Between multiple identities and personal struggles:
Healthcare professionals’ identity conflict perception and responses in challenging situations

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ABSTRACT

Due to the increasing diversity and complexity of today’s workplaces, individuals may experience identity conflict between the multiple identities they hold. Working under pressure and high uncertainty, healthcare professionals may face identity conflict between their professional and personal identities and values, especially in challenging situations. Although such conflict can significantly affect doctors and nurses’ psychological and behavioural responses and, ultimately, the quality of the healthcare system, how identity conflict emerges and unfolds remains unclear. By integrating works in organisational-management and medical literature, we thus explore healthcare professionals’ identity conflict dynamics in challenging situations, such as End-of-Life circumstances. We conducted a qualitative study, using semi-structured interviews (N= 47), among healthcare professionals working for the English National Healthcare Service. We implemented both theoretical and random samplings and followed grounded theory approaches to analyse the data. Our findings show that identity conflict was perceived between different identities but also within the same identity and, surprisingly, the conflict was stimulated by perspective taking processes. Lastly, behavioural responses to identity conflict included seeking peer support and doing reflective practices, whereas its psychological consequences unexpectedly embrace identity growth and positive learning dynamics. Hence, this paper contributes to and extends newer approaches in the identity literature by, firstly, focusing on identity conflict in depth, as one of the intrapsychic relationships of multiple identities simultaneously activated; and, secondly, unravelling some of the conditions whereby identity conflict can emerge and affect healthcare professionals’ psychological and behavioural responses.

Keywords: Identity Conflict, Perspective Taking, Behavioural and Psychological Responses
THEORETICAL BACKGROUND

Social identities and identity conflict

According to well-established identity theories, namely identity theory (Stryker and Serpe, 1982; Stryker and Burke, 2000) and social identity theory (Tajfel and Turner, 1986), identities assist individuals in the process of integration into their respective communities, which share the same values and norms (Ashforth et al., 2008). Identities, reflecting individuals’ multiple group affiliations (Brown, 2015), are hierarchically arranged in terms of the importance to the individual and the situational context (Stryker and Burke, 2000). However, in some circumstances individuals’ multiple identities can be simultaneously activated (Ramarajan and Reid, 2013) and, if disharmonious identity contents are triggered, identity conflict can arise (Horton et al., 2014).

Management/Organisational Studies (MOS) research and identity theories define identity conflict as the discrepancy between ‘values, beliefs, norms and demands inherent in individual and group identities’ (Horton et al., 2014, p. S6), which are activated at the same time and in the same context (Alvesson et al., 2008). In medical literature, incompatible identity values may cause healthcare professionals to experience ethical dilemmas and personal struggles (Kälvemark et al., 2004) which constitute a mutually-exclusive choice between equally un/desirable and morally justifiable alternatives (Genuis and Lipp, 2013).

Following the identity theories outlined above, these incompatible values can be viewed as principles belonging to different individual and social identities. Consequently, ethical dilemmas/personal struggles can be regarded as a case of identity conflicts. Healthcare professionals may perceive these identity conflicts when contrasting principles belonging to their work/professional identity and other non-work identities involved in ethically-charged circumstances, such as EoL situations, are activated. Such identity conflicts can impact healthcare professionals’ psychological outcomes (Genuis and Lipp, 2013) and decision
making (Hurst et al., 2005), as well as patient care (Bedford, 2012) and quality of the healthcare system (Sulmasy, 2008).

**Healthcare professionals’ identity conflict and practice**

Indeed, doctors and nurses’ professional identity is grounded on codified systems of clinical practice which guide their ethical choices and behaviours (Borgstrom et al., 2010) and by which they should abide as part of their occupation (Giubilini, 2016). However, the application of these principles in critical situations is not straightforward, since clinical practice norms need to be integrated with healthcare professionals’ personal values (Lawrence and Curlin, 2009).

In medical literature, such personal values are usually associated to the notion of conscience (Giubilini, 2016). Defined as individuals’ moral sanction of what is a right or wrong behaviour (Sulmasy, 2008), conscience provides instant responses in the form of internal discomfort to individuals perceiving problematic situations (Birchley, 2012). In MOS research such internal discomfort caused by important but incompatible identities values has been identified as one of the roots leading to individuals’ identity conflict (Horton et al., 2014). In this sense, identity theories help to explain the emergence of ethical dilemmas and personal struggles.

Nonetheless, such theories do not fully grasp how individuals’ multiple identity may interact simultaneously. Thus, they lack in richness when trying to explain the processes behind identity conflict emergence as perceived by individuals. Considering that personal values are vague concepts and vary between individuals (Giubilini, 2016), how do healthcare professionals perceive identity conflict involving their professional and personal values in EoL situations? What identity values trigger healthcare professionals’ identity conflicts, disrupting their everyday routine?
In medical research identity conflicts are also interlaced with the lack of universal normative standards as code of ethical behaviour (Karnik and Kanekar, 2016). Changes in social mores and medical practices over the 20th century (Genuis and Lipp, 2013) have created uncertainty and room for subjective interpretations of the course of actions in situations of ethical collision, such as EoL circumstances (Birchley, 2012). Although some constitutive principles of medical ethics exist to provide guidelines for healthcare professionals’ duty, responsibility and conduct (Ruiten, 2016), how healthcare professionals should act in ethically-charged situations to avoid moral impasses has been significantly destabilised (Curlin et al., 2007; Ruitenberg, 2016). Since MOS research and identity theories have emphasised the link between identity and behaviour as offering the possibility to target identities to produce effective behaviour (Alvesson et al., 2008), in what ways do healthcare professionals react to the confusion and consternation caused by ethical identity conflicts? What are their behavioural responses and psychological consequences to experiencing identity conflict?

Hence, since MOS and medical research has overlooked how individuals perceive the emergence of identity conflicts/ethical dilemmas and how their severity influence individual outcomes (Genuis and Lipp, 2013; Horton et al., 2014), such as healthcare professionals’ decision making and clinical practice in EoL situations, the following research questions are formulated:

**Research Question 1.** How do healthcare professionals perceive and experience identity conflict in End-of-Life situations?

**Research Question 2.** How do healthcare professionals respond to identity conflict in End-of-Life situations?
METHODS

Study Design and Data Sources

Justification of Context and Sample. In line with our research questions we were concerned with finding a context that could enhance challenges and complexities, and in which individuals may find themselves pulled between two incompatible alternatives. We thus considered EoL circumstances as an extreme and unique case in which identity conflict dynamics can be understood. Indeed, the high sensitivity of these circumstances demands enormous cognitive, emotional and ethical efforts from doctors, since issues of preserving patient’s dignity, self-determination and quality of life are number one priorities, (Hurst et al., 2005). Additionally, EoL situations precede almost 50% of deaths in Western countries (Rietjens, Deschepper, Pasman and Deliens, 2012). In Europe, more than 70% of doctors have reported experiences with ethical difficulties in EoL situations (Hurst et al., 2007) and, similarly, more than 50% of ethical dilemmas encountered by US doctors have been related to EoL circumstances (Hurst, Hull, DuVal and Danis, 2005). Hence, End-of-Life situations provide a convincing context to study identity conflict processes in healthcare professionals since, compared to less critical situations, they would emphasise and sharpen the phenomenon under consideration and enable a more transparent observation of healthcare professionals’ perceptions and responses of ethical struggles (Eisenhardt, 1989).

More specifically, we chose healthcare professionals, involved at least once in ethical dilemmas in EoL situations, due to their more generalisable as well as specific characteristics (Eisenhardt, 1989). Like other professionals (e.g. engineers, lawyers), they follow a specific code of practice with ethical principles, but they also share moral values of other social groups they belong to. However, compared to broader workforces, healthcare professionals involved in EoL situations face stronger ethical identity conflict, because of the sensitive and moral nature of their job (Borgstrom et al., 2010). Consequently, as for EoL situations, these
features make them an example of a polarised case of identity conflict, thus accentuating the dynamics we wanted to investigate (Eisenhardt, 1989).

We specifically focused on healthcare professionals’ identity conflict and subsequent responses in EoL circumstances. However, we expect that the findings of this study can be applied to other types of conflict, since the multiplicity of individuals' identities and the broad notion of identity conflict allow this generalisation. According to identity conflict research, demanding professions, such as those in the eye of the public, and problematic situations enhance the understanding of the phenomena under study (Creed et al., 2010; Kreiner et al., 2006). Healthcare professionals in EoL situations reflect these criteria, since they are exposed to public pressure and trust, intense ethical conflicts and frequent critical situations (Genuis and Lipp, 2013).

Furthermore, contributing to the intensity of their identity conflict as well as making identity processes more generalisable (Eisenhardt, 1989), doctors and nurses engage in various extra activities, i.e. managing resources, treatments costs and making decisions about quality of life (Genuis and Lipp, 2013). Our sample came from different medical specialisations, ranging from oncology to gynaecology, from anaesthesia to paediatrics, from intensive care unit to palliative care, as well as different hospitals in terms of size, location and importance. Lastly, we made sure to cover different levels of seniority and professional experience (e.g. junior and senior consultants, specialist nurses, matrons, senior nurses, etc.) These characteristics aid both in-depth descriptions and generalisability. Thus, our sample and context offered a unique opportunity to explore the perception of identity conflict that healthcare professionals experience in the context of challenging situations, such as EoL circumstances, and their responses to such conflict.

Research Instruments. We drew on three main sources of qualitative data, which provided detailed information on what happened at the macro and individual analytic levels.
(see Table 1). First, out of 61 R&Ds of National Health Services (NHS) Foundation Trusts in England originally contacted, 35 sites indicated willingness to collaborate in this research. Interviews were carried out in 12 NHS Trusts chosen for their diversified characteristics.

Table 1. Overview of Data Sources

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<th>Data sources dynamics</th>
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<td>Micro: Identity conflict perception and responses</td>
<td>• Face-to-face interviews with 47 healthcare professionals</td>
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<td>• Field notes (researcher’s observations and personal reflections)</td>
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<td>Macro: EoL context in England</td>
<td>• Face-to-face interviews</td>
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<td>• Field notes (researcher’s observations and personal reflections)</td>
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<td>• Publications by medical associations</td>
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<td>• NHS policy documents and report</td>
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We interviewed a total of 50 healthcare professionals (21 doctors, 11=F and 10=M, and 29 nurses, 25=F and 4=M), divided among the different sites following both theoretical sampling, to strengthen the rigour of the study, and random sampling, to ameliorate any bias in the selection process (Kreiner et al., 2006). The first 3 interviews were pilot interviews, for a total of 47 main in-depth interviews with consultants and nurses located across England during the period March-June 2018 (with additional unstructured observation notes taken during field visits).

Interviews were semi-structured and administered by the first author. The interviews were conducted face to face \((N=43)\) or via video conferencing \((N=4)\) and lasted between 45 minutes and 1.15 hours. Interviews were conducted at each participant’s place of work, audio recorded and transcribed verbatim, concealing participants' identity, personal data and any type of information that could link the participants to the Trust, hospital or geographical area they were working in. Trusts’ confirmation of capacity and letter of access as well as participants’ informed consent were obtained for all interviews. Each interview followed a
standard set of questions to facilitate the identification and comparison across the emerging themes. However, the interviewer maintained the possibility to tailor the questions according to the interviewee's answers to reach a greater depth of contents (Kreiner et al., 2006). There were approximately 20 questions which were formulated following previous organisational and medical studies on the topic (see: Hurst et al., 2005; Kreiner et al., 2006; Wallace and Lemaire, 2007).

Consultants and nurses were asked about: (a) the motivation behind their decision to become a consultant or a nurse in their specialty; (b) the various professional and personal values associated to their multiple identities and roles; (c) their perceptions of a personal struggle or ethical dilemma they experienced in their clinical practice; (d) the reasons why they deemed that struggle/dilemma to be particularly important to them and the role played by their multiple identity values they associated with; (e) their views regarding Baby Charlie’s case, a recent and dramatic ethical dilemma in the UK involving an infant with a genetic and degenerative disease; and (f) potential factors, of any kind, that could influence their decision-making process in challenging situations.

Second, the first author took notes and wrote personal observations right after each interview to record their own thoughts and feelings, as well information regarding the location and physical workspace where the interview was conducted. More specifically, the author made reflections on how healthcare professionals interacted with them, the presence or absence of power distance and how this could affect the way interviews were conducted. General observations were also done to compare the different settings in which consultants and nurses were working across the different NHS Trust and how this could have been related to the content of each interview. Indeed, these personal reflections and observations not only considerably enriched doctors and nurses’ descriptions of their experience of identity struggles and dilemmas, but also revealed additional data that complemented participants’
identity narratives. For instance, the first author noted the difference between location and physical workspaces across different NHS Trusts, a point that helped the authors to develop the concept of “identity growth as a psychological consequence,” which we describe in our analysis.

Finally, we drew upon secondary data sources available on-line to develop a richer context for understanding and interpreting the responses of consultants and nurses. These secondary data sources include published research articles, relevant NHS policy documents and reports, the English medical and nursing codes of conducts, as well as world-wide medical ethical principles, such as the Declaration of Helsinki. Overall, these secondary data complemented the interviews that we conducted and played a key role in helping us to define the perception and nature of the identity conflict we explored in our study. Ethical approval to conduct the research was obtained from the University Ethics Committee and the Health Research Authority (HRA). NVivo software programme was used to organise the data.

**Data Analysis**

Given our interest in the perception of healthcare professionals’ identity conflict and behavioural responses in challenging situations, we conducted an inductive, qualitative study using grounded theory approaches (Charmaz, 2006; Strauss and Corbin, 1990). Inductive, qualitative research is appropriate when the research question focuses on participants’ emotions, perceptions and feelings, as well as seeks to extend or build new theories, especially theory about process (Creswell, 1998; Strauss and Corbin, 1990). Inductive approaches are particularly opted for to allow the spontaneous emergence of themes, with the researcher’s direct and constant influence on data collection, interpretation and analysis (Charmaz, 2006).

We analysed the data iteratively, going back and forth between our data and an emerging structure of themes and theoretical arguments (Strauss and Corbin, 1990). After
coding 41 interviews we found no new themes in the remaining 6 transcripts. The absence of new codes gave us confidence for our having reached data saturation, the point at which further data yield only redundant responses (Strauss and Corbin, 1990).

We strictly relied on the language used by our informants to frame issues and concepts in our findings. In doing so, we sought to discern patterns relating to multiple themes that were consistent across interviewees (Lee, Mitchell and Sablynski, 1999). This process enabled us to identify three key identity perceptions of identity conflict experienced by our healthcare professionals as a result of facing challenging situations at their workplace. Additionally, the process led us to consider an unexpected emerging theme which consistently showed a connection with identity conflict. We were thus able to exhaustively answer our first research question. The process also led us to explore participants’ behavioural responses to and psychological consequences of facing identity conflict. In examining this data, we were able to thoroughly address our second research question by including a surprising second-order code. Figure 1 summarises the process of data analysis that we followed, and includes our first order themes, second-order theoretical categories, and aggregate theoretical dimensions (see: Gioia, Corley and Hamilton, 2012). We explain the stages shown in Figure 1 in more detail below.

**Stage 1: Constructing first-order themes.** We identified through a process of open coding those fragments that concern participants’ work and non-work identities, their perception of struggles experienced at their workplace, the conflicting values involved and participants’ responses to those struggles (Gioia et al., 2012; Strauss and Corbin, 1990). To create open codes, participants’ own expressions were maintained to underline the connection with the raw data. These open codes were then compared and clustered together into first-order themes. Again, participants’ own words were kept to describe the new first-order themes (Gioia et al., 2012; Strauss and Corbin, 1990). For instance, since statements about the
conflict between work identity and non-work identity were frequent in our data, we coded these with a first-order theme: “cognitive perception of identity conflict between different identities” (theme 1a in Figure 1). Similarly, statements about healthcare professionals’ perception of the conflict within their work identity were coded under the theme “cognitive perception of identity conflict within the same identity” (theme 1b in Figure 1).

**Stage 2: Integrating first-order themes and creating second-order theoretical categories.** We integrated first-order themes to create second-order theoretical categories through a process of axial coding (Gioia et al., 2012). The aim of this stage was to move beyond pure descriptive statements about data to obtain conceptual connections between the first-order themes (Gioia et al., 2012; Strauss and Corbin, 1990). To illustrate, the previous codes about
the cognitive perception of identity conflict were grouped together under the same second-order theme, since they were clearly connected. More specifically, the actual second-order theme was labelled “intrapersonal perception of identity conflict” rather than simply “identity conflict” as this more accurately captured our interpretation of the subjective and intrapsychic nature of the identity conflict dynamic.

Stage 3: The delineation of aggregate theoretical dimensions. We aggregated second-order categories to explore potential overarching conceptual themes that could be able to describe how different categories might fit together into a coherent overarching picture (Corley and Gioia, 2004). We brainstormed and discussed several alternative conceptual models that could describe how our themes related to one another and to existing organizational theories. Once we had identified a possible framework, we re-examined the fit or misfit to the data with our emergent theoretical understanding (Strauss and Corbin, 1990). In the findings that follow, we enriched our analysis with salient quotations to show our interpretation of the data. We display additional illustrative quotations in separate data tables.

FINDINGS

We present our findings in relation to the research question they answer to, including both first-order and second-order data. In this way, we aim to represent perceptions of, and responses to, identity conflict, in the actual words of our participants, integrating the basic (first-order) codes used in the analysis with the more abstract concepts (second-order) we developed from participants’ statements. For maximum parsimony, we interlace both orders of findings throughout this section to provide a well-grounded structure for our theory and, at the same time, the in-depth descriptions given by our data.

The participants in our study were asked to recall and reflect upon how they experienced identity conflict in challenging situations, such as EoL circumstances, as well as how they responded to the conflict. To make sense of our findings and link them to the
existing literature, we referred to Ramarajan and Reid’s (2013) conceptual model about how individuals navigate the dual forces of pressures and preferences to negotiate their non-work identities at work. More specifically, the findings answering the first research question relate to what Ramarajan and Reid termed “initial conditions” and the subsequent step concerning either the alignment or the misalignment of the initial conditions. In contrast, the findings addressing the second research question pertain the last step of their conceptual model regarding the consequences of the negotiation between work and non-work identities. We now expand on our findings considering each research question at a time.

**Research Question 1: Healthcare professionals’ perception of identity conflict**

In our first research question we sought to better understand how healthcare professionals perceive identity conflict in challenging situations at work, such as EoL circumstance. We thus asked them to recall and describe an event in which they perceived a struggle, a conflict within themselves, to elicit their own thoughts, reflections and perspective on how and why they experienced the conflict. As illustrated in Figure 2, our respondents depicted a scenario where multiple identities (work and non-work identities) and values were involved in a cognitive and emotional perception of identity conflict. Moreover, our interpretation of numerous and consistent evidence from our participants’ interviews led us to introduce a novel and unexpected theme in relation to identity conflict, what we labelled “perspective taking”.

**Psychological perception of identity conflict.** The first theme we identified represents a subjective dynamic and is rooted in our participants’ psychological perception of identity conflict. Three core perceptions were described by the healthcare professionals we interviewed. First, there was a cognitive perception of the struggles related to a pressure *between* their professional identity (“occupational” in Ramarajan and Reid’s model) and their non-work identities. We found strong and ample evidence of the different identities that our
participants felt to be involved in the experience of identity conflict. One of the most common
cconflict was between their medical identity and their family identity, since participants often
called upon their non-work identities (e.g. being a mother, a father, a daughter or a son,) to
cjudge, make decisions or evaluate the challenging situations they were facing. One nurse
working in the Intensive Care Unit, for instance, said:

“Obviously as a mother…as a mother you would fight for your children, wouldn’t you? But then
looking at it from a nursing point of view, then you would agree with the doctors’ decision,
because it’s about the child, not the family […] but as mother you would want to fight for your
child, wouldn’t you? I guess is such a destroying situation, isn’t it? Because you have to play
God…” (REC 019 NF)

Similarly, participants’ religious and moral identities were also significantly involved in a
conflict with their professional identity. Whilst the echo of our healthcare professionals’ moral
identity was a constant leitmotif in all the interviews, the medical/religious conflict was less
frequent but, when present, equally strong. For instance, this palliative care consultant clearly
underlined a conflict concerning how far to push for a treatment:

“I talked to my pastor a lot about this because some areas of Christianity believe very strongly
that you must always give everything, you must accept any treatment, you push for every
treatment, you have to prolong life as long as possible because it allows God to do a
miracle…because, you know, we believe in the miracula when it comes to healing…and if you
“give up” then how does that allow God to do…so…I have an amazing relationship with my
pastor and I speak to her frequently about the tension in my mind about that… it helps she was
a nurse before she was a full-time pastor, so she can kind of understand some of the…and she is
being teaching and she’s been encouraging me, I guess, that our job as Christians is keep praying,
you know, for that miracle…but also allow ourselves…because some Christians I’ve come
across, even in a professional context, won’t even let themselves, you know, think about what
might happen if this miracle doesn’t occur…when actually that’s, that’s a real problem for me,
because, you know, maybe you are missing an opportunity to have the right kind of
palliative care input or putting somebody through something futile, which itself is unethical…so what would I do? I guess I would pray, and pray, and pray…” (REC 037 CF)

Second, we identified a conflict within our participants’ professional identity and between their professional identity values. Quite unsurprisingly, healthcare professionals often see their profession not as a job but as a vocation and they strongly identify themselves with the medical or nursing values, as these nurses undoubtedly show:

“I think my profession and the job I do defines me hugely, enormously…I love my job, I’ve always loved nursing, but this job particularly at [name of the hospital] has been the best job really, and I think it defines me…” (REC 040 NF)

And again:

“To me, being a nurse isn’t a job, it’s a vocation, and if you don’t love to be a nurse, you can’t be a good nurse…so, you’ve got to have that pull towards the profession, you’ve got to have that drive for it, that love for it […] I met my husband 5 years ago…and he always tells me the story that when we were walking on our first date and we were having a conversation and he said “so, what do you do for work?” he says “you just lit up, and you’ve never stopped talking”…and then he says that at the end of the conversation I said “my job is not my job, my job is who I am”…” (REC 039 NF)

However, since medicine is both an art and a science, there is room for subjective interpretations of some medical principle (Birchley, 2012). Some healthcare professionals may perceive some values as incompatible, causing inner struggles in their medical practice. For instance, in the long but exemplary statement below, one consultant in palliative care was discussing how, to him, in the UK there should be a novel debate about the legality of assisted suicide and euthanasia, especially in those case where it is difficult, if not impossible, to control properly the symptoms. Referring to the inconsistency between the professional values of ‘do not harm’ and ‘respect patient autonomy’, he said:

“It’s a real dilemma, because as a medic you don’t want to let the patient down, because you can’t control their pain appropriately […] but there is this question inside me…why? Why can’t we do that? […] It’s a conflict in the sense that one side of me says that that’s the right
thing because patient should have the autonomy, but the other side, because I’m a doctor and we are so trained not to cause harm, and that’s a big problem…then, yea, “should I be doing that? Is that part of my job to do that?” […] it’s like the whole concept of providing harm has a double effect […] So, your values of being a doctor conflicts with your duty of care to the patient […] if we truly mean “quality of life”, then the quality of life is what the patient sees as quality of life, not what I decide is quality of life for the patient…because often, and that’s is another criticism of myself of my specialty, we talk about quality of life, but it’s often by proxy we decide what quality of life is for that patient, rather than asking the patient…so if quality of life is “do you know what, I had a really good life, let me die”, then sometimes I find it conflicting with my values as a doctor, I cannot “do not harm” and death…so there is that tie there…” (REC 046 CM)

Similarly, a consultant in oncology talking about her experience of identity conflict noted a disharmony between two medical values:

“I remember thinking ‘am I actually causing her harm?’…and that was haunting me […] I think I find that quite difficult and I don’t know, and that’s the bit that lay heavily on me, if I’m actually causing the death, am I’m speeding it up…and it has always troubled me, more than anything else…and when I have someone on the end-of-life care pathway it’s almost a relief when they die, because I can finally think “ok, that was the right decision”, but sometimes it’s just hard and think “oh my God, have I given up too easily? Was it the right time?”” …” (REC 008 CF)

Third, our healthcare professionals also discussed their perception of the conflict in terms of feelings and emotions, linking their perception to the emotional component of social identities and adding a more ‘visceral’ dimension to the notion of identity conflict. Some of the healthcare professionals felt upset and insecure, others stressed and with a sort of daunting feelings for being out of their comfort zone. A consultant in oncology noted:

“I think you feel unsettle in yourself if there is something you are battling with…it’s something you can’t out to bed, it’s niggling there […] for the rest of the clinic I was like “what are you going to do? What are you going to do?” in the back of my head, and I couldn’t concentrate…” (REC 011 CF)
Similarly, an onco-paediatric plainly admitted:

“I’m probably scared…you know, and a bit anxious, as well, to what kind of responses are meant to be, because it could be anything, and how would I respond to it, would I be prepared to respond, so, I’m probably scared to not be ready enough to answer the queries or the anxiety, or answer whatever comes back at me from the meeting…so, probably a bit anxious, scared, a bit of fear […] I guess, uncertainty, doubt…fear that you are getting it wrong and what the implications of that will be, both ethically and legally, I guess…wanting to, again, wanting to please people, but sometimes it’s not that easy and so you would feel frustrated and helpless…”

(REC 027 CM)

In sum, when faced with challenging situations evoking deep and core professional and personal values, our healthcare professionals felt identity conflict not only as a disharmony between their professional identity and other non-work identities important to them, but also within their own professional identity. Furthermore, as our participants’ words showed, identity conflict on an emotional level was experienced as a sense of unease, uncertainty and confusion about their practice. These cognitive, emotional and relational perceptions occurred as subjective dynamics, and participants described and dealt with the conflict in terms of the salience and centrality of their own identity values and emotions.

**Perspective taking.** The second theme related to identity conflict that we developed thanks to a constant pattern in our data is related to a core interactional dynamic in the healthcare profession, the healthcare professional-patient relationship. Such relationship had a key importance for our participants because it was able to activate identity conflict. When asked about their core professional principles and values, our healthcare professionals unanimously spoke about the cruciality of respecting patient autonomy and preference, putting the patient first and keeping in mind their best interest. For instance:

“I think you have to make sure you’ve put the patient first, you know…you may have certain ideas or they should know this piece of information, but if they hold up their hand and say “I don’t want to go there”, then they lead, it’s their life, their condition…we need to be mindful,
supporting them…they may have very different attitudes to ours sometimes, so we just need to listen to them really…” (REC 015 NM)

And again:

“In terms of values…put the patient best interest as paramount […] I can only inform the medical choice to the patient…but I don’t know what’s the best for the patient, only the patients know what’s the best for them…” (REC 046 CM)

Given the extraordinary importance of patient preferences, our healthcare professionals reported that they always try to take their patient perspectives when making a critical decision in challenging situations and described three core interpersonal processes. On a more cognitive level, our participants said that they always try to imagine themselves in the patient’s shoes to better understand their patients’ thoughts and what they deemed important. For instance:

“I really try to understand anything from the patient about themselves, what they want, what they think […] and then I spend time with the family, I try to understand what their perception of the patient is, what their life has been, what the patient has meant to them …” (REC 005 NF)

An adjuvant process to our participants’ willingness to imagine their patients’ preferences was the need to try to understand what was relevant for their patients and, their families. For our respondents this was a fundamental approach to avoid imposing our participants’ points of view on their patients’ perspective. For instance, these consultants in oncology and palliative care clearly noted:

“I think it’s being able to put yourself in the other person’s shoes, and focus on what’s important to them…” (REC 047 CF)

And again:

“I’ve done some cognitive therapy training and some communication skill training as well…and that has influenced the way I talk to people, which I see as a very important part of my role, trying to understand what are the important things for that person, and kind of
facilitating them to be able to explain to me what is like for them to be in that situation…” (REC 033 CF)

Lastly, on a more emotional level, a third process was related to a pillar of the healthcare professional-patient relationship: empathic concern. Besides being described by our participants as one of the values each doctor and nurse should have, the ability to imagine others’ feelings and feel what they might feel was seen as crucial to better understand a challenging situation and act consequently. For instance, the quote below shows how the empathic concern felt by this nurse working in Intense Care Unit affected her practice and her decision making. In recalling a dramatic event where a drunk mum caused a car accident in which her own son died, she said:

“I’m a mum, and my children were not the same age, but quite similar…and I felt for her…I could really feel for her…I cried, because it was so emotional…so the ethical and moral dilemma was that I knew that when she left that room in resus, she was going to be arrested…” (REC 032 NF)

Similarly, a nurse working in oncology noted:

“You can put yourself in that person’s positions and in her family position, because you know how you would feel if it was some of your relatives…and I suppose that’s where the emotions come in, because, you know, this is just how you would feel…you would feel upset, particularly in the knowledge that you know what’s going to happen…” (REC 049 NF)

These cognitive and emotional processes of imagining other people’s thoughts and feelings were strongly related to identity conflict and struggles in our respondents’ practice. Indeed, these processes of perspective taking can be seen as a double edge sword. On the one hand, they are fundamental to get closer to the patient, recognise what is important to them and try to meet their expectations in order to deliver an optimal care. On the other hand, however, they can make an already critical decision making even harder. A consultant in oncology was describing how difficult it was to explain to one of her patient that an excessive treatment was futile:
“I could just understand her worries and it really made me cry…it struck a chord [...] I think I probably struggled with the fact that I could see her point of view in saying “I want some treatment”…but then, because of my experience, and knowing how this disease go and how she would probably feel worse with the treatment rather than benefit, that’s clear to me, but each patient takes it differently…” (REC 011 CF)

Similarly, this matron in palliative care reported her struggles caused by an understanding of her patient’s perspective about not telling their family about their disease, but feeling against it:

“I suppose it was a struggle just because I felt uncomfortable…and I couldn’t help putting myself in that situation and think if I were in that situation what decisions would I make…you know, I could think “well, I wouldn’t do this”… I think it’s about putting myself in that situation, you know, thinking “if I was in that situation, what would I want to do?”…and I think we all do that, you can’t stop doing that sometimes…and that just made me feel uncomfortable because I was thinking about the consequences of it, I could see what was likely to happen and its consequences […] but I couldn’t do anything…” (REC 050 NF)

And going back to the dramatic event described above about the drunk mum causing the death of her child, our participant went on saying that she felt torn about what she was supposed to do because she could understand the mum’s point of view:

“I despise drunk drivers…but she is a mum, and all these emotions going on, and it was difficult […] I totally understood her…and I felt quite responsible for that, because I knew she was going to be arrested and I was like leading her to…because the police didn’t want to come into the resus room and arrest her…so, for me, I don’t know if I gave her long enough with her son…but then, “how long is long enough?”…It has never felt right, because she kept saying “please, another 5 ins, another 5 mins, another 5 mins”…because every time I was like “please, we need to move on now”…and I think her feelings were all over the place…and I knew she was never going to see him again…” (REC 032 NF)
What struck our interest was the fact that for our participants these processes of perspective taking accentuated the experience of personal struggles, activating those common identities which could facilitate an identification of our healthcare professionals with the patient in front of them. It was clear from our healthcare professionals’ words that there was a relational perception of identity conflict due to a sense of “sameness” functioning as a trigger, so that the salience of the activated professional identity was hindered by the non-work identity stimulated in that specific circumstance. Such a relational perception is illustrated in the following statement, in which a palliative care consultant explains what one of her main struggles was:

“Mostly it's not being able to get it right all the times and seeing people who often are in very similar situations to ourselves…so for instance I’m a young mother and I'm struggle when I look after young mum, because it is too much of my own situation […] I think that the danger
for me really comes when you start to on some level draw parallels between somebody else's situation and your own…” (REC 037 CF)

Our respondents spoke sincerely and with high intensity about this sense of similarity because it was perceived as one of the main causes of instability and uncertainty concerning their medical practice. The fact that they could connect with the person or the situation in front of them was stimulating doubts and reconsiderations about the way they should act compared to what they would have done if they had followed straightforward their medical identity. For instance:

“So…last year I was looking after a chap who was my age, he was a medical, he was married with two young children under the age of ten […] I think that particularly this experience stayed with me, you know, because there was that kind of strong…you know, you relate to that family, because they are a similar sort of persons, similar raising, similar background […] So, I think the difficult bit for me probably was my ability to relate to his position…so I could see myself lying there…and me thinking “What I would want me to do in that scenario?” […] and then you know, it was a terrible situation, there was nothing left…” (REC 020 CM)

And again this specialist nurse underlined how when a connection can be easily drawn between healthcare professionals and patients, then clinical practice may be affected:

“I think a lot of us nurses get a sort of swept into or affected more about the younger ones, people that are our age or people who have older parents or who got children our age…I don’t know, you sort of connect with people, you just seem to have an association…or at least I think for me they are the ones…I dealt with young people before, but maybe they hadn’t children or dynamic different from mine…but this particular family made me go “uh”…and that can be difficult because you may lose site of what’s the best thing to do…” (REC 014 NF)

Overall, when faced with circumstances evoking similarity with the person or the situation they were dealing with, our respondents experienced clear struggles within themselves. This perception occurred as a relational dynamic, as respondents reported to experience this type of conflict when interacting with other people’s perspective and identifying with them.
Research question 2: Healthcare professionals’ responses to identity conflict

In our second research question we sought to unravel how healthcare professionals respond to identity conflict in critical situations at work, such as EoL circumstance. We thus asked our participants to reflect on and explain how they addressed the challenges raised by the identity conflict they experienced. We thus asked questions to probe for possible individual level consequences of facing a struggle due to conflicting identities. As illustrated in Figure 1, our healthcare professionals reported a series of behavioural responses that range from a more moderate reflective practice to a quite drastic change in their practice. Additionally, identity conflict had on our participants a surprisingly positive influence that led to experience identity growth on a more psychological level.

**Behavioural responses to identity conflict.** Consistent and robust in all the interviews, we found three main consequences of identity conflict on our healthcare professionals. When asked what they did when experiencing the conflict, unanimously, seeking for peer support was the first response our respondents opted for. Although throughout our interviews we did not find profound differences between doctors and nurses in relation to our questions, not surprisingly, in this case there were some differentiations. Indeed, doctors tended to rely on their doctor colleagues, whilst nurses on their nurse colleagues. Nonetheless, the strength of this theme was unexpected, especially considering that healthcare professions are often associated with the idea of autonomous and ‘solo- person’ jobs. One consultant in oncology described the need to get peer support in this term:

> “Of course you use your peers, you know, I have other consultants in different university hospitals where I would be emailing them and saying “I'm not sure what to do about this or, you know”, so, again, that’s where the team work comes in and fraternity…and that’s why you can’t work in isolation in oncology…you would not cope emotionally…or I wouldn’t […] there aren’t clear answers for a lot of these things, so you are very dependent on what the fraternity would do in a similar situation…” (REC 006 CF)
The idea of having a supporting fraternity was grounded in the full awareness that, sharing the same experience, peer colleagues could understand the struggle our participants were going through. For instance:

“They’ve been very supportive, because they’ve been through the same thing as well…so, if I had a difficult decision making and, any time, I feel quite easy to pick up the phone and just ring someone who is not on call, at home, and go through the case with them…yes…especially the tricky cases, the unusual ones…” (REC 029 CM)

Indeed, being able to reflect and voice out the issue with someone was seen as a vital aspect in the clinical practice. This consultant clearly explained this point:

“We do not work in isolation, it’s not just me, about myself […] so, if I felt there was something I just didn’t feel right about, I would go to my peers and I would sit down and ask “can we reflect on this please?”…in my experience this is kind of the only way to approach these things…to have a lot of different inputs, to come and talk around…[…] it’s not just, say, that you are going to come out with the magic answer, but sometimes just identifying and voicing the issues can be really really helpful for everyone to know…” (REC 037 CF)

The importance of the support from the peer community was significantly felt by nurses too. Perhaps more than doctors, the sense of team cohesion and collaboration, team work and coordination were deemed as one of the pillars of their profession. As the following quote shoes, sharing problems and personal troubles with colleagues seen as a way to better understand and cope with challenging situations such as ethical dilemmas:

“I think what I find probably the best part of ethical dilemmas is recognising that it’s not a solo person job or responsibility…an ethical dilemma is not down to me to solve it, it’s not down to me to find a solution, and it’s very interesting to hear all the points of views of other people in the team…and very advantageous to have someone else saying “hang on a minute, have you thought about that?” […] and when you evaluate that you realise the benefits of being part of a team […] we are not just that little person in our own internal vision, but we get inputs from loads of other people as well…” (REC 039 NF)
Another form of behavioural response to identity conflict that our healthcare professional relied on was through a reflective practice. Compared to doctors, the nurses we interviewed were more prone towards this response that was seen as a mean through which solve identity conflict and struggles. As the subsequent statements show, the goal of this reflection, which was sometimes done as group reflection, was mainly to learn out of the challenging situation faced and to improve in the clinical practice:

“I suppose and I think that what you learn being a nurse is kind of a reflective practice…so, when things are more challenging and they might go wrong, you kind of reflect on them and hopefully learn from it…” (REC 044 NM)

And again:

“I’m very good at reflecting, nurses are very good at that, it’s a huge part of our professional development…with the idea of “would have I done anything differently?” […] reflection is a learning cycle, kind of preparing yourself for similar things in the future…” (REC 015 NM)

Similarly, the desire to do things differently according to the principles of best practice also spurred our doctors to reflect on the critical situations they had experienced:

“I suppose as a doctor, as a healthcare professional, you are always learning from every case you are involved with…and reflecting on that, and revaluating what you think is right or you would do differently next time…” (REC 036 CF)

This is especially true for challenging events. As an onco-paediatric discussed, ethical dilemmas are special cases in medicine that, by nature, lead healthcare professional to reflect and conduct an introspective analysis. He said:

“You know, you go back on things when you’ve been affected, and certainly those [ethical dilemmas] are significant events, so are meant to affect you, one way or the other, probably not on the spot, you probably go back to what you have actually done, and say “have I done the right thing, have I not done the right thing”…you may doubt a bit, but then, you know, you reflect…and reflecting is probably the way, or I find it’s my way, of dealing with these events…” (REC 027 CM)
Lastly, our participants responded to identity conflict through more drastic actions, such as change or stop in their practice. Although this theme was not frequent, we found that the cases where it did happen illustrated a very interesting and significant behavioural response to identity conflict perception. For instance, a nurse working first in intensive care and then in onco-paediatrics described her temporary withdrawal from the nursing profession. Due to a strong conflict she experienced between her personal and professional values, she decided to leave nursing and she said:

“The impact it [the conflict] had on me afterwards and the cost of it was difficult…I left nursing…I couldn't switch off and that made me stressed, so that was the point when I thought “I'm not ready yet, I need to get some life experience and do some other things and then come back to this”…and that's what I have done…” (REC 013 NF)

Similarly, a consultant in gynaecology was explaining how she decided to stop doing social termination on pregnancy due to a conflict between her personal moral values and her medical values. In a very delicate interview, she shared her experience and said:

“I have stopped doing termination…social termination of pregnancy, because I found them too difficult…I found that ethically and morally I was struggling to do it because quite often you would see patients coming in and that would be their second or third termination and ethnically I did start to find it difficult […] I just stopped…I just said I couldn’t do it anymore…” (REC 030 CF)

As said, only few cases opted for such a dramatic change as a result of experiencing identity conflict and throughout the interviews we found an answer to this. What emerged was that, during their long training, healthcare professionals have the time to realise which specialty they feel more aligned with. Albeit entering the healthcare profession mostly by vocation, the differences between medical areas are numerous and profound. As this consultant in palliative care explained clearly, healthcare professionals tend to choose the path that they know may cause them less conflict. She said:

“I guess, one of the reasons I would never be able to work in obs and gynae is because […] I think there would be frequently tensions because I all heartedly believe that termination is not ok…and it’s not something I can condone, it’s not something I could be involved in…” (REC 037 CF)
And then she continued:

“You hear the Catholic members of that who are very clear on their views on contraception…and, again, Catholic GPs are someone of those who feel very strongly that all contraception is against God’s will…so, how do they do their job?…because so much of a GP’s case is contraception…if you refuse to be involved in any of that, you know, is that right for the patient? I’ve seen people actively dissuaded to go into general practice if they are very strong Catholic and believe that, because you can’t…they would say “you can’t effectively do your job if you are not willing to do this”…” (REC 037 CF)

Overall, when experiencing identity conflict in their practice our healthcare professionals respond with a series of behavioural responses that help them to tackle the struggles they are going through and cope with them. Almost all our participants dealt with identity conflict seeking support from colleagues or from personal reflection and, for the reasons explain above, only rarely they would incur change or stopping their medical or nursing practice.

**Psychological consequences of identity conflict.** On a more psychological level, when asked about what consequences identity conflict had on them and their practice, our interviewees unanimously and surprisingly spoke about identity conflict as having positive consequences on their self because leading to identity growth. Such identity growth was reached through a long process of learning and gaining life experience, as well as maturing in one’s role and becoming more self-confident. The first theme we thus identified from our participants’ words groups together a series of statements in which facing identity conflict led to a positive process of learning and gaining life experience. For instance, this nurse clearly described the positive impact that identity conflict had on her. She says:

“It changed my practice in the sense that my career changed direction, but I don’t think it affected in negatively […] I suppose, if there was any impact it was positive and that was good, I wouldn’t change anything […] so, I would say that it has had definitely a positive impact on me…” (REC 013 NF)

It is clear that one of the key reasons why our participants talked about a positive psychological consequence of the conflict is the fact that they can gain real life experience out of it, and this is beneficial for their clinical and medical practice. For instance, this nurse
in palliative care underlined how the identity conflicts she faced had put her and will put her in a better position in another similar circumstance:

“Dealing with those kind of conflicts…it has always put and it will put me in a better position next time…so, even if you don’t get exactly the same situation, but in similar situations, I will be able to manage that conflict and, you know, bringing people together to work through to some kind of shared decision…so very much it will always affect your future clinical practice…it adds to your experience, isn’t it?” (REC 040 NF)

The significant relevance that our respondents put on any experience, especially the negative one, is crucial because of the learning outcomes that are associated to it. This learning process can equip and enrich healthcare professionals with a knowledge that can be then applied into other future critical cases. This consultant in onco-paediatrics, for instance, noted:

“I don’t think that anything replaces really experience, clinical experience…it’s a fact that you’ve been faced with things, and how you’ve dealt with them…and, sometimes you learn by doing mistakes, and you should learn from your mistakes and that’s why we do so many accident reports or this sort of things […] so, in a way it’s positively impacting the subsequent problems or cases, or whatever…” (REC 027 CM)

In this sense, healthcare professional can take the ‘lesson learnt’ on board and hold that experience for other circumstances. Hence, participants acknowledged that going through identity conflict can teach them to see things from different perspectives and consider potential alternatives. As highlighted by this consultant in palliative care, learning in critical situations is always a win:

“I guess, because everything teaches us every day, it’s…we're all in a sort of learning journey and I think that every time we approach something especially the dilemmas because, I guess, by definition they’re challenging us…there is always something that can be learnt […] and it might not be even something like I’ve learnt this fact and this fact, sometimes it’s more nuances than that…it’s just something in that situation kind of taught me something, even, you know, if it’s not a fact…does it make any sense?” (REC 037 CF)
The second theme we developed underlined how the experience of identity conflict had positive consequence on our participants in terms of a growth in their role given by more maturity and psychological strength. As all healthcare professionals noted, this becoming more comfortable and consistent in their role came with time. For instance, this consultant in palliative care said:

“Over the years you build those values, characteristics by experience, you do transform, you don’t change, but you evolve as a doctor […] so you become more firm, more consistent, your leadership coat is starting to build up and that becomes part of your personality…and I think that gives more confidence…” (REC 046 CM)

It was clear in our participants’ words that time, together with experience, was a fundamental element for personal development because it helped healthcare professionals to build self-awareness about what they could do and what they couldn’t do. For example:

“It just doesn't happen overnight and I think it's the same with your nursing career…you grow with your role, with your knowledge, with your experience…it's maturing really…” (REC 038 NF)

And again:

“I think probably it’s just maturity…and also I think it’s about feeling more comfortably in your own skin and in your own belief […] so it’s not a failure to change your mind, it’s more a failure not to reassess and think that you should change your mind when things change…I think that just comes with time, so, again, it’s not something that you necessarily learn as something being taught, is something that you learn by yourself through practice…” (REC 008 CF)

In sum, the experience of identity conflict had positive psychological consequences on our participants and their practice. The psychological consequences our healthcare professionals consistently mentioned showed strong patterns in relation to the importance of experiencing the conflict to gain life experience and knowledge, as well as developing and growing in their role.

**DISCUSSION AND CONCLUSION**

In order to help make sense of the various concept and their relationships in our data, we show the findings in the model illustrated in Figure 2. This model summarises the results of
our empirical analysis and presents our responses to our research questions, namely how healthcare professionals perceive and experience identity conflict in challenging situations and how they respond to it.

The model suggests that a critical situation, such as EoL circumstances, can give rise to identity conflict between the multiple work and non-work identities and values an individual holds. The conflict can be perceived by healthcare professionals in different ways, depending on the identities and values involved in the conflict. Some of them experience the conflict on a more cognitive level, between the different identities constituting their self. Others perceive the conflict between the diverse values inherent in one identity, namely their professional identity. Others experience the conflict considering its more emotional components.

This psychological perception of identity conflict is strongly associated to the process of perspective taking, which seems to be able to affect the activation of healthcare professionals’ identities, going beyond the well-established notions of salience and centrality. Indeed, through a process of interaction with the other, i.e. the patient, healthcare professionals are able to establish a strong connection with them. However, such a connection, a vital element of the healthcare professional-patient relationship, can become a major issue for doctors and nurses. By identifying with the patient in front of them and taking their perspectives, shared non-work identities can be activated, leading to uncertainties and inner struggles between those work and non-work identities. In this sense, we see perspective taking as an interpersonal condition, able to impact on the identity interactions linked to the experience of the conflict.

Our model also suggests that, as behavioural responses to identity conflict, healthcare professionals rely significantly on their peer support and reflective practices to try tackling the conflicting experience they are going through. Rarely a drastic change in clinical and
medical practice can happen as a response to personal struggles. In terms of psychological consequences of identity conflict on healthcare professionals, regardless the challenges brought up by the experience of the conflict, positive consequences were identified, ranging from learning and gaining experience to personal growth in one’s role.

We now discuss our findings in relation to the existing literature according to each research questions.

**Research question 1: Healthcare Professionals’ Perception of Identity Conflict**

In seminal conceptual studies on multiple identities relationships, researchers have underlined the need to understand the intrapsychic relationships between different identities, be it an aligned or misaligned relationships (Horton, 2014; Miscenko and Day, 2016; Ramarajan, 2014; Ramarajan and Reid, 2013). Some empirical works have focused their attention on identity interplay considering harmonious and disharmonious identity interactions (Brook et al., 2008; Ramarajan et al., 2017) and on identity work in demanding occupation and critical context (Kreiner et al., 2006; Kyratsis et al., 2017). However, they have not provided a well-grounded account of how individuals’ perceived the simultaneous activation of multiple identities.

Hence, in the first research question of this qualitative study we sought to respond to this call, focusing specifically on one of the potential outcomes of identity interaction, i.e. identity conflict. In so doing, we aimed at providing in-depth insights into how professionals perceived identity conflict in challenging situations, such as EoL circumstances. Our findings extend identity conflict literature (see: Ramarajan and Reid, 2013) showing how identity conflict perception can go beyond a misalignment between identities to include a tension between the values belonging to the same identity. Hence, by stressing the importance of considering identities not as a fix and stable block, but as a multifaceted and polyhydric construct of the self, we want to embrace a more complex perspective in which identity
values interaction can also play a part in individuals’ identity interplay. In this way, it would be possible, for instance, to have a better understanding of identity conflict experienced when the meaning associated with a particular identity is inconsistent with the actions that may follow (Morales and Lambert, 2013).

Furthermore, by developing and including perspective taking in our results, we are able to address Ramarajan and colleagues’ (2017) suggestion of examining how the dynamics of personal interactions can affect the identities of both parties and influence each other. Indeed, perspective taking allows us to explore a new triggering condition of identity conflict, since it is seen as a process stimulating relational identification whereby individuals can understand one’s own and others’ identity values (Sluss and Ashforth, 2007). For this reason, by blurring the boundaries between the self and the others, perspective taking can be thought as one of those boundary conditions that can lead individuals to experience cognitive dissonance and identity conflict.

In sum, with our first research question we expand current conceptual works on multiple identities interaction, pointing out the psychological perception of experiencing identity conflict in challenging situations. We also suggested that the work and non-work identities and identity values involved in the conflict may be activated not only at an intrapersonal level, but also at an interpersonal and relational level.

Research question 2: Healthcare professionals’ responses to identity conflict

In Ramarajan and Reid (2013) conceptual work, they consider a series of potential consequences of experiencing identity alignment or misalignment. Our findings insert themselves in their framework in relation to identity conflict, extending the psychological consequences they identified and adding novel insights on the behavioural responses to identity conflict. In so doing, we also answered research calls on investigating possible behavioural outcomes of identity conflict (Horton et al., 2014).
Indeed, our results offered an in-depth exploration of the psychological consequences of identity conflicting, underling quite a surprise positive influence on individuals. Traditionally, research has associated the experience of identity conflict to negative outcomes, such as higher levels of stress and depression, and lower levels of self-esteem and life satisfaction (Brook et al., 2008; Settles, 2004). More recent research has instead proposed a positive, rather than a negative, impact of disharmonious identities and values at individual and organisational level (Horton et al., 2014). Our results were in line with this more recent approach, since they showed that individuals try to learn, improve and grow in their role when facing struggles, uncertainties and conflict. What was particularly interesting for us was the positive identity growth our participants aimed at as a consequence of the conflict. This individual growth in fact represents a crucial dimension of what Ryff and Singer (2008) defined “psychological well-being”. Hence, this finding details a clearer direction in terms of what can be quantitatively hypothesised and tested.

Our data also showed a series of well-specified and consistent behavioural responses, namely seeking support from peer and through a reflective practise. Even though the medical literature was alluding to the healthcare profession as a “solo-person” job (Hurst et al., 2005), our participants rely greatly on their peers for support in challenging situations. Indeed, self-verification is needed to affirm one’s identity, and peers can constitute one of the sources of such self-verification (Stryker and Burke, 2000). In this sense, the approval of the medical community can also be thought of as a way whereby healthcare professionals, by emphasising the identity and values deemed more important by their peers, can try to solve potential identity conflict. As a last remark, we want to bring the attention on research that underlines how individuals are inclined to choose occupations that tend to correspond to their personal values and inner traits (Miscenko and Day, 2016). Albeit not new, this is an element
that emerged clearly in our findings and that could explain why dramatic behavioural responses, such as changing the job or limiting the practice, were not common in our data.

In sum, our second research question extended current conceptual works on the outcomes of multiple identities interaction with a focus on the behavioural and psychological consequences of identity conflict (Ramarajan and Reid, 2013). We suggested some directions to evaluate a positive impact of the conflict on psychological consequences, e.g. psychological well-being, and we proposed some behavioural responses that could also function as ameliorating conditions of the experience of identity conflict.

LIMITATION AND FUTURE RESEARCH

Although we believe that our work makes important contributions to the existing literature, as all research it has its limitations. Firstly, being a qualitative study, its intent is to expand or generalise theories rather than testing propositions (Eisenhardt, 1989). As a consequence, the theoretical observations we advanced in this paper would benefit from a quantitative evaluation, examining its validity.

Secondly, despite the fact that we believe our medical context provides an optimal setting in which to explore questions about identity conflict perception and consequences, our context is also very peculiar. Whilst this peculiarity allows a transparent investigation of the processes we were interested in, the extreme nature of our context may as well limit the transferability of our findings. It would be therefore crucial to explore other challenging cases that could stimulate identity conflict in professionals.

Thirdly, our study only focuses on a specific profession. Although cases have been made that healthcare professionals can be considered as a prototypical profession (Pratt et al., 2006) this is an important limitation for our results. Indeed, healthcare professionals have some key distinctive characteristics in terms of, for instance, the well-defined code of medical conduct they abide by. Therefore, it would be useful to take into consideration other
professions, e.g. lawyers, and explore if the processes and dynamics we found in our setting can also occur in other contexts.

Lastly, the focus of our attention has been on identity conflict. It would be interesting to investigate in depth a complementary phenomenon, namely identity alignment or enhancement (Ramarajan et al., 2017). Albeit beyond the scope of our research questions, the richness of our data showed that this identity interplay was also vividly present in our healthcare professionals. Considering that “people are constantly bringing in and leaving out various depths of their selves during the course of their work days” (Kahn, 1990, p. 692) in response of how they experience work, it would be thus useful to explore in future research identity alignment perception and how the delicate balance with identity conflict is managed.
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