.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Team-level identity conflict emerges through processes of interaction in teams; this team-level construct predicts variance in relational coordination beyond the mean level of intrapersonal identity conflict of team members.</td>
<td>Not supported</td>
</tr>
<tr>
<td>H2a</td>
<td>Mean intrapersonal identity conflict among cultural, organisational, professional and team identities in multidisciplinary patient care teams is negatively related to quality of patient care provided; this relationship is mediated by relational coordination such that less identity conflict, the more RC, and thus better work outcomes.</td>
<td>Supported</td>
</tr>
<tr>
<td>H2b</td>
<td>Mean intrapersonal identity conflict among cultural, organisational, professional and team identities in multidisciplinary teams is negatively related to clinician job satisfaction; this relationship is mediated by relational coordination such that less identity conflict, the more relational coordination, and thus better clinician job satisfaction.</td>
<td>Supported</td>
</tr>
<tr>
<td>H2c</td>
<td>Mean intrapersonal identity conflict among cultural, organisational, professional and team identities in teams increases negative group affect; this relationship is mediated by relational coordination such that more identity conflict, the less relational coordination, and the more negative group affect.</td>
<td>Supported</td>
</tr>
<tr>
<td>H3</td>
<td>Strength of team identity is positively related to relational coordination.</td>
<td>Not supported</td>
</tr>
<tr>
<td>H4a-f</td>
<td>The relationship between mean intrapersonal identity conflict and relational coordination is moderated by (a) multidisciplinary team training, (b) multidisciplinary team meetings, (c) multidisciplinary boundary spanners,(d) leadership training (e) communication training, (f), and use of informal (social) events such that they reduce the negative consequences of identity conflict for relational coordination.</td>
<td>Not supported</td>
</tr>
<tr>
<td>H5a-f</td>
<td>The relationship between (a) Multidisciplinary team training, (b) multidisciplinary team meetings, (c) use of boundary spanning positions, (d) leadership training, (e) communication training, and (f) use of social events in complex teams and strength of team identity is positive, such that more prevalent is the use of such techniques, the stronger the team identity.</td>
<td>Supported for 5e.</td>
</tr>
</tbody>
</table>
Although the qualitative study had revealed the possibility that a collective team identity conflict emerged via the phenomena of convergence and compilation, the quantitative analysis indicated that this phenomena failed to predict additional variance in relational conflict beyond the mean of intra-individual identity conflict. I suspect that I failed to find support for this relationship not only because of the small sample size but also limited between-team differences in the team level construct. Another reason for lack of support for the team identity conflict construct could be possible confusion of the respondent over the comprehension of the team definition. Although the survey questions primed the respondent to think of the most recent multidisciplinary ‘shift’ team/daily rostered team’ of which the person was a part, there is a possibility that respondents were sometimes thinking of the whole department as a team rather than the daily shift and giving more ‘socially desirable’ responses to maintain their departmental team identity in light of the inter-departmental conflicts that are well-known in healthcare settings. There is also a possibility that respondents gave more ‘socially desirable’ answers to project their ‘shift’ team in a better light. Also, since the team identity conflict is a novel construct that has not been explored in research before, further development and validation of the team identity conflict scale is needed to fully capture the elements of this collective entity. In general, quantitative research on emergence processes is lacking (Fulmer & Ostroff, 2016; Kozlowski, Chao, Kazak, Mcdaniel, & Salas, 2018) and the limited research on the topic acknowledges the challenges of developing new measures to capture the complex phenomena (Fulmer & Ostroff, 2016; Stiffman, 2009).

Similarly, I did not find support for the moderating effect of organizational practices in mitigating the negative consequences of identity conflict on relational coordination. I anticipate that this was again due to the small sample size. Detection of moderating effects needs substantially larger sample size than for non-moderated relationships (Dawson, 2014). I discuss the problems in collecting a reasonable sample size below in the limitations section.

In summary, the research model was only partially supported. The relationships that were evidenced suggest implications for theory development which I discuss below and in the next chapter. Here I also discuss the limitations of this quantitative study and avenues for future research.
Implications for Theory

I empirically investigated a model of impact of intrapersonal identity interaction on interpersonal relationships and work outcomes. Theory as to how identities interact within individuals is nascent, and extrapolating these within-person interactions to understand team dynamics has rarely been attempted. Specifically, research so far has not attempted to integrate ‘intrapersonal identities’ and ‘interpersonal relations and communications’ together in one model to understand important work outcomes. The model provides novel insights by connecting intrapsychic and interpersonal phenomena.

Exploring the model resulted in important contributions to theory regarding social identities, relational coordination, and team effectiveness in complex teams. First, with regard to social identification, I found that it was not the strength of team identity on its own that mattered for team processes and outcomes, rather it was the interaction among four sources of identity (cultural, organizational, professional and team identities) that had implications for the teams in my sample. This extends prior research which focuses on team identity in isolation of other source of identity (e.g. Eckel & Grossman, 2005; Litchfield et al., 2018), or which examines only two sources of identity and the complimentary (or detrimental) combinations of these affiliations (e.g. Mitchell et al., 2011).

The approach to understand identities important in team contexts was extended. Complex teams have become increasingly common in modern organisations (Crampton & Hinds, 2014) and several empirical studies about the determinants and success factors of such teams have been published in the recent years (Berg & Holtbrügge, 2010; Gibson & Gibbs 2006; Mockaitis, Zander, & De Cieri, 2018). However, there is limited research on complex teams that explores the impact of multiple identity interactions on team outcomes in organisations, and there remain important questions to be answered. The current study helped us understand four intrapersonal identities at the same time, as well as the conflict among them. I provide empirical evidence that it is not the strength of any one identity per se but the relationships among them that predicts team dynamics.

Second, with regard to relational coordination, I explored underlying mechanisms pertaining to interpersonal processes. The model proposed that one way to understand the psychology of complex teams is through application of the lens of the self, such that the identities one holds influence interpersonal relationships, which may then be considered a part of the
extended self. There is limited research that has empirically investigated the role of specific emergent processes for navigating identity dynamics in the context of complex teams; scholars examining relational coordination have not explicitly considered how intra-individual identity dynamics might impact the communication and relationship patterns between members of complex teams. I found that relational coordination is an important explanatory mechanism in the link between intraindividual identities and outcomes in teams, including patient care, clinician satisfaction and group affect.

Third, with regard to team effectiveness, I shed light on how identity dynamics can play out in teams. In the current study, it was not that identity conflict directly influenced team outcomes, but rather they influenced outcomes through their effects on relational coordination. This helps to direct attention toward relational coordination as an important means of bridging individual and team phenomenon in organizations, extending the current research on coordination by teams scholars (e.g. Azizan, Darus, & Othman, 2017; Bourbousson, R’kiouak, & Eccles, 2015; Gorman, 2014).

Finally, I found that communication training is a promising avenue for developing teams in health care settings. This was also evident in the Phase I interview study, with many respondents suggesting that communications were an important determinant of error reduction and quality of care. It is generally acknowledged in literature that not all teams grow organically and many fail to thrive if not adequately nurtured (Jefferies & Chan, 2004; Onyett & Ford, 1996). There is limited research that has empirically investigated the role of organizational practices in mitigating identity dynamics, and my findings point toward a specific training intervention that may improve team effectiveness.

Limitations of the Quantitative Study and Directions for Future Research

Perhaps the greatest limitation of this study is the small sample size. Particularly in health care settings, clinicians have limited time to complete onsite surveys, hence our strategy of dividing survey administration into two parts (online in non-work hours and on-site). Although response rates to each of these independently were in line with prior studies, my design required matched data and team level aggregation which meant that the final tests were conducted on a limited sample. Field research involving teams is renowned for logistic difficulties (Stiffman, 2009). I recommend future research continue to explore means of obtaining data regarding larger samples of teams. Observational data onsite may reduce the time requirements for clinicians, but increases
the researcher resources required (e.g., time, number of researchers). I believe these trade-offs are justified for the potential gain in sample size and the importance of the context. Also, the explicit focus of the quantitative study was on conflictual relationships among identities rather than a more comprehensive investigation of all possible relationships among the identities under investigation. I encourage future research to utilize a more expansive operationalization, as I discuss in the final chapter.

A second limitation is that I was unable to use a longitudinal or quasi-experimental design (due to time and resource constraints of a dissertation), so I am unable to make more definitive statements about causality. I took several precautions to reduce same source bias and mitigate limitations of the design, including separate surveys (online and onsite) for different aspects of the model, and perhaps most importantly, collecting patient perceptions of quality of care. This was time consuming and challenging (and likely reduced the sample size, because was unable to obtain patient ratings for all teams, given some patients were not in good enough health to respond), but I believe that it was critical to the validity of the findings. Longitudinal, quasi-experimental designs are very rare in teams research and more specifically in health care settings, but I implore future researchers to examine the phenomenon of interest over time and with interventions, to help understand both causality and patterns of change.

I was disappointed that the team-level identity conflict construct did not explain much variance in relational coordination. As mentioned above, this may have been due to limited between-team differences in the team-level construct. Yet, given the findings in Phase I, emergence of identity conflict as a team level construct is an exciting avenue of research. Future research should continue to refine the measure of the team level construct, to increase sensitivity to potential social desirability bias (e.g., respondents might have been reluctant to report low scores on these particular items). Understanding the developmental trajectory of team identity conflict can potentially lead to better solutions to mitigate its negative effects on relational coordination and organisationally relevant outcomes. Future studies might also investigate the emergence of team identity conflict construct in different contexts.

Organisational practices specific to the context that can strengthen relational coordination via development of a strong team identity can be explored in different settings via the research model. Although I found limited support for the moderating effects of organisational practices on mitigating the negative impact of average identity conflict on relational coordination, I implore
future researchers to investigate this effect in different contexts using larger sample sizes. Similarly, future research can explore the correlation between team identity strength and relational coordination in greater depth to identify novel practices that can lead to better interpersonal relationships in a team context.

**Conclusion**

This quantitative study helps in uncovering the complexity of multiple identity interactions in modern organisations. The study tested a model of intrapersonal identity conflict on interpersonal relationships and work outcomes in team settings and provides empirical evidence of the mediating effect of relational coordination in understanding the impact of intrapersonal identity conflict on organisationally relevant outcomes. More specifically, the study provided support for the impact of intrapersonal identity conflict on work performance, clinician job satisfaction and emergence of negative affect among members working together in complex teams. It also underscores the importance of communication training to mitigate the negative consequences of intrapersonal identity conflict. Taken together, the quantitative study provides a more comprehensive understanding of the challenges and opportunities presented by the multiple identities that a person can hold.
Chapter 5: Discussion

The purpose of this dissertation was to develop and test a model of the relationship between identity conflict and work outcomes in complex teams. Specifically, I set out to investigate how multiple identities (cultural, organisational, professional and team identities) interact intrapersonally within each member of a team, and whether identity conflict characterizes a given team. The project also examined the impact of such multiple identity interactions on outcomes such as quality of work output provided by the team, job satisfaction and emergence of group affect. Relational coordination was a proposed mediator of the relationship between team identity conflict and team work outcomes. Finally, the research also considered important potential moderators of the relationship between identity patterns and relational coordination such as multidisciplinary training, multidisciplinary meetings, use of boundary spanners, leadership training, communication training and organising social events. The current model and findings suggest that conflict among identities in a team context has important implications for interpersonal relationships and team outcomes.

The exploratory qualitative study helped in gleaning better understanding of each of the four identities (cultural, organisational, professional and team identities) and also the interrelationship among them. As discussed in chapter 3, intrapersonal identity conflict emerged as an interplay between deep and situated identities with evidence that it impacts interpersonal relationships and outcomes within a team context. This study also provided preliminary evidence of emergence of a team level identity conflict through the processes of convergence and compilation. The study uncovered the possibility that the negative consequences of identity conflicts can be alleviated by organisational practices that reveal and clarify priorities and roles of each function within the multidisciplinary team. Though exploratory in nature, this qualitative phase was a comprehensive study that not only led to refinement of the quantitative phase but can be considered an important contribution to team and identity literature in itself. It also contributes to international business and migration studies by providing rich narratives of how overseas and locally trained professionals perceive and experience the conflict between their multiple priorities and affiliations, and the challenges they face in working in complex multidisciplinary and multicultural teams.

The refined model after qualitative analysis was examined using survey methods.

The results indicated that relational coordination mediates the negative relationship between intrapersonal identity conflict and outcomes i.e. the central tendency in a team to experience intrapersonal identity conflict negatively affects communication and coordination within a team.
(relational coordination) and this in turn negatively impacts patient care outcomes and clinician job satisfaction, and results in negative group affect. Finally, communication training was positively related to strength of team identity.

Although the current model was not completely validated through the quantitative study, it did lead to better understanding of the conflictual relationship among identities in a team context. The implications of this research for both theory and practice are discussed next.

**Implications for Theory**

**Implications for identity theory.** Through a sequential mixed methods research design, where the results from qualitative and quantitative studies provided for elaboration and triangulation of results, this thesis investigated the confluence of multiple affiliations in the workplace and contributes to current identity research which is primarily focused on consideration of one identity (e.g., team identification) or a pair of identities in most instances (e.g. organisational and team identification). The scant identity research that investigates more than one or two identities (e.g. Ramarajan et al., 2017) suggests that the intrapersonal impacts of identity conflict across three or more identities is quite complex and not well understood. The current research answers the call for identity studies to move beyond a two identities approach to a more comprehensive investigation of relevant identities in a given context.

The qualitative study indicated that four different identities (cultural, organisational, professional and team identities) were relevant in the healthcare setting, and also helped us to understand that specific content of cultural identities may not always be about national or country differences. In my study, respondents indicated that the context in which they obtained their professional training was formative in terms of cultural values, hence this may be a better indicator of culture in some settings. Moreover, the current consensus in identity research is that though multiple identities exist, a single salient identity influences and guides human behaviour in a given situation. However, this was not the case in the current research, which instead highlights the impact of several identities that are co-activated together and simultaneously influence behaviour. Hence this thesis is a step forward in establishing that relationships among identities are an important means of understanding organisational outcomes.
Further, I empirically examined multiple identities interactions in complex healthcare teams across four hospitals. This research is one of the rare studies in identity research that investigates multiple identity dynamics in real life organisations; most identity studies draw from student samples or have an experimental design, not only due to the complexity of the topic but also practical difficulties of conducting identity research in real work organisations.

Identity research is limited in its approach as there is no overarching framework or model to investigate the complexity of inter-relationships between multiple identities and its impact on work outcomes. I contribute to identity literature through development of a model that can help investigate the impact of intrapersonal identity conflict on work outcomes in different contexts. Identity scholars can examine how identities are connected within and between individuals and influence intrapersonal and intergroup relationships in different contexts. Organisational outcomes of interest can be investigated using the model and novel antecedents, mediators and moderators can be considered to understand the identity dynamics specific to the context. Research on multiple identities is gaining momentum. The research model developed extends the intrapersonal identity approach to provide a way of moving forward in the area of identity research.

Finally, extant identity literature has not yet discussed emergence of collective constructs such as team identity conflict or the developmental mechanism by which team identity conflict might arise. Exploring dynamics of such emergent phenomena is an exciting avenue of identity research that can add to our current understanding of identity interactions. This study is a step forward in identity research as it attempts to understand the origin and developmental trajectory of team identity conflict. My qualitative study provided strong evidence of emergence of identity conflict as a team level construct through compilation and convergence phenomena. Although the quantitative study did not find support for the idea that a collective team identity conflict accounted for additional variance in relational coordination beyond mean intrapersonal identity conflict, I believe this collective phenomenon to be an important avenue for future research. Generally, understanding emergence of collective identity concepts within teams is a promising means of extending current theory. For example, the processes of compilation and convergence might also occur in the emergence of team identity, in the emergence of a shared professional identity, or in the emergence of shared organizational and cultural identities. I encourage additional research in this regard. An understanding of the developmental trajectory of the collective construct along with functional analysis (outcome/effects) of the construct will help in better understanding of collective identity dynamics.
Implications for team theory. A long history of research has examined the extent to which individuals identify with a given social group and how this impacts personal and organizational outcomes. In the team’s literature, particular attention has been given to team identification, demonstrating positive outcomes of it for teams and their members (e.g. Dietz et al., 2015; Mitchell et al., 2011; Mitchell et al., 2015). However, this research has failed to acknowledge and address the multiple simultaneous affiliations members may hold, alongside their team identity. Many workers report a negative experience when such identities carry with them different priorities, yet we have little systematic evidence about these inter-relationships, and no research on these issues in complex teams, which may be formed specifically to bring together the diverse knowledge which results from the affiliations members hold.

My findings extend the nascent literature on multiple individual identities in new directions, indicating the value of comprehensive consideration of team phenomenon alongside the individual concepts. Specifically, I show the importance of considering mean intraindividual conflict among identities, in order to understand how diverse teams navigate the multiple affiliations that serve as the sources of diversity within them. Thus, an important contribution of the research is integrating intrapersonal identity interactions and interpersonal relationships in one model. This research confirmed the mediation of relational coordination in the effect of intrapersonal identity conflict on teams. The relationship between identity conflict and relational coordination in teams has not been explored in literature before, making findings in this regard one of the novel contributions of this research.

Further, although prior research has demonstrated that emotions can be shared such that group affect develops (Smith et al., 2007), there is scant research that explores the role of intrapersonal identity conflict in development of negative group affect. This research shows evidence that negative group affect emerges due to identity conflicts and the coordination difficulties caused by these identity-based interactions in team settings. The qualitative study provided preliminary evidence to support the mechanism and this was further confirmed in the quantitative phase.

More generally, this research suggests that capturing the degree to which there is conflict among identities is important for understanding how best to improve the effectiveness of diverse teams. Conflict among identities might be an overlooked factor in explaining the mixed and even contradictory findings on the relationship between team diversity and team effectiveness (e.g., Van
Knippenberg & Schippers, 2007). The key here is to understand that individuals benefit in a team when they connect to perspectives associated with multiple diverse identities, as opposed to when they take one perspective based on a single identity, or a strong unifying team identity. Such interactions help members arrive at optimal distinctiveness – that is, managing the tension between the need for belonging to a group while at the same time maintaining uniqueness and individuation (Brewer, 1991; Brewer, 2001). Where distinct identities are maintained but are also compatible, allows for such optimal distinctiveness.

There is very little in the teams literature which indicates means of navigating identity dynamics as members collaborate. I controlled for psychological safety, but I also anticipate that it may be critical in terms of allowing for optimal distinctiveness of one’s identities. As psychological safety is rooted in and characterized by interpersonal trust and respect (Edmondson, 2004), members feel safe to experience and express their different identities without suppressing them. In a recent study, Rogers & Ashforth (2017) argued that there are two distinct types of respect: generalized respect is the sense that “we” are all valued in this organization, and particularized respect is the sense that the organization values “me” for particular attributes, behaviors, and achievements; further these two types of respect can lead to development of psychological safety. I contend that when employees receive particularised respect, in addition to generalized respect, they feel safe to experience and express their different identities without suppressing them. Thus, psychological safety can not only potentially support development of a strong team identity (Luan, Rico, Xie, & Zhang, 2016), but also help in simultaneously nurturing other identities important to the individual such as cultural or professional identity. I implore future research to analyse the role of psychological safety in identity interactions in greater depth.

**Implications for international management.** Skills shortage in health care has led to a reliance on overseas trained healthcare professionals; skilled migration has added to complexity of healthcare teams that are not only multidisciplinary but also increasingly multicultural. As an example, more than 50% of professionals who participated in this study had overseas qualifications. These skilled migrants are an important talent pool for the host organisations, yet they face enormous challenges in integration in the employing organisations. The qualitative study provided rich examples of how these overseas trained professionals juggle their cultural identity along with their professional, organisational and team affiliations and often experience conflict among them. Respondents often discussed their challenges in navigating their different identities and also identified organisational practices that could lead to better integration in organisations.
An often overlooked phenomenon in migration studies is the perception and experience of the local employees of working in multicultural teams and how they cope with the challenge of the demands of working across professionals who might have been trained in a different way. The qualitative study contributes by analysis of the experience of the locally trained professionals and provides examples of the challenges faced by them in complex multicultural teams.

Although the quantitative study did not investigate the overseas versus locally trained dynamics specifically, I provide empirical evidence that when members of teams experience multiple identity conflict, including their cultural identity, this is negatively related to interpersonal relationships within the team as also organisational outcomes. This occurs not just in health care but in other industries such as electronics, chemicals, mining and engineering, life sciences, education, communications and media, and logistics, to name just a few. For example, Yeoh, Lam, Fong, Verkuyten, & Choi (2016) describe how the bid to develop Singapore into a global hub for high-tech, knowledge-intensive industries has underpinned Singapore’s push to augment its local talent pool by attracting highly skilled transnational migrants and how this results in identity issues for the society. Similarly, as highly skilled immigrants and other professionals enter workplaces and collaborate in global teams, sources of identification beyond the team such as nationality or profession may become salient and may represent sources of conflict or tension in the team (Hekman et al., 2009; Kang & Bodenhausen, 2015).

The trend for skilled migration is likely to continue in the foreseeable future. A recent newspaper report (Cavanough, 2018) stated that the medical skills shortage will worsen in the coming years and healthcare systems in first world countries will come to rely more on overseas trained healthcare professionals. Similarly, the Australian Financial Review (Greber & Wiggins, 2018) reported that a worsening skills shortage across critical hotspots of the Australian national economy including mining, construction and IT has started to cause investment bottlenecks that may be limiting the broader labour market; this might necessitate influx of overseas trained professionals to address the skills shortage. This suggests the importance of considering how to be more inclusive in settings which encompass overseas and locally trained professionals side by side.

A concept that might be of help in this regard is inclusive leadership. An inclusive leadership style is a mode of ‘relational leadership’ (Hollander, 2009) where “leaders exhibit openness, accessibility, and availability in their interactions with followers” (Carmeli, Reiter-Palmon & Ziv, 2010, p.250). Thus, inclusive leadership might lead to strengthening of relational coordination within teams and improvement of work outcomes. Shore et al. (2011) describe that inclusive leaders develop an
encouraging context by creating a sense of value for the unique differences among employees and creating a sense of belonging. Such behaviours might help to ameliorate identity conflict by creation of an inclusive workplace where people feel respected for their individual differences and their contribution to the workplace. Research has established that inclusive leadership can lead to development of a psychologically safe environment where employees feel comfortable to share their ideas (Carmeli et al., 2010). As explained above, psychological safety can help employees acknowledge and experience their different identities without suppressing them resulting in reaching optimal distinctiveness, where they are proud to belong to the team, yet also experience uniqueness arising from their different identities and affiliations. I encourage future research to examine the role of inclusive leadership and psychological safety in greater depth in addressing the challenges of management of diverse teams and organisations.

Another useful concept that can be explored in future research in the context of multicultural teams is ‘diversity climate’. Diversity climate refers to the extent to which employees perceive that the organization values and promotes diversity (Kossek & Zonia 1993; Hajro, Gibson, & Pudelko, 2017). It is likely that when a strong diversity climate exists in an organisation or team, different identities can coexist and be expressed simultaneously, resulting in less intrapersonal identity conflict, better relational coordination and better work outcomes. For example, Hofhuis, Van der Zee & Otten (2011) in an empirical study investigating organisational and cultural identities, showed that in organisations with a strong diversity climate, members display a dual identity and identify both with their organisation and cultural groups simultaneously, manifesting in positive job-related outcomes. This research can be extended to explore more than a pair of identities to understand and appreciate the importance of diversity climate in mitigating intrapersonal identity conflict among multiple identities.

Implications for Practice

This study revealed managerial points of leverage that can potentially facilitate functional inter-relationships at both the intrapersonal and inter-personal levels, as well as the development of a strong team identity. This study also identifies recommendations for management of healthcare organisations and healthcare professionals. These recommendations can serve as important guidelines for development of healthcare policies. The research is of particular relevance in Australian organisations because although the Australian medical system has an enviable international reputation for the quality of its health care, it has a shortage of healthcare professionals and there are ethnic, regional and discipline related shortfalls in health and related services (Department of Jobs & Small Business, 2018).
For example, the Labour Market Research Health Professions Australia (2017-2018) Report states that 45 per cent of employers had unfilled vacancies in 2017-18, compared with 34 per cent in 2016-17 in the healthcare sector. Additionally, more than 28 per cent of employers attracted no suitable applicants for their vacancies in 2017-18, compared with 22 per cent in the previous year. It is apparent that Australia is competing in a global market for health professionals. The pool of available health professionals is drying up and there is a strong business case for Australian public health care system to understand and address the perceptions and needs of health professionals. The study attempts to provide answers for these pertinent questions.

Managers who understand how different identities can compete with each other are in a better position to design strategies to address the problems of low job performance and job satisfaction. Our findings indicate that if managers can understand and nurture the many different identities of their employees, and build strategies to create compatibility among multiple identities, they are better able to prevent multiple identity conflict. The key here is trying not to suppress important identities through over-emphasis on one particular identity and creating understanding about the interconnections between different identities.

My qualitative study underscored the importance of various organisational practices that team members deemed important for improving relational coordination and work outcomes and this is discussed in detail in Chapter 3. I have also provided illustrative quotes around utility of such organisational practices in Table 3. As an example, both the qualitative and quantitative studies emphasized the importance of communication training. Our interview study also highlighted that overseas trained professionals deem communication training to be the single most important intervention for their successful integration in healthcare organisations. As such, they also consider communication as the biggest challenge they face in Australian healthcare organisations. One respondent reiterated the importance of communication training during the interview in these words:

So if I’ve had incidences of staff where I need to address their communication skills, we actually don’t have much in the way of specific learning packages if someone who you felt was not dealing well with communication that you could send them to do. So we have, seemingly, lots of packages for lots of other things but I personally think we could do far better with the communication side of it because ninety per cent of the complaints and issues that I deal with, communication would be the basis, and if we’d sorted that then it wouldn’t have got to where it had...

However, our survey findings indicated that a good percentage of respondents (57.9 %) had never received communication training and some reported having only one day (16.5%) or 2 days
(15.7%) training in a given year. Given the importance of communication training, as evidenced by our study, we recommend increasing the frequency of this training, but also with special attention to training which occurs in teams (rather than individually). Team-training has been defined as a constellation of content (i.e. the specific knowledge, skills and attitudes that underlie targeted teamwork competencies), tools (i.e. team task analysis, performance measures) and delivery methods (i.e. information, demonstration and practice-based learning methods) that together form an instructional strategy (Weaver et al., 2017).

Several reviews have provided support for the notion that team training can improve participant knowledge/attitudes and both teamwork and outcomes processes (Schmutz & Manser, 2013; Sevdalis, Hull, & Birnbach, 2012; Weaver et al., 2017). Team communication training could potentially help members to understand and appreciate the differences that different professions and cultures bring to communication and help in development of a team identity. Interviewees indicated that important elements of this training might include communication with different professionals of the multidisciplinary team as also patients and family members. For example, an ICU consultant explained the importance of accurate and empathetic communication with families of critically ill patients and the difference in approach to this communication that arises due to differing professional or cultural affiliations. Team communication training around such issues, including all professionals of the multidisciplinary team, might develop more consistent information being conveyed to the families. I contend that team communication training can be developed by combining specific content with opportunities for practice, formative feedback and tools to support transfer of training to the daily care environment; such training is likely to enhance not only communication but also situational awareness, role clarity and better coordination to achieve better patient care outcomes.

More generally, I was surprised at how few of the organizational practices had been implemented multiple times in a given year. For example, 44.6% respondents indicated never receiving leadership training and my qualitative study findings show that such training is usually provided to team members in administrative roles only (for e.g. head of departments or nurse unit managers only). Similarly, multidisciplinary team training was deemed very important in the interviews but my survey findings indicated that less than 25% respondents had the opportunity to participate in such training. Yet, the interviews were filled with stories of errors and mistakes in judgement, as well as conflicts that may have been avoided with simple practices.
In contrast to the three practices of multidisciplinary, leadership and communication training, our respondents reported that they engaged in multidisciplinary meetings very frequently, in form of daily handovers and more formal meetings once in a week or fortnight. However, respondents noted that although held frequently and useful in theory, the meetings lacked a proper structure and efficient leadership and were usually not productive. The survey study indicated that 4.15% of respondents considered multidisciplinary meetings extremely useless, 8.3% mostly useless and 30.7% only somewhat useful. Respondents suggested that training for clinicians conducting such meeting was very important. This was summed up very well by one of the clinicians during our interview study, who noted

*I think multidisciplinary meetings are like any kind of meeting and it depends on the content and the Chair. So if the person who is leading the meeting ensures that the meeting is effective and efficient and meets the goal, then they're very effective. But I don’t think we really – traditionally in health we don’t know what (the MDT meeting) should look like. People don’t get any training on what it should look like, how to lead it, how to manage, how to facilitate. Yeah, they might not have any idea before they start leading the MDT meeting around what even all the professions do. So MDTs are very, very useful but they need to be structured and led. And probably a training issue as well, because people don’t really know how to do that. It’s something of an assumption that you would know but it’s not in place and even if you were a very skilled clinician, you might not be good at that. And that is partly the problem. So sometimes we expect the people who are very skilled, who have been around a long time, will be able to manage well or lead well or be able to facilitate things like that well but it’s a different skillset. They may have it, they may not.*

Similar issues of lack of efficient direction and leadership were raised around use of boundary spanning positions such as shift and ward coordinators. Again, respondents indicated that although potentially such positions could be very important in developing team identity and increasing relational coordination, many clinicians did not have the right skill set for such positions.

In summary, my study offers encouragement and guidance for those administrators considering different ways of improving team effectiveness. Organisational practices such as multidisciplinary training, multidisciplinary meetings, leadership training, communication training, use of social events and boundary spanners can prove to be effective managerial tools of better team management if used properly. Training of clinicians in administrative roles and team training seem to be the most pertinent solutions to address the challenge of successful implementation of such organisational practices.
Directions for Future Research

This study indicates several important avenues for future research. First, the proposed model can provide an agenda for future research. Identity scholars can examine how identities are connected within and between individuals and influence interpersonal and intergroup relationships in different contexts. Organisational outcomes of interest can be investigated using our model and novel antecedents, mediators and moderators can be considered to understand the identity dynamics specific to the context. Research on multiple identities is gaining momentum. My model extends the intrapersonal identity approach to provide a way of moving forward in the area of identity research.

Second, future identity studies are implored to take context and content of identities in consideration when designing the research studies. This is particularly relevant when research is focused on impact of multiple identities on specific performance outcomes, rather than investigating generalized outcomes. Qualitative research is especially important to capture the content and meaning of identities; recent examples of this include Kourtii 2016; Livingston & Haslam, 2008; Meister et al., 2017; Stubbs & Sallee, 2013. For example, Meister et al. (2017), through in-depth qualitative interviews of senior women leaders working in male-dominated industries, explored how they experience and respond to feeling misidentified between gender and leader identities throughout their careers. My finding that country of professional training was an important feature of cultural identity is another example. I anticipate other surprises may yet to be revealed if examining cultural identities. The literature on culture is wrought with empirical path dependence, wherein most studies examine the same dimensions popularized by international management research in the early 1980s (see Kirkman, Lowe and Gibson, 2017 for a review). Yet qualitative analysis might reveal collective experiences that are even more central to defining and characterizing a culture, or other reference groups beyond country that are essential components of cultural identity.

Likewise there is little known about the content of team identity. The interviewees indicated that shift work is central to defining “my team” in the healthcare context. Indeed, night shift workers, and in particular night shift workers in emergency rooms, often develop a particular identity that is a source of pride and self-concept. Similarly, healthcare professionals working in acute departments such as ICU often develop an identity which is different from the identity of professionals working in sub-acute departments such as Geriatrics/Aged Care as they face challenges that are totally different to each
other. In other settings, it may be a particular skill set or task experience that defines the content of the team identity. I view explorations of these elements as important next steps in the identity literature.

Third, the interview analysis suggests there may be a reciprocal relationship between intrapersonal identity patterns and inter-group relationships. Intrapersonal and interpersonal conflicts were interrelated and seemed to be reinforcing each other. For example, an overseas trained doctor (with a strong professional identity reinforced by training institutions, perhaps not having worked in multidisciplinary teams before), may re-examine his/her intrapersonal cultural, professional and team affiliations in light of the team dynamics over a period of time and this altered intrapersonal identity configuration will then impact the interpersonal relationships in the team.

Recent literature shows evidence for a reciprocal linkage between intrapersonal identity conflicts and group relationship quality. For example, research in a variety of areas is converging on the importance of identity dynamics in understanding ongoing and persistently negative interactions in organizations between and among professional groups (Fiol et al., 2009; O’Connor, Fiol, & Guthrie, 2006; Pratt & Rafaeli, 1997). Ashforth, Rogers and Corley (2011) postulate that identities at higher levels of analysis simultaneously constrain and enable the form and enactment of identities at lower levels, which similarly constrain and enable the higher-order identities. Measuring this reciprocity of intrapersonal and interpersonal identity conflict was outside the scope of this project. However, this is an important avenue for future research.

Finally, I mentioned previously that quasi-experimental designs that include interventions are a critical next step. I view as particularly promising the investigation of in situ simulation-based team training. 90.9% of our respondents rated the team training they had participated in as highly useful, suggesting this is promising. Multidisciplinary simulation in healthcare is defined as a broad training modality for teams that may include physical simulation of clinical care environments, standardised patients, cognitive simulations and role-play in both centre-based and in-situ activities that occur in the actual environment where care is provided (Daniels & Auguste, 2013). Evidence demonstrates that simulation-based team training has been successfully used for teaching technical/clinical skills and minimize poor patient care outcomes (Bayliss-Pratt, 2013; Kneebone et al., 2006; Moorthy et al., 2005; Yee et al., 2005). I contend that multidisciplinary simulation team training can be enhanced by a more explicit focus on non-technical skills, such as communication and coordination, in addition to teaching clinical skills.
Traditionally, healthcare education and training take place in separate schools for each profession (doctors, nurses and allied healthcare professionals). However, once formal education is complete, many health professionals and specialties find themselves caring for the same patient. It is not surprising that members of such teams have a slightly different focus to patient care rather than a team based approach to achieve optimum care outcomes. Similarly, overseas trained professionals may use a different lens to define and communicate health-related problems; this may result in communication and coordination challenges. In such a scenario, multidisciplinary simulation training can serve as a useful tool for perfecting the teamwork skills that cannot be taught in didactic settings. It can also be used to detect latent system errors in existing or new teams, to rehearse complicated procedures, and to identify knowledge gaps of healthcare teams. More importantly, it can help to understand the different schema people are using in a particular context and provide a platform for open communication and clarification. This can also help in identification of best practice for a particular context.

Multidisciplinary simulation-based team training should be an integral component of ongoing quality-improvement efforts to produce teams of experts that perform proficiently and cohesively. Future research can investigate in detail the different components of such training and effective ways of delivering such training. For example, research has shown that communication and leadership training both can be augmented by use of team simulation (Daniels & Auguste, 2013). Future research can help in development of specific packages to improve team outcomes.

**Conclusion**

As employees navigate different roles in complex teams in modern organisations, they often face conflicting priorities that map onto the content of their identities, resulting in multiple identity conflict. Using mixed methods research, I demonstrated how multiple identity conflict is related to interpersonal relationships and work outcomes of interest in a team context. Multiple identity conflict can not only impact relational coordination within a team but also negatively impact team performance and job satisfaction. It can also lead to development of negative group affect. An understanding of multiple identity interactions can prove useful to better team management and outcomes.

In addition, my study provides useful guidelines for healthcare policy and healthcare administrators. Given that members of healthcare teams often receive their education in silos, organisational practices that have a multidisciplinary team training approach can help in achieving
better care outcomes. Multidisciplinary simulation team training, including communication and leadership training, is deemed to be particularly beneficial in this context. Given that Australia continues to have a skills shortage in the healthcare sector and relies on the services of overseas trained professionals, I recommend better management of team diversity, addressing the perceptions and various affiliations of not only the overseas trained professionals but also their local counterparts.

Multiple identities can pose both opportunities and challenges and given the complexity of modern organisations, employees are likely to identify with an increasing number of social groups and roles. This study shows that one way of harnessing the benefits of multiple identities in modern organisations is to understand how these multiple identities relate to each other intrapersonally. Organisational policies and practices that promote experience and expression of different identities important to individuals and create synergy among them may be key to organisational success.
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Appendix A

Interview Protocol for healthcare professionals

1. Interviewee’s background

a. Profession (doctor, nurse, allied health professional, healthcare administrator) and designation (consultant doctor, senior registrar, resident/junior/trainee doctor, Nurse unit manager (NUM), senior nurse, junior nurse, medical director, physiotherapist, dietician, social worker, healthcare administrator)
b. Country of birth
c. Country of medical/nursing/healthcare education – date certification achieved
d. How long have you worked in Australia?
e. Have you worked in countries other than Australia? What was the duration of such overseas appointments?
f. Hospital – how long have you worked with this hospital?
g. Work unit – how long have you worked with this work unit?

2. Identity

a. How would you typically introduce yourself in a work-related environment?
b. Do you feel more allegiance to this hospital, your profession or your work-unit (specialty)?
c. How do you negotiate the demands of your specialty (work-unit) with that of the hospital? Do you sometimes encounter conflicting priorities? Can you give an example?
d. Do you think of members of your work-unit (specialty) you interact with as a team?
e. Does work occur in smaller subsets within the work-unit? Do you consider this your work team? Who is a part of each of these teams? How often do the members of this team change (Is it different for every patient? Consistent across patients with in a given day, but different across days? Every week?)
f. Do you think that the country of your birth or medical education impacts your view on society and health? How?
g. Does your country of birth or medical education impact what you expect from the organization, profession, your specialty and attitudes toward team work? How?

3. Relational coordination

For these next questions, please think about the subset of people you work with on a daily basis; I will refer to these people as your “work team.”

a. Do you feel comfortable being pretty open with other members of your work team about any work-related issues/questions/concerns?
b. How frequently does your work team communicate with you about the status of the patient?
c. Do people in your work team communicate with you in an accurate and timely manner about the status of the patients?
d. When an error has been made regarding patient care, to what extent do people in your work team blame other rather than share responsibility?
e. Do people in your work team know about your work and respect your contribution to patient care?
f. Do you think that the people in your work team share your goals for the care of patients?
4. Points of Leverage

a. Are there any specific practices that enable you to work better across the different professional titles? What are the hand-offs, challenges, or tensions they help resolve?
b. Are there any specific practices that also help to resolve any differences that arise due to different training backgrounds (overseas vs. locally trained)? What are the hand-offs, challenges, or tensions they help resolve?
c. Are there practices that also help to emphasize the priorities of the hospital and how to achieve these across different specialties and positions/titles? What are the hand-offs, challenges, or tensions they help resolve?
d. Did you get any training on working as a member of a multidisciplinary team? If yes, what type of training was provided?
e. Do you think that multidisciplinary training could help in improving the relationship and communication between members of the team?
f. Do you use multidisciplinary meetings (explain)? Describe them (duration, frequency, who attends, content). Are they helpful? How so? Are there any drawbacks?
g. Are there particular people that bridge the disciplines, specialties or backgrounds? Are they helpful? How so? Would you describe them as boundary spanners (explain)?

5. Outcomes

a. Is the current level of patient care adequate? Of high quality? How do you know this (e.g., on what basis do you say that it is excellent or poor?)
b. Are there any specific measures by which the unit assesses patient care outcomes? Are any patient satisfaction or clinician satisfaction surveys carried out by the unit?
c. Can you provide examples of specific practices of how patient care outcomes can be improved?
d. Do you feel that the current interaction between your specialty members leads to optimum patient care?
e. Are there other factors that we have not addressed yet that you feel impact the patient care? These might be aspects of the work environment, the work team, or the individuals involved in the patient care.
Table 19: First Order Codes with Illustrative Quotes

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<thead>
<tr>
<th>FIRST ORDER CODES</th>
<th>ILLUSTRATIVE QUOTES</th>
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<tr>
<td><strong>Country of qualification and training as cultural identity</strong></td>
<td>I mean I would say that I think it’s unlikely the country of birth. I would imagine the country of training would have some impact more than the country of birth. I think that somebody who’s born in a different country who then trains in a certain system – I imagine they would probably end up in that system because at least for me I had very little understanding of what actually happened in a medical team until I did my training and then the cultural norms were set by my training institutions, I think. …74BS, Doctor. Having worked with a variety of different nurses and other allied health professionals from other cultures, I think it does impact. I think the health systems in which we grow up and that we’re trained in shape our paradigm of how care is to be delivered, in what manner it’s to be delivered. Possibly some of the philosophies that we have in regards to care, I think generally across all disciplines we have a value and a belief in assisting others. I think sometimes some of the differences come about in how we go about doing that and whose role what parts of that. So I think that’s how the culture affects. …5KE, Nurse Unit Manager</td>
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<td><strong>Country of birth as cultural identity</strong></td>
<td>So if you're born or trained outside of that area, then I think the view for example that you might have on family and families’ rights and responsibilities to care for somebody could be quite different across different cultures. So I think it does have an impact and I think those things are probably deep-grained within who we are as professional people and unless you have an awareness about that, you probably tend to practice from a point of view that would value your own values, not necessarily that of another culture. …4CA, Social Worker. With most Asian cultures, it’s very hierarchical and you can have an opinion on what you think is happening or you can have your own opinion but you’re not expected to voice it. And one of the ways that it’s seen where you’re paying due respect to your elders is that you won’t tell them how you feel but you expect them to read between the lines. And actually when I was an intern in ED, that particular concern was also raised by, I think a few of the ED consultants because they thought that I was O.K. but they weren't happy with me because they thought that I wasn’t telling them enough about what I thought was going on with the patients so they assumed I didn’t know what was going on. And actually when that was passed on to me I was actually quite upset because I absolutely knew what was going on and how could they say that? I just didn’t tell them what I thought was going on because they’re the boss, they’re the one that makes the call and I thought that I made it clear between the lines what was going on. …39AL, Overseas Trained Doctor.</td>
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<td><strong>Organisational identity</strong></td>
<td>I think if you’d have asked me 12 months ago I would have said ICU is my team but having a chance to act in different roles has kind of made me look at the more global aspect of the organisation. So now I take a wider figure and take in the whole hospital as a team rather than just the unit. …49PL, Nurse Unit Manager and Clinical Nurse. I think my team comprises obviously of the doctors, the nurses, the allied health input, different department of the doctors, of course, and like obviously being the Surgical team we would also include the theatre team members, the scrub nurses, so basically anyone who is included in the patient treatment. So when I think of my team, it's basically like the whole hospital. …38SI, Doctor.</td>
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<td>FIRST ORDER CODES</td>
<td>ILLUSTRATIVE QUOTES</td>
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<td><strong>Professional identity</strong></td>
<td>Me personally, I think of the hospital. I've had people say, you know, “Oh, but I'm just a PCA (Patient Care Assistant)” and I'll say to them, “No, you're not just. You're all part of the team”. And when everybody does their jobs it runs really smoothly. You know, it doesn't matter whether you're the coordinator of nursing or whether you're the person that empties the rubbish bins, it's all important work. ...12KF, Nurse.</td>
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<td>...part of it has to come from the old system of hierarchy where doctors were the main person of the team and had the maximal responsibility of patient care and I think most of my team members still have some old style values where they feel that they are the key person in the team and they have the maximum responsibility and I think as a good practice as well as a team head they should be taking all responsibility on behalf of the team....42LG, Doctor.</td>
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<td>You take everybody's opinion but if I am accountable for patient care then it has to be my decision. If for example you look at mortality then nobody is going to question the physiotherapist “Why is the mortality high?” or something or nobody is going to question the dietitian, so the final responsibility rests with the consultant who I think should have the final say. ...62RS, Consultant Doctor.</td>
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<td>I think we (the doctors) still carry the baggage. I think even now sometimes deep down I still carry that baggage, I think. So over time I have softened a little bit and, you know, I've become more sympathetic to other colleagues whereas if you ask me deep-rooted there is still that little bit sense of a doctor superiority. ...63P, Doctor.</td>
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<td>It's nursing here that sort of does the bed management and, you know, has that overall hospital focus. ...20PS, Nurse.</td>
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<td>I feel like the allied health and the nursing staff on the ward is a higher quality of – like especially the nurses they're very good. ...11Klu, Nurse</td>
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<td>...allegiance is with the nursing team and the care they provide because it's really important - they're the direct contact with the patients and the community. ...20PS. Nurse.</td>
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<td>...certainly within nursing teams, nurses tend to be fairly egalitarian and democratic whatever country they trained in, so I think that nurses are fairly adaptable and don't have terribly set views on hierarchy or team structure. ...60FG, Nurse.</td>
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<td>Allied health is actually really good, yeah, especially physiotherapist and OT, they're all really good at communicating. ...11Klu, Allied Healthcare Professional.</td>
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<td>I think as allied health we are probably some of the stronger communication linkers, I feel like we kind of are the link between a lot of the medical and nursing and obviously the patient particularly and the patients’ families, so I think there definitely could be as an overall but specifically more so probably for medical and nursing. I feel like our own discipline – so for example occupational therapy – our own disciplines have quite a strong culture within themselves. So we have a really good team bond and therefore to be able to come onto a ward every day we have good professional development, we have good rapport with one another if we need to, you know, make queries or if we’re bouncing ideas off one another. ...56 PC, Occupational Therapist.</td>
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<td><strong>Rostered team for the day as team identity</strong></td>
<td>I would probably look at my team as changing every day, depending on the shift that I’m working with. I mean yes there is one big group of, I don’t know, about 15 consultants, 20-odd registrars, probably about 16 residents and interns from the medical point of view, then there’s the senior nursing staff and the more sort of clinical based nursing staff. So there’s this one big team interaction but on a day to day basis the team would be who you’re working with on shift that day. There’s this sort of bigger group that your vision, the people that you’ll make your plans with for the future but you might not see them there for weeks. ...69EP, Consultant Doctor. I think our multidisciplinary team provides quite good patient care. We do communicate well. I think there’s always room for improvement in communication and it does depend on the team members on the day because it’s obviously not the same every day ...the dynamics is totally different on a given day because you have different team members. ...56PC, Occupational Therapist. As a whole, I characterise it (the department) as a team but it changes day to day because consultants might change and registrars might change and nursing staff might change. In that way, while I’m on call, that particular shift, that is the team, that’s what I will take as a team. ....13KC, Doctor. My team is my Emergency Department team. So my Emergency Department team would include to me staff, so ranging from doctors, nurses, the allied health professionals – so we have a very good CCT – it would involve our psychiatric nurses and doctors, we have the mental health liaison, also the clerks and then porters, whatever we want to refer to them as PCAs, the people who do cleaning, you know. It’s a whole big team and the department needs everyone to function. Security I should mention also. That would be my thoughts of my team. ....74BS, Doctor. I believe in my multidisciplinary team. I think I personally recognise the value of every discipline in the multidisciplinary team. ...67TB, Occupational Therapist. I guess when I think of the team here, I think we’ve got teams within teams. So we’ve got like a micro team, which might be my nursing colleagues’ team but I think that extends out into the multidisciplinary team that involves all – I guess my definition of a team is a group of clinicians or group of people working together using their expertise, training, values, to come together to ultimately provide care for a patient using the patient and their carers as part of that team as well, so we’re all focused on the same goal. ....SCE, NUM. Well, I guess my team is made up of lots of little teams. I see the big team is the multidisciplinary team on the wards, which includes not just allied health but also doctors and nursing staff because it’s important for everyone to do their roles but working together to make the ward function. If your team was only physios and we only worked with ourselves, it wouldn’t function as well, definitely, and same for each other profession. ...28SK, Physiotherapist.</td>
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<td><strong>Team identity strength</strong></td>
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<td><strong>INTRAPERSONAL IDENTITY CONFLICT</strong></td>
<td>And so I have to make sure the patient gets the best outcome in any situation, my profession doesn’t get a bad name. And then I think, yes, my team means my department and the hospital, the organisation that I work for. They do come after my patient and the profession in a general sense, so I’ll try and protect the first two first. <strong>…42LG, Doctor.</strong></td>
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<td>There is a lot of conflicts and in the nursing management role you’re sort of in the middle. So you have the staff providing the care but then obviously you have the expectations of the hospital and then the organisation as a whole, you know, as in the region. So it’s a balancing act every day, actually, because your (my) allegiance is with the nursing team and the care they provide because it’s really important - they’re the direct contact with the patients and the community - but unfortunately the expectations of the organisation and the KPIs around that make it quite challenging. <strong>…20PS, Nurse Unit Manager and Clinical Nurse.</strong></td>
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<td>Intraperpersonal identity conflict</td>
<td>...sometimes feel like there is a conflict between what your profession guidelines are and what the requirement of the team and the organisation is. And often, you know, one of the values of the AASW, the Australian Association of Social Workers is around self-determination and that becomes a real sticking point when you start talking with people about somebody’s competency to be able to make those decisions. And, you know, poor old Mrs Smith is saying she wants to go home because she wants to look after her dog and that and as a social worker I should be supporting that but as part of the MDT they may well be telling me that Mrs Smith actually doesn’t have the ability to make those decisions. So, yeah, sometimes it is a conflict. <strong>…4CA, Social Worker.</strong></td>
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<td>I sometimes feel a struggle between what is good for the organisation and for my team and for my profession. For example, the ICU has limited patient beds and we as intensivists have clear practice guidelines on who can be admitted in ICU or not. Sometimes when the hospital bed capacity is full, there is pressure to admit patients in ICU who may not be critically ill and can be easily managed on the ward. It is a difficult decision to take because if we admit such patients in ICU, we might not have a bed for a critically ill patient who arrives later who actually needs the ICU support more; moreover my team will be deskilled over a period of time if we keep accepting patients who are not critically ill, it is also a waste of the hospital resources. My training as a doctor and intensivist suggests that we should only take in patients who actually need ICU support and this practice will be good for the team as well but then I also understand the hospital constraints. <strong>…41AC, Doctor.</strong></td>
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<td>Navigating intraperpersonal identity conflict</td>
<td>It is difficult sometimes because the demands of what is the bigger picture of the hospital, like for instance today when there aren’t – so take for instance today. So the hospital as a whole, you know, we need to increase the amount of discharges because we don’t have any beds. So I take that on board at the senior management meeting in the morning but then when you come back to here I know what the capabilities are of the team within here. ...Yes, absolutely, with the demands of what is needed for the hospital business, compared to what I know is within safe working practice as a registered nurse of what we should and shouldn’t be doing...that would probably be, you know, a daily struggle but we always come back to “we work within our registration of what we’re supposed to do”. <strong>…9JY, Nurse Unit Manager.</strong></td>
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<td>I think for us that (different identities/affiliations) becomes very interwoven because there are times when if I just stood on my morals as a social worker, we would have a hospital full of homeless people that have no family support, that have issues of living in the community and the addicts and that, you know, like if I just stuck to that. I have to balance the allegiance of the healthcare system and the hospital, so I have to balance the bed management, if you like, with my profession, our social work profession. So in most cases it’s around, you know, good safely timely discharge. ...4CA, Social Worker.</td>
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**Positive identity interactions**

|                   | I think certainly coming from Malaysia, which is where I was born and having lived in Malaysia and Singapore, there are cultural differences compared to Australia, I think mainly related to the view of family relationships and dynamics but also a lot more to do with respect for elders in society and families and I think at least personally I like to think that I've carried over that respect for my elders to my workplace. ...19MG, Doctor. |
|                   | ...you sometimes take your own cultural values and beliefs and then you tailor it to the country that you’re moving to. For example, I've been in the UK and I've adapted some of the practices, the English practices and principles, but you still have your cultural beliefs or culture, how you’ve been brought up, so it does have a little bit of impact but obviously if it’s involving education and things you change your practices or adapt your practice to suit the local needs. ...21RP, Overseas Trained Doctor. |

**INTERPERSONAL IDENTITY CONFLICT**

<p>|                   | Some different countries I've noticed hierarchical differences between particularly doctors and nurses. It seems that the perception of some medical doctors about the role of nurses is different than doctors from Australia. I don't know how to do it diplomatically but it seems sometimes that they've obviously had more of a delegation thing, you know, “This is what you do. You do this”, rather than - I think we work fairly autonomously in Australia as clinicians, nurses, you know. ...46PT, Local Nurse. |
|                   | I could see my colleagues who were from local background, they could challenge the consultant much more easily or they could challenge people very easily whereas I from an overseas background, though I knew that I was right, it felt very difficult to do that because my upbringing right from the childhood is that you don't question, you just listen to people who are senior to you. So, yes, I feel that is the case. And then sometimes people who are not from the same cultural background would not understand that aspect of a culture and they may interpret it as sometimes people being inadequate or not well trained. Because we don't open our mouths, we don't express ourselves, then they seem to treat it as somebody is lacking knowledge or lacking experience, lacking expertise. ...63P, Overseas Trained Doctor |
|                   | I think that where that person got their qualification, he was a psychiatrist and I think that psychiatrists ruled the world where he came from whereas in the team that we were working in with him, it was a constant struggle to remind him that “Actually, I have something to contribute here and my profession has something to contribute here” and, yeah, it was a constant problem... people come with their own interpretation of what a multidisciplinary team is and for some of those old school doctors it’s “Me up here and everybody else down there and they all better just do what I say” and that doesn't work because that doctor doesn’t have social work skills, doesn’t have physiotherapy skills and needs those professions to consult. ...54LA, Local Allied Healthcare Professional. |</p>
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<td><strong>Professional identity vs. team and organisational identity</strong></td>
<td>The ICU is our team, so I definitely see our consultants, our registrars and the nurses as our team. I know that dietitians and physios are supposed to be members of our team as well and I guess they are part of the wider team but if for example a dietitian comes along and says “We need to do such and such”, it can quickly be overridden. I worked for a doctor who would refuse to have a dietitian come onto the unit. ...52AJ, Nurse.</td>
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<td>Each one of us, despite our professional education, each one of us is being paid to do the same job and that is to assess the needs of older people. You obviously bring your own clinical experience into that but we’re all trying to do the same job. So I’m frustrated mainly by social worker or occupational therapists or nurses telling me “I look at it differently, though”. Of course you do but you’re still being paid to do the same job and when people tell me that that impacts on their productivity, that’s when I find I’ve got a real challenge. Yes, just because you’re a nurse or a social work or an OT, just because you’re that doesn’t mean that you shouldn’t be able to have the same productivity as someone else. You can’t hide behind your professional background as an excuse to not be as productive as the other members of the team and that’s a real challenge I’m having at the moment. Some people can’t take off their professional hat, you know. My challenge is to keep the team that I manage with the same focus and not be able to sort of use this idea that “I’m this or that profession and therefore I have to do things differently” You have to have a team perspective. ...68PW, NUM.</td>
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<td>When I left (my country), there was a compartmentalisation of medical and nursing care and there wasn’t a concept of this (multidisciplinary) team. I think the medical training as such teaches you that your opinion is right and it has to be based on medical facts and when you do get questioned from a nursing staff or allied health staffs, you can take it personally and sometimes unwillingly take your focus off the patient and it becomes personal for both the parties involved. So for example, when I came to Australia I had a lady. She was quite ill, quite terminal 80 year old lady, and she was at a risk of aspiration. That means you can get the food. So she wanted to eat ice cream but with the aspiration, when people are quite drowsy they can get it in the wrong way and it can go into the lung, can make them worse but given that lady was likely to survive less than a day, I asked her what she wanted and she said, “I would like to eat an ice cream”. I said, “O.K. Well, I’ll get you an ice cream”. So we authorised it but the speech pathology as a part of allied health team, she felt quite uncomfortable with the decision and felt that it was very inappropriate. And my medical training till that point suggested that if a person is at the end of life you could be relaxed. But I had allied health staff and nursing staff alter my decision which caused some distress to the patient. And I really wish that the lady would have been able to fulfil her wishes. ...42LG, Doctor.</td>
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<td>Within every multidisciplinary team I’ve worked with, there are subtle power games that come into play. Obviously doctors - I don’t know whether it’s part of their medical doctorate, I don’t know whether it’s part of the way they’re trained - have an assumption of superiority, have an assumption that they are the ones that should hold the clinical governance of the patient at all times. And, of course, other health professions are so well-educated these days and know so much more than doctors about many aspects of patient care but doctors won’t - they subtly acknowledge that because they need that advice and that input but they’re not prepared to have a shared approach to clinical decision-making. ...68PW, Nurse Unit Manager.</td>
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<th>I try and take a fairly open view and be sensitive to other people’s opinions and try and gain an understanding of where they’re coming from. So I’ll question, I’ll ask, seek clarification, to better understand where they’re coming from, because their point may be very valid and it might be that I need to change my point of view. ...<strong>5CE, Nurse Unit Manager.</strong></th>
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<td><strong>Navigating interpersonal conflict</strong></td>
<td>I always believe in teamwork and I always feel that every member of the team should be respected. Whenever there is a difference of opinion, which is bound to be there, my practice is to try to listen to the other person, respect that person’s opinion and try to convey my views about it and most of the times you would be able to get to a mutual agreement. ...<strong>41AC, doctor.</strong></td>
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<td>I think the main thing where it (team) works well is when you have a patient at the centre. So all of your conversations fundamentally come back to what does the patient need, what would be best for them?....when METs work well, there is a degree of compromise, there’s a degree of flexibility and there’s a degree of openness where the individual is less important than the outcome for the patient. So what I want to do or what I think would be best is not the only outcome as I’m only a contributor. ...<strong>3CB, Allied Health Care Manager.</strong></td>
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<td>And I certainly do and always think that being honest and giving that context around it, so instead of just saying the action that needs to happen, there has to be some context and background given, so to respect their profession and their knowledge and expertise. ...<strong>20PS, NUM.</strong></td>
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<td>I suppose I always kind of come back to my core training. When we were trained, it was if you can always answer “why”, if somebody asks you why you’re doing something and it’s got “for the better of the patient’s interest”, that’s not ideally breaking any rules of law or, you know, any kind of ethical rules, then you should be able to most likely come up with a plan that works within the kind of, I suppose, policies, procedures, etcetera, that’s best for that patient. ...<strong>2AC, Nurse.</strong></td>
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<td>It is difficult because when somebody sort of says something that’s different or confronting to you, you almost feel as if you want to go back into your shell and protect yourself is the first response you get from any human being but if you put the patient at the centre of it, if you say “What is in the best interest of the patient?” then I think things will be much more clear and we will do the right thing for the patient. ...<strong>63P, Doctor.</strong></td>
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<td>I would say ultimately that, look, the way our health system is structured – and I say this quite regularly to the consultants – “That’s fine, you’re entitled to discharge your patient. It’s under your bed card. This is my recommendation. I’m not going to force you to follow that recommendation. This is what I think. I’ve documented that I don’t think the patient’s safe to go” if that’s the case and they can make their call from there to be honest. Yeah, I don’t see any point in really fighting that battle any more than it needs to be. Ultimately the legal responsibility falls with the consultant for that team and should anything happen it will come back to them and my documentation. ...<strong>55DV, Physiotherapist.</strong></td>
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<td><strong>EMERGENCE of TEAM IDENTITY CONFLICT</strong></td>
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| Negative impacts of identity conflict | Sometimes I have to compromise my medical judgement to accommodate hospital demands, for example, the hospital has an important KPI around patient waiting time in the emergency department i.e. the patients should be seen and either admitted or discharged within 4 hours of presentation. There are times when I have to accept patients in my unit to keep to the hospital KPIs although the patient does not need aggressive care. I find that I have to put the hospital above my medical opinion in such situations and it could be very frustrating and stressful, I have to admit. ...41AC, Doctor.  

Working in healthcare multidisciplinary teams is difficult. When I came here, I had no concept of multidisciplinary teams; we had doctors and nurses but of course doctors run the show in my country. I find that my enthusiasm for my job is decreasing and I feel very stressed because I feel pulled in different directions. ...00VC, Doctor. |
| Convergence of team identity conflict | I think when a person is not happy within themselves or is stressed at work, it affects everyone in the team and that stress is shared across everyone. Over a period of time, there is a spill over effect and the team as a whole experiences conflict...00VC, Doctor.  

Most of the times, till now what I noticed was that I never tend to have any conflicting problems once I settle into the unit. But the initial part, as usual, with others I don’t know but for me, first three to four or six months that’s the settling phase. I tend to have more conflict with a lot of things like in the sense that is called work culture in that particular hospital and until I am used to that kind of work culture, those things (conflicts) used to and can happen into the future also but once I settle, I think things go very smoothly. ...2AC, Nurse.  

What I noticed is that usually these conflicts happen when those two people don’t know each other and don’t know each other’s capabilities - that’s what I felt is the most important thing. For example, when I came here, there were more number of conflicts with more number of nurses, in the sense when I asked for something, “No, I don’t want to do it”, kind of but the same nurse, now if I say that, she does the same thing without any issues... the understanding, like in the sense of working together and what I am capable of and what she is capable of, has increased. ...3KC, AHC.  

When I joined this hospital around 4 years back, I came from a big tertiary hospital which had a team culture of people being very direct to each other. I started practicing here in the same way but the nurses interpreted my approach as authoritative and me not being a good team member. I think it was also because my training is not from Australia. In my country, communication training is not as important as clinical training but medical graduates here have good training. I was not aware of this but when I got to know how upset my team was, I talked to other doctors and nurses and changed my practice. Now, a few years down the line, people also have accepted that I am passionate about patient care and if I say something under stress, I do not mean it. ....41AC, Doctor. |
| Compilation to team identity conflict | |

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<td>RELATIONAL COORDINATION</td>
<td>I think the primary thing which is prevalent in the health care is having the medical staff as the primary leading care but also the primary facilitator of the communication between the team. I don't think that happens here consistently...I think there's a lot of requests given or instructions given from the medical team but I don't think there's a lot of collaborative discussion, certainly not proactively. Certainly, if we had a crisis or there's something that's going wrong, that would probably happen but I don't think it's proactive, I don't think it happens as part of regular daily ongoing business. ...3CB, Allied Health Care Manager.</td>
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<td>Communication practices</td>
<td>So normally our day would start with a very quick handover with the junior doctors who was there on the nightshift to convey about all the patients and it is normally attended by a nurse coordinator as well and by that we come to know about as to what's happening in the unit, what are the patients like, what are the ongoing issues. And then obviously it would be followed by a regular round with the consultant and the junior doctors and the nurse coordinator would come with us and we would convey to each other and mainly the consultant would convey to the nurse coordinator about ongoing issues with the patient and the plan. In the meanwhile, we would certainly discuss with allied health team members as well, depending on the need of the patient. So on a given day we certainly need a lot of people from allied health but not every team member is required. ...41AC, Doctor.</td>
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<td>Communication practices</td>
<td>Communication is better between allied health care staff and nurses but not always with doctors. I think like an example of that is that the doctor will do his ward round before – before our daily meeting (multidisciplinary daily meeting of nurses and allied health care staff) and on the ward round he hasn’t spoken to us for a whole week because the meeting (weekly multidisciplinary meeting including doctors) was last Tuesday. So he might say to the patient, “You’re going home tomorrow” but as allied health we’ve realised, “Ooh, the patient’s not quite ready” but he only finds that out in the MDT meeting afterwards. So that’s probably one of the biggest communication breakdowns because of that. ...29SS, Occupational Therapist.</td>
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<td>Communication practices</td>
<td>Is it accurate information? Not always. The nature of Chinese whispers, I suppose, from having been admitted to ED, that information being passed from one team or one lot of consultants to a medical team to nursing staff that might have changed two lots of nursing staff and then gets to the referral process the next day, so quite often that information isn't accurate. We prioritise things within our own profession. So if for example it might not have even been tagged as a social work referral but it might be that, you know, a mum who’s got two young children and whose husband is a fly-in, fly-out worker has been admitted overnight, so we would immediately look at that and say, “Well, we need to check where the children are? Are the children being looked after?” So some of them are self-generated referrals, mostly are written and not always accurate. ...4CA, Social Worker.</td>
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<td>Communication practices</td>
<td>So I guess we have a number of both formal and informal processes by which we communicate. So in the formal sense we have formal handover at changes of shift and we actually have a formalised handover process which involves using the isobar handover tool as part of that communication. In addition to that, in terms of communication – so that’s a doctor to doctor communication predominantly although often the charge nurse will sit in on those handovers – in terms of communication within the team at a formal level in terms of process there are both written and verbal communications between the nursing and medical staff regarding patients who are seen as they are seen. ...30BP, Doctor.</td>
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| **Patient care coordination** | Sometimes a doctor can come along and write some medication they want and you’ve just done your drugs round and then they can write medication up but not tell you. So you know before that, you’ve though, “Oh, I haven't got any medication due till two hours’ time” and then just by chance you glance and you go, “Huh, what’s that? I've missed that” and then you find out really – and you see the doctor, “Have you just written this up?” and they go, “Oh, yeah”...**48ER, Nurse.**  
I think nursing is more likely to communicate concerns rather than communicate anything regarding plan, if that makes any sense. So they’re more likely to report concerns, which I think is great but sometimes I think what’s bitten me in the back is that I haven't had a chance to talk to nurses because they were busy and I was busy and I was meaning to go back to them and clarify or in a way I've wrongly assumed that, you know, because they knew I wasn’t available to discuss a plan that they would come by and discuss or at least ask but that hasn’t happened so it’s bitten me in the back. ...**39AL, Doctor.**  
The communication between nurses is really good; like we’re constantly talking to each other. With doctors not so much, not verbal anyway. If there’s any orders or anything the doctors want the nurses to do, the only way we’ll find out is if we read patient notes; they won’t actually verbally tell us. And it’s really frustrating sometimes because you won’t get a chance to read the patient notes till hours later and you'll look and you’re like, “Oh, I haven't even done that. They didn’t even tell me”. Actually, it happened yesterday. I only read the notes till in the afternoon. I sat down to write my notes and the doctors had done a round between seven and eight in the morning and I saw that they said that they wanted the dressing taken down. I said, “Well, I haven't done it because they didn’t tell me”...**27Shy, Nurse.** |
| Roles and responsibilities across members are mostly implicit. The explicit side of it comes, I guess, with when you get to more specific cases. So the good example of this is in a trauma team situation or a resuscitation team situation and we actually take explicit designated roles and we put stickers on our uniforms to show who is who. ...**30BP, Doctor.**  
Between nurses priorities are discussed but, yeah, not with doctors and with the allied health it is really good and they’ll come and ask me and we’ll liaise a time which is best to do a certain task with a patient but with the doctors, because there’s different teams, like the orthopaedic team, the gen. surg. team, and they done communicate within each other, so then it’s, yeah, I think that’s where – because I mean I suppose they feel they don’t need to but because we’re looking after all the patients and, yeah, it is really hard to prioritise because sometimes one team will be telling you to do this for an orthopaedic patient but then the other team’s saying, “No, you need to do this” for a general surgery patient and you're kind of like, “Well, yeah, what’s more important?”...**27Shy, Surgery Nurse.**  
Because it’s such a well-established structure in terms of roles and responsibilities, they are implied and assigned because it’s a well-established structure. In terms of priorities, certainly there is frequent discussion between the team members because priorities can change. For example, our physiotherapist may want to see the patient but the nursing priority may be more or a medical priority may be more. ...**22RK, Doctor.** |
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<td>Proactively helping team members</td>
<td>I think we have, I think we have a bit of a grey, bit of an overlap or a bit of confusion. Because we have a physio available, we think that they should be there for mobility assessment and, you know, tests. If someone’s coming with asthma or pneumonia, we think that they should be looking at their chests. So because there’s an allied health team, I think roles that are educated during your study are sometimes sort of taken away. So you could be listening to their chest and go, “Well, I think you need to see the physio” or lots of people are just, “Let’s just call the physio” because they’re time poor, “We’ve got someone available to do that, you know, to sort that out”. Or not necessarily OT, social worker, this person’s got some family problem, “Well, we’ll just call the social worker in” and the social worker will say “Why?” You’re going, “Well, they’ve got family issues”, “What issues are they?” So they’re thing the nurse could explore that overlap those other roles of allied health, which I see that sort of thing. ...10KL, Nurse. I'm someone that doesn’t believe in huge boundaries. I believe in a boundary with respect to my skills whereas sometimes I think the junior doctors will be a bit more, “That patient needs medication. That’s for the nurse to do. That patient needs a mobility assessment. That’s for the physio or OT to do”. This patient’s got a housing problem. That’s for social work to do. I mean I kind of do everything and I know I'm not good at anything but I'm someone who’s very much – our nursing staff will cannulate, our nursing staff will do ECGs, things that a few years ago were considered a doctor job to do. And now they do that. In return, I'll go out and I’ll make a cup of tea for the patient, I'll get them a sandwich, I'll get them a commode, you know. ...63EP, Consultant Doctor. I think in the main around the clinical care for the patient, yes, absolutely. So if we had a patient, you know, that we were trying to get an outcome for immediately, we would do that well. I think probably around discharge planning not so much. I think around, yeah, coordinating care I don't think that is something that we have a clear responsibility around. I think the view is that probably each area has responsibility for that but probably what needs to happen is that it is led by someone and we don't have that. ...3CB, Allied Health Care Manager. I think with allied health we’re really good at offering (help) and even the majority of the nurses. I've worked with for four years on Medical so there’s a great relationship there. I think the doctors maybe the expectation is that we will do what they ask us to but not necessarily what we ask them to. ...71SM, Occupational Therapist. I mean it’s (proactive behaviour) certainly what we try and foster. We certainly do have it but, of course, human beings being as they are, that comes with if things have happened before, they might be a bit jaded about it and they're assuming it’s not going to work before they've even tried if it works. So, of course, there is a little bit of that. I find newer people coming in, like our junior doctors that come in, our junior allied health and our junior nurses that come in, they are very proactive and very enthusiastic. Probably as you go along the older, more experienced of each of those disciplines it gets less that. ...9JY, NUM. In general yes, I think they are and if they’re not, again I think that’s just an individual basis that some people don’t see other people struggling or some people do but think “That’s not my problem to sort out”. But in general I think they do spot when other people are needing assistance and again I think that’s partly just because we work in such a concentrated environment we can see most of what’s going on and how busy people are and if they need help. ...69EP, Doctor.</td>
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<td>Not always, I have to say. Sometimes, you do have to repeatedly ask people for help. A lot of that obviously does come down to time constraints and, the same as always, obviously the staffing issues for every department and every walk of it. ...2AC, Nurse.</td>
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<td>I would say across allied health yes. I would say not so much medical or nursing. ...78VP, Occupational Therapist.</td>
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<td>In an ideal world, people would be proactive but there are quite a few tasks that could relate to a nursing staff that could relate to occupational therapists that could relate to physiotherapists or could relate to social work or welfare officer type things. Like for example collecting a social history of that person that could actually be the role of any one of those professionals. And unfortunately it'll usually come down to just workload as to who actually has the ability to be able to do that. Sometimes that's lost in, “Oh, I thought you were doing it”. “No, I was doing the other one. You were meant to be doing that one”. “Sorry, didn’t realise that”. You know, that can be lost but there are some tasks that go across disciplines. ...4CA, Social Worker.</td>
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<td>I would expect everybody, especially the senior doctors in my team, would take blame because we do know that in a busy environment errors will happen and only by discussing them and trying to find solution, you can avoid them next time and I believe most of my colleagues would like to openly disclose and rectify the error. Yes, I think sometimes the junior doctors and the nursing staff, they could be fearful of being blamed and may try to hide or feel a bit scared and I particularly feel it is important that we counsel them so that they do not feel as scared. ...42LG, Consultant Doctor.</td>
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<td>There is a culture where unfortunately in our society, whistle-blowers and people who have problems are not always treated in the best way. Similarly, while there is talk of a no blame culture, from the high levels of management in certain scenarios some of which may also be reflected in medicine, often things come out to try and find a scapegoat. And so I think there is some level of concern amongst staff – this is just speculation – that they will be made a scapegoat and that means that error reporting and also, you know, working out problems with systems is probably less effective. It doesn’t mean people don’t want to work together and try and help each other but I think there is certainly a level of concern amongst junior staff and it’s disappointing. ...74BS, Doctor.</td>
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<td>Sharing responsibility</td>
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<td>I think if the care of the patient had been an agreed plan – so if for example while this patient’s been in hospital, the agreed plan was to do X, Y and Z and X, Y and Z were done and the patient was discharged home and then came back again with the same sort of complaint, I think there would be some, you know, “Well, we did our best and it didn’t work”, so I think there would be some sharing of that. If there’s disagreement about that – like for example some team members are saying, you know, “I think we should keep this person in and that they should go to rehab and that we should try and do this and that” and maybe the medical team say, “No, I disagree with this. Send them home”, if the person bounces back, I think there is a little bit of, “Well, I told you so” and, you know, “I knew that that was going to happen” or, “That’s not what I wanted. If you’re disappointed, you probably need to take it up with” – you know, a little bit of a blaming sort of thing. ...4CA, Social Worker.</td>
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We try not to (blame) but we do. And again I come from ED which is a very big workforce, both medical, nursing and the multidisciplinary team, and whenever a significant error occurred that required, you know, information, a change of practice, education or something like that, there was always a significant proportion of the staff that said, “It doesn’t relate to me. I wasn’t there, nothing to do with me. I wouldn’t do that”. ...60FG, Nurse.

Moving to Australia I found, yes, clinical governance does exist here and adverse events do happen but here it’s very much a blame culture. The aim of an investigation is to find who’s responsible for that. It is not the system or that something has gone wrong but it is an individual that has to be eventually held responsible. ...77AB, Doctor.

I suppose at the moment there’s a bit of a culture of people being really short staffed and constrained with their time, that when something does happen at the moment there does seem to be quite a bad feeling for I’d say a few months, that people are quite willing to pass the blame. There’s not a lot of people who are willing to take responsibility for their own actions, which is quite a shame because that’s how you grow and how you learn and if we all kind of supported each other it should be a learning curve, not necessarily, you know, a kind of disciplinary per se type issue. Obviously, you’ve got to stay within your rules of the hospital, but, yeah, it would be nice to not have as big a blame culture. There is quite a bit of a blame culture that goes on. ...2AC, Nurse.

Unfortunately, when an error is made its still people try to protect themselves or their teams. That’s what I have seen generally. Because there is a still a scare, worry, that though people say it’s a no blame culture I don’t see a no blame culture. There’s always a blame culture out: somebody needs to be responsible, that’s the way I feel. So people obviously feel vulnerable if they have done a mistake so there is that reluctance to own up to mistakes in my experiences. ...63P, Doctor.

People are very easily put off and will point the finger of who was wrong and what needs to be fixed. I think, though, especially if it’s a medical team error, it’s certainly not pointed out as frequently and sort of just moved along, whereas if it’s allied health people are far more quick to say, “Well, you discharged them too quickly” or “You didn’t do that” and so forth. So for allied health, I think we get blamed easier whereas medical team not so much. And again it’s the hierarchical system and that’s why. ...18Mst, Physiotherapist.

Well, sometimes I’ve found that if, say, it’s a doctor error we are more isolated. It kind of puts in like, “Oh, the doctor’s made the mistake” but if sometimes it’s the nursing staff, sometimes we have found that they will be like, “No, it’s O.K.” - they will take more responsibility for it. ...38SI, Doctor.
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<td><strong>TEAM TRAINING PRACTICES</strong></td>
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<td>Multidisciplinary training prevalence</td>
<td>No, not as such. I feel like they, as in the organisation, make the assumption that you will use your initiative in resourcing the multidisciplinary teams that are available or you might find out about some service by chance, you know, or by mistake or by liaising and learning from other staff members than actually having a day, saying “You’ve got all these services available” or a little directory or something, “This is the correct process for accessing them”, no, nothing like that. …5CE, Nurse. This (multidisciplinary training) is done on an ad hoc basis during the ward rounds informally but there is no formal program. …42LG, Doctor.</td>
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<td>Multidisciplinary training utility</td>
<td>I’m quite certain it will make a difference because, look, I am a strong proponent of a multidisciplinary approach in patient care and I personally feel that when people are actually chosen for a given job, more concentration is actually given on the clinical work and all over training is normally focused on the clinical work and not much emphasis is given to the non-clinical aspect which is equally important, if not more. So I’m quite certain that it’s an important aspect and if some training is given to senior and junior doctors and the nurse and allied health people together it will certainly help in patients’ care. …41AC, Doctor. We’re quite big on that (use of social/informal events for team building). We try and do a lunch every month and that’s across the board for doctors, allied health nurses. A few of us push that really hard. We’ve got kind of someone from each area that pushes that and that’s made a big, big difference to the way that the team works; it’s really brought the team together. We also have just other social events. If we want to do things together, we’ll try and suggest things - we have lottery syndicates – so we try and do things that include everybody and anybody that wants to be involved in it and it’s optional if people do or not; obviously it’s not compulsory that they should. …2AC, Nurse.</td>
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<td>Informal or social events</td>
<td>Our department, what we do quite often is we’ll have shared lunches and it certainly builds a lot more cohesiveness in the team and when you get to talk to other people, nursing staff, doctors and get to know them on a little bit more of a personal level it makes the working relationship and those harder to have conversations a lot easier in the workplace. So we do activities like that, shared lunches or morning tea every two or three weeks, just bringing food onto the ward. We’ve got an amazing OT who she’ll often have like a little quiz day or something and bring something in to eat and it makes a huge difference. And also just our allied health manager, he’s amazing in actually recognising people. So on our monthly meetings, you know, the team are asked to actually put in things about their team members, things that they’ve done well and they’ll read it out and they’ll have the Ron Burgundy(?) award and it’s sort of a silly thing but it actually makes a massive difference in the team in terms of morale. …18MSt, Physiotherapist. I mean they do have some events that we’re invited to, certainly. Yeah, they do. I mean there’s things like – I mean minor things but everything’s appreciated. Informal social events or even like everyone bring in food from their home country or that sort of thing. So everyone, you know, National Food Day, that sort of thing. I think its most probably organised by the department rather than the hospital. …74BS, Doctor.</td>
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<td><strong>MEETING PRACTICES</strong></td>
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<td><strong>Multidisciplinary Meetings Prevalence</strong></td>
<td>We have two multidisciplinary team meetings a week in Sub-acute department that are an hour long that go through all the patients and we discuss each in turn what progress a patient’s making towards the defined patient set of goals that we develop as a team with the patient. We also have another MDT meeting every day at the board to go through and we also have every fortnight an MDT meeting that involves key senior clinicians in looking at the MDT structure, how we work together as a team and how we can implement quality activities to improve the overall patient care across our disciplines. ...<strong>SCE, NUM, Sub-acute.</strong> Multidisciplinary meeting in ICU happens on every Tuesday for half an hour from 11:00 to 11:30 and we chose this time just to make sure that all the team members could attend that meeting because every member is busy in some way or the other way, so that is all suitable for everybody. And for this half an hour, the consultants on the day takes the responsibility, every other team member would be present and we talk in details about the patient needs as far as different allied health input is required and during that time all the team members are more than welcome to give their input in the discussions. And that way I think it has really helped us to bridge the gap where every team member feels a part of the team and I think it makes a huge difference and the feedback I've got from different team members is that it has actually helped quite a lot and I'm quite happy with that. ...<strong>41AC, Doctor.</strong></td>
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<td><strong>Multidisciplinary Meetings Utility</strong></td>
<td>I think multidisciplinary meetings are like any kind of meeting and it depends on the content and the Chair. So if the person who is leading the meeting ensures that the meeting is effective and efficient and meets the goal, then they're very effective. But I don't think we really – traditionally in health we don’t know what that (MDT meeting) should look like, we don’t know what that shouldn’t look like. People don’t get any training on what it should look like, what it shouldn't look like, how to lead it, how to manage, how to facilitate, how to chair even. Yeah, they might not have any idea before they start, you know, leading the MDT meeting around what even all the professions do. So MDTs are very, very useful but they need to be structured and led. And probably a training issue as well, because people don’t really know how to do that. It’s something of an assumption that you would know but it’s not in place and even if you were a very skilled clinician, you might not be good at that. And that is partly the problem. So sometime we expect the people who are very skilled, who have been around a long time, will be able to manage well or lead well or be able to facilitate things like that well but it’s a different skillset. They may have it, they may not. ...<strong>3CB, Allied Health Care Manager.</strong> In terms of content, we try to be goal directed, we try and be targeted, so we talk about what are the goals of the patients, what we’re trying to achieve for the goals, how far we are from the goals and what more needs to be done and then we also talk about discharge planning and any other barriers that could hinder that. ...<strong>19MG, Doctor.</strong> We have multidisciplinary team meeting but in multidisciplinary team meetings the non-medical persons do not have much of a say. If you call it a meeting like that, you have to allow that person to talk and not only just talk, allow that person’s ideas to be taken on board, not just talking, but also give encouragement. One has to know what multidisciplinary means and you have to have very high regard and respect for your colleagues from other professions...<strong>7AB, Doctor.</strong> If it’s done properly, they are brilliant. They can weed out so many things and especially as an allied health team you can actually sit down and go, say between OT and physio, and go, “O.K. Well, this looks like more of an OT problem so you go see them. Let me know</td>
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<td>if I need to be involved” or social work, “This looks more like a social thing, so we’ll stand back and let us know” because otherwise with the demands of the job there’s just too many people and if all three of you go and see one person it’s a waste of time for everybody involved. And also for the patient, that means they’re getting similar questions from three different people, plus your doctor and your nursing staff who also ask questions. ...18MS, Physiotherapist.</td>
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<th>BOUNDARY SPANNING PRACTICES</th>
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<td><strong>Boundary spanners Prevalence</strong></td>
<td>We have on every shift a shift coordinator who on the weekday mornings is a clinical nurse specialist who’s the most senior nurse under the nurse unit manager. And then we have clinical nurses who are higher level nursing staff. But it’s usually always a very senior registered nurse or clinical nurse that coordinates the shifts because they receive communication from the nurses under them, they receive communication from the allied health and they will communicate with allied health and medical staff. ...20PS, NUM.</td>
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<td>No, we don't have that (case coordinators). We have looked at that in the past but the problem that we have is that we have an awful lot of part time and casual staff. So in terms of getting consistency of practice I think at this point in time very difficult to have that, like a key worker type role. ...5CE, NUM.</td>
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<td><strong>Boundary spanners utility</strong></td>
<td>So there’s the doctor teams. So you have your doctor, your registrar, your intern, who are managing you patients. Then you'll have your multidisciplinary team who will be more of you allied health, so your physio, OT, aged care, dieticians, speech, that sort of thing and then you'll have your nursing team, so your whole crew that are on in the morning, say. So you’ve got your nurse in charge, a float and then allocations to your different patient care levels. So you’ve got sort of three or four teams working within, so your coordinator becomes more of your liaison between your multidisciplinary and your doctors but also the nurses. ...10KL, Nurse.</td>
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<td>There are coordinators, definitely. Yes, they do work across but I don’t know how effective their role is. I'm not very sure how effective that role is, whether the role is very clear and there’s clarity as to what the role intends. I don’t think it promotes multidisciplinary team working. It’s more to do with theatre efficiency than team work, yeah. ...63P, Doctor.</td>
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<td>The coordinator really for each ward, they kind of manage, I suppose, the ward. I suppose it comes down to people. That sounds a bit nasty in a way but I suppose to be that role you have to be quite forward in a sense because you’re trying to control all the situations that come your way that day and manage them safely for the patients and staff members, you know, that are kind of not even working on the ward because you're managing it out, patients, families, the whole kind of show’s coming to you. And I think you need to be able to have that good time management, good self- control of, “O.K, this is my patient. You need to link in with this team, this team and I need to be able to get this information to help that” and work it as a one and you need to pull a lot of teams together at those points, which can be a bit tricky at times, obviously with everyone doing different jobs, etcetera. So, I do think the shift coordinator’s role is quite important but I think it needs to be quite specific. ...2AC, Nurse.</td>
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<td><strong>COMMUNICATION AND LEADERSHIP TRAINING PRACTICES</strong></td>
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### Communication training

Communication training is important. I think in general how to communicate is very important. If you know how to communicate then you can be in any team or the rules of communication like, you know, you are to listen, you are to acknowledge and not to blame anybody and build that team spirit. ...62RS, Doctor.

So if I’ve had incidences of staff where I need to address their communication skills, we actually don't have much in the way of specific learning packages if someone who you felt was not dealing well with communication that you could send them to do. So we have, seemingly, lots of packages for lots of other things but I personally think we could do far better with the communication side of it because ninety per cent of the complaints and issues that I deal with, it’s communication would be the basis and if we’d sorted that then it wouldn’t have got where it had. ...9JY, NUM

Communication, my personal favourite. We try and it doesn’t matter whether its written communication or oral communication, everybody does it differently. We do have standards and procedures for documenting, for clinical handover, bedside handover, multidisciplinary team communication and all the rest of it. We do try but I would say that our primary issue with anything that goes wrong, communication is part of it in that the message wasn’t sent, the message wasn’t received. Despite your best efforts we’re very human. ...60FG, Nurse.

### Leadership training

I think simulation multidisciplinary training would be extremely useful but maybe towards a greater goal, as part of a package of developing various skillsets like leadership for example. You know, because ultimately we expect all clinical staff, including doctors, to be leaders in our own field but to be leaders is not just to have an insane amount of knowledge or expertise in a field, it’s also about being able to bring out the best in each other and your team. And I think a lot of that depends on not just people management skills but communication skills and so on and that’s a huge part of working in a team. ...19MG, Doctor.

As part of the leadership team, quite a lot of the nurse unit managers and other managers have been to a course called ‘Leading Great Care’, which combines with Notre Dame University. So you all do a section on teamwork in that and you work as a team with people from all different hospitals in that. So the hospital really encourages those sorts of things. ...40GM, Doctor.

I’ve had a variety of different training and working, particularly leadership training, working with teams, so it hasn’t been multidisciplinary. They’ve done various Leading 100 courses whereby they invite clinicians from a variety of different backgrounds to come in and learn about working within a team. I think it’s more designed to be inter-professional learning, so it’s not necessarily MDT specific. ...5CE, NUM.
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<td><strong>PATIENT OUTCOMES</strong></td>
<td>I don’t know. I know we’ve got like customer feedback and complaint forms which are readily available to patients. So, you know, if they wanted to give feedback they could do it that way but I’m not aware of a patient survey. ...65TT, OT.</td>
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<td>“Not too sure. I’m not sure if there’s a patient satisfaction survey but I know that, you know, if a patient does want to make a complaint they can. ...17MoD, Dietitian</td>
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<td>“There is. So the hospital does, I believe, a yearly patient satisfaction survey which includes patients from all areas, including Emergency Medicine and then that data gets fed back to the departments separately and in a combined fashion to administration.” ...30BP, Doctor.</td>
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<td>“Not necessarily a patient satisfaction survey with us, although the medical staff were speaking at a meeting the other day that they wanted to do like a patient family satisfaction. The way that we look at outcomes from our point of view in terms of patient care is that we have key indicators and we have audits which we do and that gives us some indication of how well we are managing our patients.”...33LH, Nurse.</td>
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<td><strong>Patient perception of patient care</strong></td>
<td>I believe hospitals and actually I know the hospitals do patient satisfaction surveys. I’m unsure of the frequency with which my particular hospital does it. And sometimes we are fed informally the positive feedbacks or slightly negative feedbacks. My department does not, unfortunately, actively do any patient feedbacks in terms of a fora patient feedback but we do get informal feedbacks. ...42LG, Doctor.</td>
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<td>We don’t have a patient satisfaction survey. That’s something that we are trying to establish. We know that’s our sort of shortcoming in the unit but when we look at the standardised mortality rates and our other measures of quality, we are doing very, very well compared to other units. So there is objective evidence of the quality of care but there’s no objective evidence of the consumer satisfaction so that’s something that we are trying to do in the next maybe six months. ...63P, Doctor.</td>
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<td>Well, there is a patient satisfaction survey. It has, as you’ll know from research, it’s got such bad methodological problems that it’s pointless. It’s a voluntary survey and the hospital’s paid someone to do a voluntary survey which means that you have less than one per cent of people who come to the department will respond, many of them are quite upset but it would seem a very clear selection bias that people who are upset enough to want to respond are the ones whereas people who’ve thought it was O.K. probably don’t. So I don’t know about that. ...74BS, Doctor.</td>
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<td>So that’s probably once a year they’ll have that survey and a lot of that is a person or two people from each ward meet, learn about consumer centre care, go out and do surveys and they’ll each do a patient, a nurse and maybe like a PCA or something like that. So they’ll get their perspectives. That all goes statistically gathered and that goes out. ...10KL, Nurse.</td>
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<td>There are complaint forms. As I said before, you give them to the patient, “Are you happy with your care? Have a complaint form”, you know. They’re available if people would like them. If patients are voicing – when I’ve been caring for patients, if they’re voicing...</td>
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<td>any complaints or if they're happy with care, then I'll give them a piece of paper and say, “Look, can you just write down are you happy with this?” ...10KL, Nurse.</td>
<td>“Yeah, yeah. I think more on the basis of if somebody has loved their stay and they would like to tell us about it they can fill in a feedback form or probably more likely is if people have got problems. They are encouraged to use the feedback forms but, you know, they're often people that have got to the end of their tether and they've coped and they've accepted the limitations as far as they could and then got to a point where it's just not very good(). Yeah, so as far as I know, I think it's just if people are bringing up those things then we can encourage them to fill in the forms but they're not routinely handed out to everybody that comes in.” ...11KLu, OT</td>
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<td>I think overall the quality of care is very good. I think the safety of the patient is very high on the list and I think that we do that very well and all the data supports that we do that very well. And given the resources we have, we do exceptionally well. And I think that's really important. So although obviously there's lots of things we can improve on, I think we're very safe and that's really important. ...3CB, Allied health care manager.</td>
<td>I like to think that we do a good job. We get our fair share of compliments. We do get complaints as well, and we do get critical incidents. We try and learn from those but I always think we can strive to do better. We shouldn’t rest on our laurels. It’d be nice to have no complaints and no clinical incidents and people not lying around the Emergency Department for days on end, waiting a bed. ...69 EP, Doctor.</td>
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<td>“Well, we are proud of it because I think we are providing high quality which reflects our complaints. In the last five years, we’ve probably had two or three in the whole five years. ...21RP, Doctor.</td>
<td>I think we provide excellent care, I honestly do. I think that with the resources that we have and the busyness of this place, I think we provide excellent care. ...9JY, Nurse.</td>
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<td>I always believe things can always be better and going by that I sometimes believe that I can do better, my members of the team can do better and the hospital as an entity, as an organisation, can do things much better. And again some of these suggestions I give which are undertaken, some of the times I'm able to take suggestions and look for suggestions but overall I think that the people work hard and we do get excellent results and actually patients are quite happy at a lot of times. We don't always get a favourable outcome but we try and at least communicate it to the patient and families so that they at least expect it. ...42LG, Doctor.</td>
<td>“What’s my perception of it? Look, I think it’s good. It’s probably not great. I think there’s definitely room for improvement. I'm sympathetic to why it is as it is. I think we're working within hard structures and we have – like I said to you before, there’s a lot of people changing out, there’s constant handover and I think the constant handover even just between our own professions where we may have had three different OTs on the ward in one week, you lose a certain amount of information every time you hand over, so that’s not the most efficient, you know, it’s not continuity of care and all of those things and I think it can be a stressful, time‐pressured place and often people are just surviving. That's kind of my perception.” ...11KLu, OT.</td>
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Clinician perception of patient care
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<th>FIRST ORDER CODES</th>
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<td><strong>CLINICIAN OUTCOMES</strong></td>
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<td><strong>Negative group affect</strong></td>
<td>Working in healthcare multidisciplinary teams is difficult. When I came here, I had no concept of multidisciplinary teams; we had doctors and nurses but of course doctors run the show in my country. I find that my enthusiasm for my job is decreasing and I feel very stressed because I feel pulled in different directions. ...43LG, Doctor</td>
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<td>I do believe negative vibes are contagious and can be picked up by the team members. I often feel stressed and upset because I have to keep juggling my priorities. It is a vicious circle. If I am upset, however hard I try, it comes up in my behaviour and I would say something to the nurse who then might say something to a junior doctor and it affects the whole team. ...41AC, doctor.</td>
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<td>I think, though, especially if it’s a medical team error, it’s certainly not pointed out as frequently and sort of just moved along, whereas if it’s allied health, people are far more quick to say, “Well, you discharged them too quickly” or “You didn’t do that” and so forth. So for allied health, I think we get blamed easier whereas medical team not so much. ...18MSt, AHP.</td>
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<td>“Not that I’m aware of. That probably wouldn’t be a bad idea to do something like that to see where people are enjoying – you know, “Are you enjoying this work environment?”” ...10KL, Nurse</td>
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<td>“I don’t think I have seen any clinician satisfaction or anything else here. I have not come across any such thing as such.” ...13KC, Doctor.</td>
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<td>Not that I’ve seen – I’ve never seen one since I’ve been here. ...29SS, OT.</td>
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<td>They do those as well about every couple of years, I think, or maybe even more frequently than that, which again I think the big thing with the last one was that it showed there was a gap between management or the hospital sort of goals and the goals and needs of the people at the front line. They didn’t know who these people were and they didn’t really understand what the point was and there was that again communication breakdown; they didn’t understand the context. ...3CB, AHC</td>
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<td>Not really. I wish if I was part of it and if I could do that – look, when you’re asking me I feel it is a very important component in providing good care to the patients, mainly because I strongly believe that you have to be happy yourself or you can’t do work to give the best possible care to the patients and that’s the reason I really believe in good teamwork. And I strongly believe that every team member of the team has to be happy to give their 100 per cent. Whether they are or not, again it’s a matter of guess. If I have to say, I would say hopefully they are. But, no, I think it’s something really good and important part and I wouldn’t mind actually looking at it and maybe doing it myself at some stage. ...41AC, Doctor.</td>
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<td>Nothing that I’ve done or that I’m aware of in terms of working within the team. And again part of the multidisciplinary team is something like that becomes problematic because I think a medical team sees things differently to how a nursing roster might see things that might be different to how an allied health team might see things. So within those teams there’s teams as well, so it’s a really good sort of systems theory: you know, within the systems there are systems. ...4CA, Social worker.</td>
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<td>There was a recent – I don’t know if that was technically a clinician survey but there was a recent survey about – it was more about organisational culture and satisfaction around that as well. So, yeah, I've recently done that, I think about six months. ...56PC, OT.</td>
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<td>No one’s ever asked me, no one ever. ...57TB, Nurse.</td>
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<td>Look, I think we know what the issues are. We don't need a survey to tell us what the issues are - the same issues keep coming up every time – so people feel not listened to, they don't feel valued. And it's little things, like having somewhere to go and have your lunch, all those sorts of things, it's little things that really irk people and not having enough staff, having to do lots of overtime, and I think if you’ve got Bunbury’s staff satisfaction survey and put it against Perth’s or Fremantle, I think you’d have the same, similar issues. ...5CE, NUM.</td>
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