Developmental Paper

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**Doctors’ professional and religious identity conflict:**
**Micro and macro dynamics in End-of-Life circumstances**

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**Summary** (149 words)

This developmental paper reports a work in progress study. It aims at investigating micro- and macro-level processes related to doctors’ professional/religious identity conflict in critical situations, such as End-of-Life (EoL) circumstances, and the consequences of such conflict on doctors’ psychological well-being (PWB). It achieves this by testing in a multilevel, moderated mediation analysis four hypotheses in a two-wave study of doctors working in 30 NHS Trusts in England. By providing a holistic framework on identity conflict dynamics (its emergence, unfolding and individual consequences), this developmental paper has the potential to make two key contributions to the literature on identity and identity conflict as experienced by doctors in EoL circumstance. First, it clarifies micro-level conditions and mechanisms of professional/religious identity conflict in doctors and its impact on PWB. Second, by including ‘extra-individual’ forces as macro-level boundary conditions, namely organisational ethical climate, it extends identity theories with social information processing theory.

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Doctors’ professional and religious identity conflict: Micro and macro dynamics in End-of-Life circumstances

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Introduction

Increasing uncertainty and complexity in today’s healthcare organisations (Borgström, & Walter, 2015; Karnik & Kanekar, 2016) have challenged doctors’ clinical practice and decision making, especially in End-of-Life (EoL) circumstances (Curlin et al. 2007; Hurst et al., 2005). These ethically-charged circumstances can give rise to doctors’ identity conflict, or ethical dilemma (Kälvemark et al., 2004), between their professional and other non-work identities, such as doctors’ religious identity. Indeed, religious beliefs remarkably influence doctors’ clinical practice (Lawrence & Curlin, 2009; Miccinesi, 2005). As such, when values inherent in doctors’ professional and religious identity are salient and central but incompatible, professional/religious identity conflict can emerge (Ashforth et al., 2008; Horton et al., 2014).

Despite the consequences at individual, organisational and societal levels, in terms of doctors’ psychological and behavioural outcomes (Genuis & Lipp, 2013), patient care (Firth-Cozens, 2001) and quality of the healthcare system (Sulmasy, 2008), how such professional and religious identity conflict in doctors arises, unfolds and affects their PWB remains unclear. Therefore, this developmental paper has the potential to make two major contributions to the literature on identity conflict as experienced by doctors in EoL circumstances. First, it clarifies the underlying micro processes and mechanisms of identity conflict and its consequences on PWB in EoL situations. Second, it extends well-established identity theories (Stryker & Serpe, 1982; Tajfel & Turner, 1986) with social information processing theory (Salancik & Pfeffer, 1978) and its contextual, macro-level forces, such as organisational ethical climate.

The paper is divided in three main sections. Whilst the first section illustrates the theoretical background and the hypotheses development of this paper, the second section explains its research methods. Lastly, the third section highlights possible implications for theory and practice.

Theoretical Background & Hypotheses Development

Identity theories (Stryker & Serpe, 1982; Tajfel & Turner, 1986) posit that individuals take on multiple identities embodying meanings and expectations associated with the different social roles and groups individuals belong to (Alvesson et al., 2008; Ramarajan & Reid, 2013). These multiple identities are hierarchically arranged in terms of the salience and centrality to the individual and the situational context (Ashmore et al., 2004; Stryker & Burke, 2000). Some situations simultaneously trigger individuals’ multiple identities and this can lead to identity conflict (Alvesson et al., 2008; Horton et al., 2014; Petriglieri, 2011).

Legal changes in medical regulations and advancements in medical technology have accentuated the emergence of identity conflict in healthcare organisations (Kälvemark et al., 2004; Karnik & Kanekar, 2016; Sulmasy, 2008). Especially in EoL situations, the application of doctors’ rigorous code of medical practice and professional duties may come into conflict with their religious beliefs (Giubilini, 2016; Lawrence & Curlin, 2009). Religious beliefs constitute individuals’ religious identity and, by informing people’s ethical principles, can
influence doctors’ clinical practice (Lawrence & Curlin, 2009; Miccinesi, 2005). The following figure (Figure 1) depicts the model tested in this paper.

![Hypothesised Model](image)

**Figure 1: Hypothesised Model**

Whilst medical research has recognised the interplay between religious and professional identity in doctors in EoL situations (Curlin et al., 2007), management/organisational studies (MOS) research has overlooked the interaction between professional and religious identity in organisational settings (Leavitt et al., 2012; Tracey, 2012; Weaver & Stansbury, 2014). However, compared to the atheoretical medical works on ethical dilemmas, identity theories in MOS research have explained identity conflict emergence in terms of a simultaneous activation of individuals’ salient and central but incompatible identities (Stryker & Burke, 2000).

Nevertheless, only little and incomplete empirical evidence has proposed that identity conflict can be viewed as the result of the interaction of important but incompatible identity content (see: Brook et al., 2008; Settles, 2004). Therefore, since in ethically-charged situations doctors’ professional and religious values can conflict (Curlin et al., 2007; Genuis & Lipp, 2013), the following hypothesis is put forward:

**Hypothesis 1: The stronger the salience and centrality of doctors’ religious and professional identity, the stronger the professional/religious identity conflict.**

Doctors’ well-being is crucial for clinical practice and patient care (Wallace & Lemaire, 2007). According to MOS research, the conflict stemming from the activation of salient and central but incompatible identities can produce a sense of discomfort and unease (Brook et al., 2008; Horton et al., 2014), leading to harmful outcomes, such as higher levels of depression, stress and anxiety (Brook et al., 2008; Karelaia & Guillén, 2014; Settles, 2004).

Similarly, medical research has highlighted that professional/personal struggles in ethically-charged situations can be seen as potential source of burnout, stress and emotional strain (Genuis & Lipp, 2013; Gabel, 2011; Glasberg et al., 2007). However, no studies in MOS and medical literature, to the best of the researchers’ knowledge, have looked at identity conflict influence on psychological well-being (PWB) (Ryff & Singer 2008). Thus, the subsequent hypothesis is suggested:

**Hypothesis 2: Doctors’ professional/religious identity conflict will have a negative impact on doctors’ PWB.**
Given the hypotheses above and suggestions from research (Horton, 2014; Karelaia & Guillén, 2014), identity conflict can be seen as the mechanism underpinning the interaction between multiple salient and central but incompatible identities and individual outcomes. Nonetheless, research examining this mechanism has reported inconsistent findings in terms of mediation and no interaction between the two identities, conceptualised only in terms of positive identity, has been considered (see: Karelaia & Guillén, 2014).

Therefore, since studies have shown that the interaction between professional and religious identity can be associated with ethical identity conflict involving such identities, (Curlin et al., 2007; Genuis & Lipp, 2013), and that this professional/religious identity conflict may affect doctors psychological outcomes (Genuis & Lipp, 2013), the following hypothesis is thus proposed:

**Hypothesis 3: Doctors' professional/religious identity conflict mediates the relationship between the coexistence of doctors' religious and professional identity and their PWB.**

Although contextual forces can prompt people to prioritise a salient and central identity over another (Treviño et al., 2008; Weaver, 2006), MOS research on identity conflict has mostly neglected potential extra-individual forces affecting identity conflict relationships (Alvesson et al., 2008; Horton et al., 2014). Medical studies on ethical dilemmas have instead dedicated greater attention to these macro-level forces (see: Hurst et al., 2007; Lemaire & Wallace, 2010; Woo et al., 2006), and organisational ethical climate has stood out as a paramount element in EoL situations (see: Hurst et al., 2005; Joseph & Deshpande, 1997; Woo et al., 2006). Nevertheless, medical literature has never justified the influence of such contextual forces with strong theoretical explanations and studied them in association with doctors’ professional/religious identity conflict and their PWB. On the contrary, albeit never integrated with identity theories and identity conflict, a theoretical justification in MOS research that can explain the influence of extra-individual forces is social information processing theory (SIPT; Salancik & Pfeffer, 1978).

SIPT posits that individuals, through cues provided by the surrounding social context, can construct and interpret events and information about desirable attitudes and behaviour to adopt (Salancik & Pfeffer, 1978). Hence, doctors could try to solve their professional/religious identity conflict in EoL situations by mean of contextual cues, such as organisational ethical climate, which could help them to become more aware of what is treasured in their workplace and which identity should be prioritised.

Organisational ethical climate is a renowned concept in both medical and MOS research. It depicts individuals’ shared perceptions of what constitutes correct attitudes and behaviours (Victor & Cullen, 1988), and how ethical problems and their implications should be handled in organizations (Hart, 2005). Some MOS research has found a positive direct relationship between organisational ethical climate and individuals’ well-being (Martin & Cullen, 2006), as well as moderating, buffering effects (Barnett & Vaicys, 2000; Simha & Cullen, 2012). In the medical literature, studies exploring ethical climate at the organisational (hospital) level, have involved ethical climate in relation to nurses’ turnover, stress (Hart, 2005) and job satisfaction (Joseph & Deshpande, 1997), finding significant direct and indirect effects. Therefore, the following hypothesis is suggested:

**Hypothesis 4: Organisational ethical climate positively moderates the relationship between doctors’ professional/religious identity conflict and their PWB.**
Research Methods

61 R&Ds of NHS Foundation Trusts, identified on the NHS website on the basis of the services provided and then randomly sampled, have been asked to collaborate in this project. The only requirement for doctors to be participants is having experienced at least once ethical conflict/dilemma in EoL situations and defined themselves as religious. 30 Foundation Trusts have been willing to participate in the project.

Data will be collected during the period of July-August 2018 through an online survey among doctors. Hospital-specific codes and doctors-personal codes are generated at the beginning of the survey. These codes help to match data from hospitals and doctors for the subsequent multilevel and two-wave analysis. Ethical approvals have been obtained both from the University Ethics Committee (FEO) and the Health Research Authority (HRA).

The final sample size for individuals is still to be obtained. However, to reduce biases related to aggregation procedures for organisational ethical climate, hospitals with at least 8 doctors are considered (Bliese & Halverson, 1998; Ostroff et al., 2002). To detect, instead, cross-level interactions and guarantee statistical power, at least 20 organisations were needed (Kreft et al., 1998). To test the proposed model (Figure 1) Structural Equation Modelling (SEM) is used and Kline’s (2011) recommendations followed.

Since this study is about perceptual variables and intrapersonal processes, self-report measures are appropriate (Conway & Lance, 2010). Podsakoff and colleagues’ (2003; 2012) guidelines are implemented to minimise potential sources of method bias in building and disseminating the questionnaire. If dropouts happen, due actions will be undertaken according to Rosenbaum and Rubin’s (1983) and Puhani’s (2000) suggestions to control for sample selection bias. The survey is built following well-established scales in MOS. Analyses will be conducted with the statistical software package MPlus. The following variables and scales constitute the main part of the final questionnaire. All items used a 5-point Likert-type scale (1 = strongly disagree and 5 = strongly agree).

Religious and Professional Identity Salience and Centrality is measured adapting the 6 items of the Identity Salience and Centrality Scale (Cameron, 2004; based on Gurin and Townsend, 1986 and Luhtanen & Crocker, 1992).

Religious/Professional Identity Conflict is assessed using 6 items, adapted from the Woman/Leader Identity Conflict Scale (Karelaia & Guillén, 2014).

Psychological Well-being is measured with 30 items from the original Psychological Wellbeing Scale (Ryff & Keyes., 1995).

Ethical Climate is assessed implementing the short version (16 items) of the Ethical Climate Scale (ECQ, Victor & Cullen's, 1988) as suggested by Schminke et al. (2005).

Aggregation Procedure for Ethical Climate is obtained according to Chan’s (1998) “direct consensus models” as explained by González-Romá and colleagues (2002).

Potential Implications

Unravelling doctors’ professional/religious identity conflict dynamics in critical contexts of EoL situations has implications for theory and practice. Research implications would be to provide holistic perspective on professional/religious identity conflict in doctors integrating MOS and medical research. This synergy will allow a more thorough exploration of identity conflict processes in terms of their moderating and mediating mechanisms, at both micro and macro level, towards PWB.
Practical implications could involve doctors’ development of psychological skills to promptly tackle potential professional/religious identity conflict in EoL situations, thus safeguarding their PWB. Healthcare managers could consider promoting counselling and training schemes to stimulate the development of such skills and guarantee their employees and patients a safe environment and clinical practice.

Additionally, evaluating the effect of organisational ethical climate on identity conflict/PWB relationship could prompt healthcare organisations to promote courses and strategies to foster a strong group collaboration and trustworthy organisational support. These factors could also help to develop rigorous policies and efficient interdisciplinary ethics committees for EoL situations, which could protect organisations from undue costs and lawsuits risks.

**Final Remarks**

This paper is a work in progress as part of my PhD research project on identity conflict in healthcare professionals in critical situations. As at this point of submission, data collection has not been completed and the ideas proposed need further refinements. As such, more details on the methodology, variables, scales and analyses will be provided at the conference during the discussion time to better understand how this paper will examine micro- and macro-level processes of doctors’ identity conflict in EoL situations.
References


