Changing professional identities:

The evolution of professional delineations in the healthcare sector

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ABSTRACT

Recent Australian research suggests that professional boundaries are not necessarily bounded and static, but reconstituted in response to reform. An examination of professional identities within the healthcare sector suggests that societal and political change serve to liquefy professional delineations. Yet, how do these changes affect traditional labour divisions; and how do the forces for change affect the reconstruction of professional identity? This paper demonstrates that organisational pressures are changing the historically anchored medical profession and the emerging nursing profession. Such change is also influenced by the void between clinicians cum managers and clinicians. Because the success of healthcare reform is contingent on professional interdependence, it is important that the evolution of professional delineations within the sector is understood.

KEYWORDS

Profession, hospital, healthcare, inter-professional practice, identity

INTRODUCTION

The formation of healthcare professions, with clear and defined boundaries, is evolving under the strain of organisational changes to the healthcare system. Organisational developments as a result of societal and political changes, have influenced the way professionals view themselves, view others and are perceived by others (Goffman, 1959, Gouldner, 1957, Marshall, 1998).

Conversely, such change is also stifled by those professional identities that are historically anchored. Professions that maintain established traditions serve to somewhat constrain the force of organisational influence (Freidson, 1988). Within the healthcare sector, this orientation may thus impede attempts at hospital reforms and, as such, influence the management of organisational and professional-boundary changes.

The malleability of professional identity has important implications when reform is high on the agenda. Research suggests that the success of healthcare reform is contingent on professional interdependence (Edwards & Marshall, 2003). When the working alliance between professions is collaborative and synergistic, there is greater opportunity for reform within the workplace to be
discussed, contextualised and adopted. In light of current political debate around the need for, and implementation of, reform in the healthcare sector (Degeling, Maxwell, Kennedy & Coyle, 2003, King, Kerridge & Cansdell, 2004, Zhan, Short & Lawrence, 2005), it is important that the evolution of professional delineations within the sector be understood. This is the purpose of the present paper.

The Profession

Before explicating the evolution of professional delineations in the healthcare sector, it is important to understand what constitutes a profession. Although there is no single, widely accepted definition that offers clarity of meaning (Freidson, 1994, Millerson, 1964), existing literature suggests that the management of professional knowledge distinguishes a profession from other occupations. Within a profession, members exclusively determine the way in which their professional knowledge is passed on, and to whom this knowledge is conveyed to. They also govern who can legitimately do its work, how the work should be done, when such work should be evaluated, and who should evaluate it (Abbott, 1988, Ackroyd, 1996, Conrad & Kern, 1994, Freidson, 1988, Hinings, 2001, Morgan, Calnan & Manning, 1985, Zola, 1994). Evidently, a profession is an occupation that has assumed a dominant position in the division of labour, controlling the core of its own work (Freidson, 1994). Professions are self-directed, autonomous and enjoy a privileged status. Through professional societies, a profession has complete managerial control with clearly defined rules, regulations and standards. These in turn, become the hoops that newcomers must jump to prove their worthiness, before admission into the profession.

Theoretical considerations of the term describe the crystallisation of a profession in three ways. Firstly, it is described a tri-way relationship between autonomy, authority and sovereignty (Ackroyd, 1996, Conrad & Kern, 1994, Freidson, 1970, Morgan, Calnan & Manning, 1985, Zola, 1977). Although not mutually exclusive, the three elements collectively suggest that professionals operate independently, are self-regulated and are self-evaluated (Fitzgerald, 2002). Medical professionals, akin to other professionals, preserve a clandestine or tacit wisdom that others are not privy to. As Illich (1977) explains:
Professionals tell you what you need and claim the power to prescribe. They not only recommend what is good, but actually ordain what is right. Neither income, long training, delicate tasks nor social standing is the mark of the professional. Rather, it is his authority to define a person as client, to determine that person’s need and to hand the person a prescription (17).

Secondly, and perhaps more critically, professions are depicted as being associated with particular prerogatives (Illich, 1984). And thirdly, a feminist viewpoint regards the profession as part of an established dominant paradigm (David, 2000, Gardner, 1995, Roberts, Howe, Winterburn & Fox, 2000, Roberts, 2000). While seemingly divergent, these three schools of thought acknowledge the important role of identity within the profession.

Professional Identity

Professional processes encompass the development of an idiosyncratic professional identity. This is an awareness of the role and functions that one performs, or is expected to perform, in a social context as a member of a particular profession (Sharma, 1998). It is also understood as an approach to assign subjective meaning to work, both generally and specifically.

This understanding of professional identity suggests that it essentially concerns the self and the self in relation with others – be they individuals or institutional bodies. This is indicated by Olesen (2001) who views professional identity as an ongoing concern of the professional involving the practice of his/her work, social interactions with colleagues and clients, and his/her place within the professional institution and the professional discourse.

Early considerations of the profession and professional identity portray the constructs as historically anchored and, for the most part, static. They were largely perceived as fixed with strong, well-defined characteristics (Abbott, 1988, Ackroyd, 1996, Conrad & Kern, 1994, Freidson, 1977, Morgan, Calnan & Manning, 1985, Zola, 1977). However, this supposed state of permanence is challenged by unprecedented societal and political change (Iedema, Degeling, Braithwaite & White, 2003).
The Influence of Social and Political Change

At times of institutional and organisational change, there may be limits to professional hegemony. Research efforts by Greenwood and colleagues (2002) suggest that, despite the protective efforts of its members, professions are not static entities. They are swayed by wider societal and political changes, and the way these are mediated by the workplace and professional bodies.

For instance, technological advances in healthcare, volatile market forces, increased community expectations of quality service, policy development, as well as higher economic responsibility and consciousness are all mediated by healthcare organisations. Hospitals, for example, might introduce different modes of working or deploy existing personnel into new terrain. In turn, these intercessions potentially impinge on, if not liquefy professional demarcations. So too does the way in which professional associations respond to these forces. Confronted by change, these bodies may recognise a need to modify their practices to protect their established monopolies.

As Western societies witness greater socio-political change, and the gradual closing of the public purse, professionals, particularly those in the healthcare sector, are required to reassert their expertise and authority in different ways. Even if attempts are made to maintain the status quo, the outcomes might be different, if not new, for both the professions and inter-professional relations (Abbott, 1988, Greenwood, Suddaby & Hinings, 2002). In light of such change, it might be naive to assume that professions remain static.

Organisational Change within Healthcare Settings

One demonstration of the relationship between socio-political change and change within healthcare professions is the increasing focus on management. Literature suggests that the drivers for change, including politicians, health consumers, health economists, biomedical engineers, auditors and professionals themselves, have forced healthcare services to adopt management practices that are somewhat comparable to those found within administrative bodies (Brock, Powell & Hinings, 1999). This has had marked implications for the planning of healthcare services, the management of human resources and the existing professional hierarchy.
The adoption of multidisciplinary teams

For example, notions of a patient focus and the continuous improvement of quality care are exhorting the use of multidisciplinary teams. This approach requires previously autonomous disciplines to collaborate more intensely. Theoretically, this redefinition of boundaries causes professional groups and their managers to interact in order to “invent collective solutions and to reconcile needs for change and new learning” (Denis, Lamothe, Langley & Valette, 1999). Hence, change in formal boundaries is assumed to beget change in the distribution of professional influence.

However, whether effective teamwork eventuates in practice is questionable. The notion of teamwork presupposes that doctors, nurses and allied health professionals will work together in unison to diagnose, treat and deliver follow-up care to patients. Such multidisciplinary collaboration requires group decision-making around best practice for both the cure of and care for the patient. Yet, this undermines the notion of professional autonomy, particularly in terms of medical dominance. It also raises concern around whether or not healthcare could and/or should be provided without the supervision of doctors.

Turning clinicians into managers

Another demonstration of increased management practices within the healthcare sector is the deployment of clinicians into managerial roles. Within most New South Wales (NSW) public hospitals are examples of clinicians cum managers – doctors, nurses and other clinical personnel who have assumed the role of manager. Ostensibly, this appears to make efficient use of medical experience; it assumes that managers will draw upon their clinical expertise to manage hospital resources effectively. While the repercussions on professional identity and inter-professional relations are not well understood, one might presuppose that professional delineations within the healthcare sector might be diluted further. As Iedema and colleagues (2003) explain:

‘Medical managers’… have one foot in the world of treatment and care, characterized by individualized trust and professional-expert authority, and another in the world of organizational management, characterized by resource expenditures, budget overruns, information management, issues of treatment proceduralization, evidence-based
decision-making, and appropriateness. Most problematic here is the
disjunction that appears to arise between doctors’ commitment to
individual patients and their concern as ‘managers’ with more socially
abstracted issues centring around projected treatment levels, yearly
budget allocations, and comparative treatment standards (16).

The blurring of professional boundaries
The concepts of functional autonomy and control are central to the argument of professional
interdependence within the healthcare sector. Historically, the strongly defined division of labour
between doctors and nurses was closely related to the medical paradigm and its jurisdiction over roles
that can only be assumed by those who have been admitted into the profession. However, bona fide
multidisciplinary teamwork will require compromise. Doctors and nurses will need to negotiate the
division of labour and associated changes to functional autonomy and authority.

In Australia, the functional authority and autonomy of nurses have changed considerably since the
mid-eighties. This corresponds with radical changes to tertiary education for nurses. Furthermore, the
introduction of nurse practitioners in NSW required nurses to acquire a number of privileges,
including limited prescribing rights that were previously only granted to doctors.

However, healthcare reforms and their organisational consequences may not necessarily facilitate
professional interdependence. In fact, as professional boundaries liquify and medical authority and
professional privileges relinquish, professional interdependence maybe hindered. Doctors, who were
once at the helm of medical work, might perceive the loss of control as a disintegration of the medical
profession (McKinlay & Stoeckle, 1994). Consequently, change might be strongly opposed to.

In Australia, there is evidence that supports proponents of the proletarianisation thesis; that is, the loss
of prerogatives associated with professional dominance (Willis, 1989), as suggested by McKinlay and
Stoeckle (1994). The work of Willis (1989) confirms the existence of medical dominance in terms of
autonomy, authority and sovereignty, although he states that its form and operation is changing. The
negotiation of medical prerogatives and rights is changing the nature of professional identities;
however, according to Willis, this does not necessarily denote a decline in overall medical dominance.
It therefore seems that well-established professional identities are changing. However, what effect does healthcare reform, and in particular, the increased use of multidisciplinary efforts by doctors and nurses, have on professional boundaries? This is the very question explored in the present paper.

**Research Method**

Given the exploratory nature of the study, a qualitative methodology was adopted. The methodological framework for this research was developed by combining research material collected through focus group discussions and semi-structured face-to-face interviews. To illuminate subsequent findings, observational notes were also used.

The group discussions and interviews focused on socialisation between professionals. More specifically, they explored collaboration in decision-making between doctors and nurses around healthcare reform and the associated changes in organisational and occupational culture. Approval to conduct the research was gained from the university ethics committee, as well as the relevant Area Health Service ethics committee.

**Focus groups**

A team of researchers conducted six focus group sessions over a period of three months at a NSW public hospital. Research participants were recruited through a request for voluntary participants via email distribution and hospital noticeboards.

Those interested in contributing to the study were provided with detailed information about the project. This included information about its purpose, the way in which research material would be used and the fact that individual contributors to the project would remain anonymous in the presentation of research findings.

Twenty-seven research participants were recruited, each of whom was accommodated into a focus group regardless of sex, professional status and/or length of service. The composition of each group was contingent on the availability of hospital personnel as well as an appropriate meeting place. Consequently, the composition of each focus group varied. While some included a mix of doctors, nurses, managers, clinicians and non-clinical staff, others consisted of nurse-managers alone. Due to
medical emergencies and other unplanned events, doctors proved to be the most difficult cohort to attract to the study.

To ease the collection of research material, the group discussions were audio taped and a second researcher recorded notes.

**Interviews**

In addition to focus group discussions, interviews were held with 24 organisational key informants. To extend current understanding of inter-professional relationships in a climate of change, active attempts were made to recruit doctors and managers in this phase of the study.

**Analysis of research material**

The strategy used for integrating the research material was comparative analysis (Lambert & McKevitt, 2002). This approach involves interrogating the material to identify similarities and differences, and to develop and test theory, as illustrated by narratives from the field (Blaikie, 2000).

To ensure the thorough analysis of the material, the following six steps were followed:

1. A comparison of the research material within each focus group.
2. A comparison of the research material between each focus group.
3. A comparison of the research material within each interview.
4. A comparison of the research material between each interview.
5. A comparison of the research material within each profession.
6. A comparison of the research material between each profession.

Each step was aided by a consideration of several factors. Namely:

1. The source of the research material.
2. The questions asked of this material.
3. The overarching aim of the present project.
4. The findings to emerge from the analytical process.
The sequential presentation of the six aforementioned steps should not suggest that the analytical process was linear. In fact, each step was visited and repeatedly revisited to support the cyclical method espoused by comparative analysis (Blaikie, 2000).

Comparative analysis encourages the researcher to engage with a process of reflection. Reflection is systematic thinking about all the linkages and interconnections between players in the social field, in this case, of a healthcare facility (Kleining & Witt, 2000). In the present study, reflection was used to identify and understand fundamental conventions that govern situations in which doctors, nurses, managers, clinicians and other hospital personnel find themselves. Consequent findings are presented through ethnographic portraits to illustrate the way in which the identified themes manifest in the professional lives of the research participants.

**Research Findings**

This section presents the identified changes to professional prerogatives, such as authority and autonomy. It demonstrates a shift in the professional boundaries between doctors and nurses, with particular reference to decision-making power. It also highlights the need for a closer interdisciplinary alliance when making (clinical) patient-management decisions.

Furthermore, the following section demonstrates the formation of a new professional identity in the form of clinician *cum* manager. This involves a close working alliance between doctors and nurses in managing a ward, unit or division and is heavily influenced by organisational protocol and convention within the hospital setting. This context has resulted in the formation of the professional healthcare manager, which lies beyond the professional identities of both doctors and nurses.

**Changes to professional prerogatives**

Much of the tension between occupational groups and professional identities concern professional privileges. These include power and control over best practice for both the professional and the profession. In the past, this involved thickening inter-professional boundaries to protect the rights and interests of professional members. However, changes in public policy, the organisational dynamics of hospitals and in the organisation of work have initiated change within the professions; consequently,
the boundaries that divide professional identities are becoming more permeable. One nurse-manager aptly illustrated this:

> The traditional medical model of, ‘you treat the doctor as the pinnacle, and the holder of all knowledge when making decisions,’ has probably gone because a lot of care these days is collaborative amongst a whole team of people.

Another nurse concurred:

> In my area, doctors have to make decisions in a collaborative manner now. We, the nurses, often don’t feel the patient is ready for discharge and we block it… or the OT [occupational therapist] hasn’t assessed the home situation yet. They cannot discharge until all disciplines have done their bit. The [doctors] don’t always like it, but this is the way it is now.

According to a number of research participants, specialist doctors, like those in the Intensive Care Unit (ICU), demonstrated this close working relationship. They displayed an acceptance of the professionalisation of the ICU nurse by openly supporting the nurses’ capabilities for clinical decision-making to other doctors visiting the ICU. A nurse in the following excerpt expresses this sentiment:

> The residents that come into intensive care get a handbook on working in intensive care and on one of the pages it actually states that, ‘the nursing staff can appear very bossy but they’re a bunch of very knowledgeable, intelligent people and their opinions are to be valued, and if you have a problem and don’t feel that you can deal with it, then go to someone higher; don’t challenge them as such.’

A Visiting Medical Officer (VMO) supported this philosophy, stating:

> The status of nurses has changed relative to doctors, and probably a few doctors have realised this. Probably nurses have become more
important in changing the health system and doctors have become less important.

According to this statement, a number of doctors are adapting to the changed role of nurses. They are acclimatising to the greater authority and decision-making power nurses have assumed consequent to the acquisition of specialised knowledge (through university training), and perhaps experience (given the increased average age of nurses (Gardner & McCoppin, 1995)). Accordingly, there has been an apparent increase in collaboration between doctors and nurses when curing and caring for a patient. One doctor spoke of such collaboration:

> It’s evolving I think, and it’s probably evolving slower than I personally would have liked… I think the main influence is that it still comes back to the medical staff accepting nursing and allied health as equals and part of the team focus.

Another doctor, who is also a manager, commented on the transition doctors had experienced. According to this research participant, they are now expected to be part of a collaborative team:

> The traditional team in hospitals was in fact the surgeon and the team around him and there was a very clear single leader who was almost the autocrat, the Sir Lancelot… and I guess that was in an era where medicine was clearly the profession in health, and others were barely… sub-professions to medicine. I think what one is seeing now is that medical staff still play a major leadership role and it’s partly the nature of the role they have held in hospitals. It’s partly the nature of education; it’s partly the nature of the way patients come into hospitals under the care of doctors. But that doesn’t necessarily mean they provide leadership of all aspects of the team. We’re seeing more and more teams where there may well be a Medical Officer supervising clinical leadership, but the actual running of the team is managed by somebody else who might be a nurse.
The above illustrations clearly indicate a boundary shift between the professional identities of doctors and nurses. This is partly because of shifts in professional prerogatives.

Other themes identified through the group discussions were the (in)ability or (un)willingness of doctors to collaborate and consult with other professionals about clinical or managerial issues. Ostensibly, these appear to be related to a fear of the continued disintegration of medical dominance. For example, one surgeon was observed to exert authority by influencing a patient to accept discharge, so that another of his patients can be admitted. The nurse in charge of the unit could not meet this request, as policy does not allow the patient to be discharged after 21:00. The surgeon who, in his opinion, was faced by an uncooperative nurse, asked the patient to telephone relatives to claim her, so the bed could be made available. Evidently, this was a clear display of power and influence by the doctor, despite hospital policy or nursing opinion about the quality of patient care.

In addition, the group discussions and interviews suggest that nurses can feel (sometimes conveniently) comfortable in a position of subordination. Relative to doctors, they have less autonomy, less authority and therefore less responsibility. This is associated with (an accepted) inertia, as they are less involved with the professional development endeavours. This is verified by one (experienced) nurse, who stated:

I am not really interested in getting involved… I come here, do what I am supposed to do and go home… Easy.

However, it became clear from both doctors and nurses that their professional boundaries are shifting. Historically confined precincts of professions are slowly integrating with regard to division of labour, responsibility, accountability and sovereignty. Furthermore, both nurses and doctors welcome this boundary shift. Health managers also require this shift to facilitate the increasing interdependence of professions. Although delineations between professions continue, different forms of distinctiveness are forming within and between the professions.

**The emergence of the hybrid role**

In addition to changes in professional prerogatives, the findings also highlight the emergence of a hybrid manager/clinician role. The traditional hospital hierarchy is characterised by a distinction
between the medical and administrative domains of activity (Fitzgerald & Ferlie, 2000, Kitchener, 1994). In this model, administrators, whose activity is contained by clear policies and procedures, appear to accept their non-clinical role (Freidson, 1994). In contrast, the medical domain is based upon notions of autonomy, self-discipline and adherence to professionally-set standards.

Yet, this organisational model is changing. Clinical professions, like medicine and nursing, are now separating into managers and clinicians, each with its own subculture. Interestingly, this divide provides another opportunity for doctors and nurses to work collaboratively. One nurse-manager stated:

> Over the last three years, I have seen an amazing shift in the relationship between my medical director and me, as nurse-manager. I have gained his respect and I think that this is because the medical manager is relating to me as a manager, rather than a nurse. We make a very effective management team and are clear about each other’s role.

The introduction of hybrid roles is a relatively recent example of healthcare reform. It requires doctors and nurses to work in confluence across permeable boundaries, while protecting, upholding and adjusting their own professional identities. While the hybrid role appears to divide doctor-managers and doctor-clinicians, it also unifies doctor-managers and nurse-managers. The role therefore blurs conventional identities and necessitates role re-definition. Evidently, this recent evolution constitutes an interesting area for further research.

Although they assumed a hybrid role, some of the senior nurse-managers involved in the present study also chose to partake in weekly clinical work. A penchant for their traditional nursing role enticed them to ensure regular patient contact. However, colleagues did not always welcome this. As one nurse-manager explained:

> It is good for me. I get to understand what is happening on the shopfloor. However, the staff do not like it. They think I am spying
and [they] behave differently. I think it confuses them… some are even angry and cannot wait till I get out of there.

Ward personnel were equally unsure. The coffee room was often a place where they would critique the manager’s clinical ability. Some thought he did not “pull his weight,” that he took the “easier” patients and that he was generally “a nuisance to have around.”

These sentiments may indicate that the introduction of the hybrid role may not facilitate the permeability of role boundaries. Rather, it may reinforce the delineation between manager and clinician.

The research material here presented suggests that, consequent to healthcare reform, hospital personnel are continually negotiating and renegotiating the professional roles of themselves and their colleagues. Consequently, the conventional roles assumed by doctors, nurses, managers and clinicians are fragmenting. They are becoming more organic as professional delineations liquefy. This changes the hallmarks of each profession and may in turn change the traditional hierarchical division of labour.

**DISCUSSION**

Historically, the delivery of healthcare was based on the independence, dependence and functional autonomy of professionals who were situated in a hierarchical division of labour. However, recent healthcare reform calls for integration and occupational interdependence. This is particularly evident through joint patient-care planning.

Conducted in a NSW public hospital, the present study confirms that professional identities among hospital personnel are changing. There are clear shifts in role boundaries that were once distinct. This was particularly evident when doctors and nurses made clinical decisions in specialist areas, like the ICU. Through their participation in clinical decision-making, nurses can experience an increase in professional prerogatives. They are actively involved in tasks that were once considered medical; they also contribute to the management of clinical processes. While these changes have not necessarily weakened the dominance of the medical paradigm, they have increased the permeability of previously thick professional boundaries.
In addition to such collaboration between doctors and nurses are new forms of distinction within professions. In the context of healthcare reform, the clear demarcation of managerial, administrative, and clinical processes has given rise to the hybrid role of clinician-cum-manager. The formation of a role involving two distinct professional backgrounds modifies existing precincts and unifies different clinical professions – namely, doctors and nurses who have assumed a managerial role.

However, the research material suggests that the hybrid role also widens the divide between managers and clinicians. Some clinicians for instance, are cynical of colleagues who have gone to dark side and adopted a managerial role.

Despite the apparent change in the professional identities of doctors and nurses, professionals are remarkably resilient in protecting and defending professional and occupational interests. While conventional roles might liquefy, professionals find different ways to adapt and maintain traditional identities.

Notwithstanding the value of the present findings, a number of methodological limitations must be considered. For example, the cross-sectional nature of this project indicates that the research participants merely provide a snapshot of socialisation between professionals. Qualitative research is also limited by time, context, and the nature of individual perspectives. Additionally, the use of convenience sampling may have biased the present findings. Furthermore, the interpretive approach used to analyse the research material should be acknowledged (Lambert & McKevitt, 2002). The findings reflect the interaction between the research team and the research participants. They also reflect the research team’s interpretation of these interactions, and are thus tainted by the frames the team members bring to the project. The construction of themes from the research material may therefore not adequately encapsulate the perceptions voiced by the research participants. Further, the epistemological dilemma associated with interpretive methodologies – given that interpretation is continually evolving, the present findings that were the result of a cross-sectional design, have a limited lifespan.

Despite these limitations, the findings that emerged from this study – notably, the fluidity of professional identities among hospital personnel, constitutes an important discovery. This is
particularly because the existing body of relevant literature is limited. The present study therefore poses a number of important challenges, as well as opportunities – not only for healthcare professionals, but also those seeking to effectively implement healthcare reform.
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