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Leader identity development in healthcare: an existential-phenomenological study

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Leader Identity Development in Healthcare:

An Existential-Phenomenological Study

Abstract

Purpose

The study takes an existential-phenomenological perspective to understand and describe the experienced leader identity development of healthcare leaders working in dual roles. Leader identity development under the influence of strong professional identities of nurses and doctors has remained an under-researched phenomenon to which the study contributes.

Methodology

Existential-phenomenology serves as a perspective underpinning the whole research, and an existential-phenomenological method is applied in the interview data analysis.

Findings

The study showed leader identity development in healthcare to be most strongly influenced and affected by (1) clinical work and its meanings and (2) followers' needs and leader-follower relationships. In addition, four other key categories were presented as meaningful in leader identity development; Leader identity development is an ongoing process occurring in relations of the key categories.

Originality

The existential-phenomenological approach and analysis method offer a novel way to understand leader identity development and work identities as experienced.

Keywords: Leadership, Healthcare, Leader identity, Identity development, Experience, Phenomenology, Existentialism

Introduction

In healthcare organizations, leadership emerges across multiple professions, expert groups and special fields. These organizations – for example, hospitals – can be described as hierarchical expert organizations, in which many professions work together to enable the

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organization's primary mission, which in the case of the hospital is providing quality patient care (Powell and Davies, 2012; Virtanen, 2010). In ensuring smooth cooperation, employee well-being and productivity, leadership and leaders are key elements at all organizational levels (Dewar and Cook, 2014). Leadership structures in clinical healthcare organizations are usually multilevel and multilateral, both horizontally and vertically, and extend both across professions and within them. According to the World Health Organization (2014), the largest professions in healthcare organizations are nurses and doctors. Traditionally, nurses are led by nurse leaders and doctors by doctor leaders in their professions' own line organizations, even though clinical work is performed multiprofessionally, in partnership. The multi-professionality that includes different professional groups working in cooperation towards the same ultimate goal is a strength in healthcare. However, it also brings a challenge for operations, as the members of different professions and special fields hold diverse habits, values and interpretations concerning everyday work, for example, knowledge sharing and leadership (Nugus *et al.*, 2010; Powell and Davies, 2012). In this study, multi-professionality in healthcare is considered from the viewpoint of experiential identity, which has not been applied in research thus far.

The current research examines doctor and nurse leaders' – also referred to as "healthcare leaders" – experiences of developing to be leaders by taking an existential-phenomenological approach (see Perttula, 1998; Rauhala, 2005). The existential-phenomenological approach is not only related to the analysis but is also a perspective underpinning the whole study, including the researched phenomenon and the participants as human beings. The key terms included in this perspective are a holistic conception of man, experiential meanings and a general meaning network. The perspective and included terms, as well as the quality criteria, will be explicated after grounding the value of the perspective by reviewing the contemporary leader identity literature. The current research is situated in Finnish healthcare organizations. It is a characteristic of Finland that healthcare is the primary publicly funded field, with the aim of ensuring universal access to health services to every citizen (Ministry of Social Affairs and Health, Finland, 2010).

Acting as a healthcare leader requires the skills for dealing with several managerial and relational dimensions within organizations (Witman *et al.*, 2011), which requires leader identity formation (DeRue and Ashford, 2010) in addition to the existing healthcare

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professional identity. Experiencing the self as a leader, that is, adopting the leader identity, is an essential element in leadership (Koskiniemi *et al.*, 2015; Lord and Hall, 2005) because it supports leadership actions by strengthening motivation, the tendency to learn and use new knowledge, and the desire to develop both oneself and one's work practices (Day and Harrison, 2007; Lord and Hall, 2005). However, the process of forming and achieving leader identity is not self-evident for healthcare professionals, primarily because of the strong, already adopted professional identities of nurses (Croft *et al.,* 2015) and doctors (Witman *et al.*, 2011).

The meaning of identity and self in the context of leadership has been a growing interest among leadership theorists in recent years (for example, Haslam *et al.*, 2012; Nyberg and Sveningsson, 2014). However, research examining leader identity development under the influence of professional identities is still an under-researched phenomenon (Croft *et al.*, 2015), about which this article aims to increase understanding. Professional identities can be studied from the perspective of individual development, as well as a socially created and maintained reality (Oyserman *et al.*, 2012). In this study, professional identity is understood as social identity, which is a common way to comprehend the identity in question. Leader identity, however, is not regarded necessarily and primarily as social. Nevertheless, leader identity's *development* is at least partly social, as identities cannot develop in a vacuum (Jenkins, 2008). The main distinction between personal and social identities when developed is that social identities connect an individual to a social group, such as the nurse or doctor profession, whereas personal identities reflect primarily the person as an individual (Jenkins, 2008; Oyserman *et al.,* 2012). It is not argued that leader identities should be diverse among leaders but that they *can* be diverse. Specifically, this paper discusses *in which ways the leader identity development of a healthcare leader can be comprehended as an experiential phenomenon.*

Leading Professionals in Knowledge-Intensive Healthcare Organizations

Leading professionals and their expertise in healthcare are connected to many concepts and areas of research, such as human resource management (HRM, e.g., Pynes, 2009) or knowledge management (KM, e.g., Zipperer, 2014). In addition, leading professionals can be connected with transformational leadership or talent management (e.g., Yukl, 2006). Expertise in the healthcare context is being understood increasingly as a flexible, wide

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phenomenon that exists in relation to the complexity of its environment (Vartiainen, 2008). In this study, the characteristics of the healthcare culture and leadership from the perspectives of professions and expertise are considered to be especially meaningful.

Based on strong ethical and patient-centered values, healthcare organizations are considered to consist of educated, skilled and ethically conscious individuals. Most professionals are highly educated, and all professional groups continuously update their skills (Virtanen, 2010). However, social contexts and patient care are formed and ruled by structures of medical specialties, professional groups and organizational structures. Healthcare organizations are commonly described as hierarchic, where evidence-based knowledge, specific rules and agreed-upon working methods steer actions. Creating and sharing knowledge and developing personal skills are affected by cultural and social factors (e.g., Currie and White, 2012). The professional cultural base and the differences between main groups strongly affect daily work and interactions (e.g., Powell and Davies, 2012). As healthcare organizations work for the patients, errors and mistakes have traditionally been forbidden and punished. A culture that does not allow mistakes is considered one of the biggest obstacles to developing knowledge sharing, process and efficiency in healthcare (Kim *et al.*, 2012).

Training programs, additional education and the development of work practices have been important in healthcare leadership. For individuals – especially clinicians – the possibility of proceeding in one's career has a strong influence on commitment. Developing work and knowledge are therefore important methods for leading professionals, especially, to support motivation and long-term commitment (e.g., Pynes, 2009). This turns attention back to the cultural features underlining the responsibility of the whole organization in leading professionals. One leader can be supportive in a given unit, but real efforts in managing professionals and their strong work experience require effective leadership actions and a culture that appreciates and enhances knowledge and personal growth.

However, in change situations and organizational development actions, strong professionalism and cultural subgroups can be very critical and object changes, especially when this means limiting freedom or power. Strong professional groups may oppose changes and strive to maintain traditional roles, rules and positions (Powell and Davies, 2012). This makes leading professionals and clinicians a matter of power and structures, but also requires

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follower and environmental appreciation and "earned" leadership, which combines a constructive viewpoint with social structures and dynamics.

The Meaning of Me and Others in Leader Identity Development

Through development in the life context, identities come to include various meanings attached to a person, for example, traits and roles (Oyserman *et al.*, 2012) by which the person defines who he/she is (Maurer and London, in press). The function and the development of these identities mutually influence each other. Identities guide behaviors and experiences (Lord and Hall, 2005) and, at the same time, new experiences guide identity development (DeRue and Ashford, 2010). DeRue and Ashford (2010) stress the importance of social context in leader identity development by presenting that when a person is collectively treated as a member of some group, such as a professional or a leader group, the likelihood of that person to develop a related identity grows. Thus, the leader identity development is a matter of me and others.

In addition to DeRue and Ashford (2010), many other scholars have increasingly begun to stress the meaning of relational aspects in construction of leader identity (e.g. Andersson, 2015; Day and Harrison, 2007). Steffens *et al.* (2014) pointed out that in light of the recent research and literature, leaders need not only "be one of us" but also "do it for us" to "craft a sense of us" and to "embed a sense of us". When combining this relational others-level and me-level, leader identity development seems to be a matter of i) achieving the experience of being a leader, ii) the followers' experience that the leader is a leader for them, and iii) a mutual understanding of what being a leader and being a follower mean. However, the feeling of being a leader as such does not necessarily require a managerial position. The experience is true for the experiencer, the leader, him/herself despite of what others may think (Koskiniemi *et al.*, 2015). For example, doctors feel that they have the definitive responsibility for the patient (Nugus *et al.*, 2010). Thus, they tend to place themselves at the top of the professional hierarchy and have the feeling of being leaders (Snelgrove and Hughes, 2000). No one could argue that they do not have a leader identity just because they may not have a formal managerial position. If they experience being leaders, they also own the related identity at some level.

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Even though professional identities in healthcare are considered strong, they are responsive to environmental pressures and changes and thus are open to change themselves (Korica and Molloy, 2010), for example, towards leader identities. It is commonly thought that if healthcare leaders continue their clinical work, it enhances their influence among followers, since they belong to the same professional "us" group instead of a "they" group as leaders (Croft *et al.*, 2015; Witman *et al.*, 2011). In this case, however, leadership is based on being a nurse or doctor, not on being a leader (Andersson, 2015). The mechanism of emotional attachment to the profession explains in part the difficulty of leader identity development: if a doctor or nurse leader feels that he/she belongs primarily to the professional group, and other group members express the same feeling, the feeling of togetherness may become more important than developing a separate leader identity (DeRue and Ashford, 2010). Healthcare leaders themselves may also consider their clinical work to be more meaningful than the leadership practices (Croft *et al.*, 2015) because the professional identity has already been stabilized as a part of everyday work before the leader identity development.

An Existential-Phenomenological Approach to Leader Identity Development

The existential-phenomenological approach employed here is a synthesis of Edmund Husserl's and Martin Heidegger's phenomenology, elaborated by Finnish philosopher and psychologist Lauri Rauhala (Koskiniemi and Perttula, 2013). An existential-phenomenological methodology suits the social sciences due to its ontological foundation in the holistic conception of man, according to which a human being is comprehended as a unity of three existential modes of consciousness, materiality and situatedness (Perttula, 1998; Rauhala, 2005). An empirical phenomenon belonging to an existential mode must be studied according to the structure of the existential mode in question (Perttula, 1998), in this case, consciousness. Here, "experience" is understood as a meaning relation between the healthcare leaders, as subjects, and the daily work settings in which their being a leader occurs, as objects (Giorgi, 1997). A pure existential approach is interested in the individuality of experiences, and a pure phenomenological approach looks for general experiences. By combining the two approaches, the current study allows both individual and general experiences to emerge.

In light of the current identity research, two main perspectives can be distinguished in understanding identity development: individual and social. First, identity development can be

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understood as a result of one's individual personality, that is, acting, experiencing and being as an individual in different situations (Oyserman *et al.*, 2012), on the basis of which identities are formed. As a research perspective, this would lead to investigating experiences only as an individual. The second way to understand identity development is to see it as a result of social discourse, in which the identities are socially formed and exist in relational contexts (Jenkins, 2008; Oyserman *et al.*, 2012). As a research perspective, the social emphasis would lead to investigating social discourse and events in which the identities are formed, making identity development a shared and mutual process.

Conceptually close to the current study has been the research of Olivares, Peterson and Hess (2007) on leadership development, in which they applied an existential-phenomenological viewpoint mixed with quantitative methods in the context of the U.S. Army. The present study aims to stay as loyal to the original, most fundamental roots of existentialism and phenomenology as possible. This means that the way leader identity development is understood is not unanimously conceptualized in the present study before the analysis. It can be experienced as individual, social or something else, but it is not *researched as* individual, social or anything else. Thus, the existential-phenomenological approach provides an opportunity to find new perspectives to leader identity development compared to previous research. The main goal of existential-phenomenological research is to understand the phenomenon through experiences. Consequently, as a research aim, we investigate leader identity development as an experienced phenomenon within the public healthcare context.

Method

Research design

In Finland, healthcare consists of public and private sector operators that provide both individual services and services in cooperation. The primary operator has been the public sector, with the aim of ensuring equal access to health services for every citizen, enhancing and maintaining well-being and working ability and reducing health inequalities between different population groups. The joint municipal authorities, 21 hospital districts, are mainly responsible for these services (Ministry of Social Affairs and Health, Finland, 2010).

In this existential-phenomenological study, data was gathered through interviews with 25 nurse and doctor leaders from Lapland Hospital District and Northern Ostrobothnia Hospital

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District. The participants were randomly selected from the lists received from the hospital districts after sorting for those who i) held a dual role (worked both as leader and doctor/nurse) and ii) had subordinates and, as a result, were involved in leading human beings, not just operations. Every participant had a formal managerial position. It did not appear until during the interview that one participant did not work in a dual role. Hence, this participant was excluded from the analysis data, resulting in analyzing interviews of 11 nurse leaders and 13 doctor leaders. The units of hospital districts are very different in their sizes, structures and contents of operations, so all were not represented absolutely evenhandedly in the interviews. However, from the perspective of the hospital districts as organizations, the participants represented their organizations' gestalt comprehensively, working in the divisions of medicine, operative care, psychiatric care, children and women, and medical support services.

The interviews were open in nature. At the beginning of each interview, the participant was asked to talk about his/her work. The objective was to get the participants to describe experiences regarding their work, which included both leadership and clinical work, as thoroughly as possible. Leader identity development was part of the research and tied to other perspectives of work. The concept of leader identity development was not introduced during the interviews, as it was not adequate. In line with the methodology, the experiences as they are described by participants are meaningful, not the theoretical concepts that are later used by the researcher to illuminate the topic scientifically.

The interviewer strove to ask specifying questions about the issues the participant told to understand also the background of the experiences. The most important thing was to make clear that the interview was about the experiences, and not about the formal rules or guidelines when they did not relate to one's own experiences. At all times, the interviewer tried to be as "clueless" as possible, not to know a thing to avoid presumptions and to give space for the participant's experience to appear exactly the way it was. The participants were encouraged to relate concrete examples, in which their descriptions of the self as a leader came alive and was attached to the environment. Characteristically, the participants were very open and gave straightforward descriptions of their work and their selves as leaders and clinicians.

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The interviews included in the analysis, 24 in total, varied in length between 60 and 151 minutes, each resulting in a total of 2,548 minutes of data. The interviews were transcribed verbatim, resulting in approximately 1,012 pages in 12 pt Times New Roman font and 1.5 line space.

Analysis

The analysis method was constructed by modifying the phenomenological method developed by Amedeo Giorgi (1985, 1997) and the related, further developed existential-phenomenological method by Perttula (1998).

Describing the method by steps, steps 1–5 concern the individual part of the method, and steps 6–8 encompass the general part of the method.

Step 1: The transcribed descriptions were read as open-mindedly as possible by bracketing the already owned knowledge related to the phenomenon (for example, writing down presumptions about leadership in healthcare before reading the transcriptions) (Perttula, 1998, p. 78). The presumptions included, for example, the idea that leader identity development happens differently among nurse and doctor leaders in line with the thought that professional identities among these two professions are diverse. The presumptions were not set as hypotheses because the existential-phenomenological approach does not support hypotheses.

Step 2: The entire research material was divided into meaning relations by the character "/". A meaning relation is the unit of the research material that includes one experiential meaning of "something". Separating the meaning relations attached to leader identity development from others has not yet been pursued (cf. Perttula, 1998, p. 79, pp. 88–90) (see Table I).

Step 3: The classifying themes that organize the research data according to the factuality of the experiential meanings and relate to leader identity development were formed separately for each participant (Perttula, 1998, pp. 78–79, p. 88).

Step 4: The meaning relations were transformed into transparent, general language through phenomenological reduction so that the focus was on the essence of experiential meanings. Only those meaning relations that relate to leader identity development were transformed. Using phenomenological reduction means continuing to bracket the existing knowledge about the phenomenon. Furthermore, so-called imaginative variation was used, which is discovering the necessary and sufficient meaning of each meaning relation that is

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inevitable for the meaning to be the way it is. For example, the interviewee may have described what kind of mother and father he/she has and the work experience and still meaningful values he/she gained by working in the family company ten years ago. The transformed meaning should not include the specific adjectives the interviewee uses to describe his/her parents nor the specific year of working in family company. Instead, the transformed meaning must include the notion that personal work history affects the values the interviewee owns today. Also, if the interviewee talks about the meaning of *family* company or *private* sector, these should be included in transformation. Finally, every transformation is based on intuitive evidence received while applying phenomenological reduction (Giorgi, 1997; Perttula, 1998, pp. 53–54, pp. 79–80) (see Table I).

Step 5: Each transformation was placed under a contextually appropriate classifying theme (cf. Perttula, 1998, p. 80, pp. 90–93) (see Table I).

Step 6: A more general attitude was adopted. A general meaning network proposal was constructed for each classifying theme. The aim was to construct theme proposals one theme at a time by paying attention to the core meanings of the theme from leader identity development. The language was transformed so that the individuality of meanings was removed (Perttula, 1998, p. 85, pp. 120–123) (see Table I).

Step 7: Each proposal received the form of a tentative general meaning network, that is, a coherent description of the phenomenon as a whole, rooted in a particular individual description (cf. Perttula, 1998, p. 85, pp. 123–125). Core meanings of the leader identity development were sharpened and become more precise. Twenty-four tentative general meaning networks of the leader identity development were constructed in this study.

Step 8: One general meaning network was constructed, which included the core meanings of leader identity development from the 24 interviews (cf. Perttula, 1998, pp. 125–130). For example, at step 4, the theme "The nature of clinical leadership" comprehended meaning relations that, after being sharpened during analysis, revealed meanings from different perspectives – in categories "Society, era, Organization's culture and management system" and "Clinical work and its meanings" – at step 8 (see Table I). The general meaning network includes the meaning categories that are common to every nurse and doctor leader interviewed: the meaning category as relevant to leader identity development was expressed by more than 80% of interviewees. As a result of the analysis, a detailed description of the general meaning network was rendered.

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Table I presents examples of the essential analysis steps to elucidate the progression of the analysis and the formation of the results.

Step 2: Dividing into meaning relations	**Step 4: Transforming the language (individual part)**	**Step 5: Classifying theme of transformation (individual part)**	**Step 6: Core meaning in general language (general part)**	**Step 8: Meaning category or categories of the core meaning**
… comparing it to the past is that today the planning of operations is much more demanding. We cannot make a five or three or even one-year plan anymore as the necessary actions and also the environment are kind of changing all the time./	He/she experiences present time to be more hectic and changing than the past and hence, the actions in organization happen rather through situations than planning.	The nature of clinical leadership	The present time is more hectic and change oriented than the past, as is the organization, making the work likewise.	**Society, era**, **Organization's culture and management system** and **Clinical work and its meanings**
So you have to be ready for changes all the time, every day, and to think what changes are useful and evaluate which could even worsen the situation./	He/she considers readiness for change and their evaluations to be continuous demands of leadership today.	The nature of clinical leadership	Readiness for and evaluation of changes are continuous demands of today's leadership.	**Society, era, Organization's culture and management system**

Table I. The progression of analysis

The credibility of the existential-phenomenological method comes from the researcher's ability to reflect, enabling the distinction between his/her own experiences and those of the participants (Koskiniemi and Perttula, 2013). Even though it is impossible for the researcher, as a human being, to bracket existing knowledge regarding the phenomenon absolutely, it must be striven for constantly in phenomenological reduction. The most central credibility criteria of existential-phenomenological analysis are transparency and rigor, which refer to i) describing the analysis steps as clearly and visibly as possible and ii) executing the analysis consistently and specifically as concerns every step and expression for every interviewee (cf. Perttula, 1998).

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Results

Leader identity development of healthcare leaders appears to be multidimensional. The most strongly emphasized meaning categories, treated as the key meaning categories, in leader identity development are (1) clinical work and its meanings and (2) followers' characteristics and leader-follower relationships, both of which are connected to each other. In addition, meaning categories of (3) leader's individuality (e.g. characteristics, values); (4) society, era, organization's culture and management system; (5) reflection surfaces (e.g. feedback, trainings); and (6) personal work history affect leader identity development straightforwardly and through the two key meaning categories.

Clinical work. The experienced meaningfulness of clinical work and mental reward gained from helping patients are important for leaders because they give both reason and meaning for leadership. Clinical work and leadership happen simultaneously and support one another so that self as a leader is developed and leadership is executed around clinical work and on its terms. It seems that helping the patient and being the clinician is often more important than being a doctor or nurse per se. Because clinical work is the core mission, the demands of clincal tasks (e.g. patient care) that require a leader's clinical contribution often surpass the demands of leadership duties (e.g. developmental planning).

" It [clinical work] *is satisfying work because patients get true help … I know what I'm doing and I'm good in it."* (Doctor leader 7)

"Medical practices change always a bit, which needs straining yourself in that you stay up to date … I have to bring the information to our unit and make sure the information is used and applied in patient care correctly..." (Nurse leader 5)

Being a leader is necessarily attached to a hospital's core mission, clinical work, such as patient care or tasks required to discover the right treatment (for example, clinical examination). In addition to liking clinical work, knowing the nature of a work unit, its operations and responsibilities support leadership – a leader knows how to lead when he/she understands the target of leadership, that is, clinical work and the workers. On one hand, a leader wants to utilize the clinical skills he/she has gained during his/her career to support

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leadership practices. On the other hand, it is about limited resources. Clinical work and leadership are executed simultaneously when it is regarded essential in guaranteeing the best possible patient care and adequate clinical human resources.

Followers' characteristics and leader-follower relationships. Followers' characteristics and leader-follower relationships have strong effects on a leader's development of his/herself because leadership is developed on the base of how leading employees to provide quality patient care succeeds. Working as and being one of the clinical colleagues, not one of the leaders, is regarded significantly relevant in executing leadership. Developmental needs and ideas become more apparent and understandable when a leader either works as a clinician or is physically close to those doing the clinical work. The goal is not so much about leading but rather creating a working environment in which followers want to develop themselves as clinicians, which requires both a comprehensive understanding of followers' clinical work and being familiar with followers.

"Well, I think it has been a good background that I have done much clinical work, I have the kind of strong clinical know-how and I know the personnel respects that … It has helped in it [developing leadership practices in work unit]…" (Doctor leader 11)

"… when you get to stay close to this work community, you can act as an example… there I see concretely how this system works … also, am able to give appropriate feedback right then and there." (Doctor leader 10)

Clinical work and related nurse and doctor professional identities hold central roles in leader identity development and acting as a leader: either one identifies as a clinician regardless of the leadership position or one feels clinical know-how to be a prerequisite for trust and respect from followers. Clinical expertise *from the same profession* being a prerequisite for successful leadership is usually situated in traditions and applies most strongly to the doctor profession.

Leader's individuality. A leader's individuality including, for example, values and ambition is strongly linked to clinical work, while at the same time, doing the work reforms oneself. The

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experienced permission to be an individual and to think independently are important features in leader identity development.

"… no education gives you the skills of how to be a leader, it has to come from your self." (Nurse leader 5)

"You don't have to think you have to show or prove you know everything." (Doctor leader 10)

Being a leader necessitates that leader him/herself experiences to being able to be a leader by the values he/she owns. Even though this cannot happen all the time, it should be experienced somehow possible. Ambition and motivation to develop oneself and clinical work are central for leader identity development. Motivation is determined, for example, by the experienced possibilities to influence the development of clinical working methods. However, a leader does not have to, do not and cannot know everything or be better than others. The strength of one's work as a leader or clinician actually comes from cooperation with others.

Society, era, organization's culture and management system. Change-oriented developmental directions in healthcare, as well as the general work culture, affect an organization's operations. Varying projects presume leaders to be able to face change challenges frequently. Even though the necessity of changes may be understood, the fear that projects transfer too much attention away from the main mission – patient care – may still exist.

"… comparing it to the past is that today the planning of operations is much more demanding … the necessary actions and also the environment are changing all the time." (Doctor leader 2)

"This line organization system needs development, it is too bureaucratic and multilevel management system going on in our organization." (Nurse leader 5)

The complexity, hierarchies and rigidity of the hospital organization complicate being a "good" leader. Culture, values and rules, both in one's own organization and in the outer environment, also create profession-related meanings independent of the individual. For example, a value hierarchy of nurses and doctors can be mostly maintained by traditions that

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are supported by the doctor's legal responsibility to be the head of patient care. However, the reality of hierarchies is always attached to its experiencer.

Reflection surfaces. The environment guides the contents of leader identity by offering many reflection surfaces. For example, the well-being of followers or the fulfillment of a unit's goals create experiences of success and encourage the continuing development of the self as a leader.

"… often I look at the work well-being survey, which provides the kind of feedback for me that I know i have succeeded as a leader if employees' well-being is good." (Nurse leader 4)

Education and training programs in leadership and own special field reinforce the development of leader identity by giving concrete instructions, collegial support for being a leader and the perspective of a leader in addition to being a clinician. The way one reacts and perceives the environment stems from both clinical and managerial work experiences and the kind of human being one is; what is regarded relevant in leadership and clinical work. Perceptions, in turn, direct actions, motivation and behavior.

Personal work history. On one hand, work experiences in different assignments and positions affect leader identity development by creating its surface. On the other hand, one can constantly change as new work experiences associate and accumulate.

"…at that time [before taking the managerial position]*, I didn't know a thing and hadn't any idea about how difficult the work* [as a leader] *really is…"* (Doctor leader 13)

It is almost impossible to know for sure whether one wants to be a leader until he/she has enough possibilities to do the work and to try whether the leader identity fits. However, trying on the leader identity prerequisites time, and it can actually be pushed aside purely because of a lack of time or space to try something new. Through work experience, a leader is able to place him/herself in a work community in an appropriate manner through previously gained awareness of others' expertise and areas of responsibility. Thus, work experience in own organization supports leader's knowledge about what he/she leads and who he/she leads.

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However, experiences in different organizations can provide useful perspectives on working and leading without getting stuck with one organization's methods and learned practices.

Discussion

The study has shown that despite the diverse clinical backgrounds of nurses and doctors, the development of leader identity is guided by similar core factors when working in dual roles. *Clinical work and its meanings* and *followers' characteristics and leader-follower relationships* guide leader identity development most strongly, affect one another and are under the influence of *society, era,* and an *organization's culture and management system*. In addition, *personal work history* with colleague-followers may have created expectations about leader-follower relationships. Furthermore, a *leader's individuality*, including characteristics and values, determine what clinical work and what being a clinician means for the leader. By his/her own individuality and personality, a leader constructs leader-follower relationships and is also affected by those relationships. *Reflection surfaces* take part in modifying the characteristics and values one owns as a leader and a human being – leader's individuality.

The methodological choices and the inclusion of both nurse and doctor leaders under empirical examination in leader identity development provides the present study its unique nature. The previous studies on leader identity development in healthcare have concerned, for example, nurse managers' experiences from a narrative perspective (Croft *et al.*, 2015), doctor managers' execution of leadership examined by the concepts of Bourdieu while using different data gathering methods (Witman *et al.*, 2011) and doctors with medical leadership positions in a study based on data from four different qualitative case studies (Andersson, 2015).

Despite the unique approach applied in the present study, the results include many features common to social identity theories suggesting that leader identity development in the healthcare profession is a social process. Especially, Haslam *et al.*'s (2012) and Hogg's (2001, 2014) theories of social identity explained by the emotional attachment to healthcare professions as presented by Croft *et al.* (2015) contribute to the understanding of the experienced leader identity development of a healthcare leader.

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As Haslam *et al.* (2012) suggest, individuals construct social identities together to include a varied set of meanings important to them as members of a specific group. The sense of "we-ness" and belonging to the same "ingroup" (see Haslam *et al.*, 2012) of doctors or nurses as patient advocates acts as a ground for developing leader identity. The reason is in the emotional importance of professional identity (Croft *et al.*, 2015) and related clinical work that is, according to the data presented in the current study, the most meaningful issue in a healthcare professional's work in spite of the position. While wanting to belong to the "ingroup" of doctors or nurses, the managerial leaders in an administrative organization are experienced at being the "outgroup" members with the outgroup prototype (Hogg, 2001), with which one does not relate (cf. Haslam *et al.*, 2012). By taking the clinical work as the core mission also in leadership, the leaders can experience acting as an ingroup member while working in a position of an outgroup and, as a result, are able to form leader identity in terms of social, professional identity. Staying close to clinical work, professional identity and related patient-centered values enables leaders to experience the sense of "remaining true" to the persons they feel they are and want to be.

According to Hogg (2014, p. 339) a group prototype is a fuzzy set of attributes that defines the group and differentiates it from others, while also prescribing how one should behave as a group member. Thoughts of "'we' as clinicians are like this" and "'they' as managerial leaders are like that" illuminate Hogg's group prototypes. The results of the current study present organization as managerial administration as not relating to prototype of clinical professional group that results in and is a result of leader identity to be inconvenient and emotionally unimportant without the clinical feature. Depersonalization and self-categorization as presented by Hogg (2001, 2014) do exist in healthcare professional groups, even though self-categorization is not absolute; in spite of having strong professional identities as clinicians, healthcare leaders are doing the work according to the managerial position. Thus, one's work-related, primarily social identities also include individual nature – one behaves against the social group prototype of being a clinician when one experiences it to be meaningful, interesting or necessary (cf. Croft *et al.*, 2015).

It seems that patient care as an emotionally meaningful value is attached more easily to followers and their work as professionals than to managerial work in an organization. The studies of Croft *et al.* (2015), among others (Hogg, 2001; Petriglieri and Stein, 2012; Witman

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et al., 2011), support the presumption the healthcare leaders of the current study own, that is, leaders have to retain the social group identity in order to have influence on group members and gain trust. Furthermore, the current study suggests healthcare organizations to be too unpredictable and change-oriented in relation to clinical work requirements, which makes the organization even more unattractive. Hence, the relationship between a leader and a managerial organization seems to be more complex than the one with followers. Leading clinical work and followers as clinical professionals more easily suits a healthcare leader's ideal image of being a leader than leading employees and operations in general. Leadership and leader identity development in the clinical world is, thus, diverse from that of the organizational world.

Conclusions and implications

This existential-phenomenological study of the development of healthcare leader identity indicates that leader identity develops through and in interactions of emotionally meaningful clinical work and followers as professionals. The current study shows that clinical work is, compared to leadership, more important for healthcare leaders in dual roles. The constant change of work environments resulting in constantly changing leadership demands cause the leader identity to be, as well, under pressures all the time.

Through an open attitude and phenomenological reduction, the existential-phenomenological method offers a way to search information and experiences from perspectives that have not been known in healthcare organizations, thus far. Healthcare leadership needs these kinds of open research methods that exclude presumptions to understand what healthcare leadership is today in its multidimensionality, without adhering to the traditional thinking that the field carries. The results of the present study deepen and complement leader identity development theory in healthcare organizations.

In practice, the existential-phenomenological approach can be availed as a tool for healthcare leader training and development. It offers, as opposed to more managerial approaches, an in-depth method for examining identity development pathways and, hence, different ways to support one's leader identity development.

Limitations and further research

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Because the existential-phenomenological method is partly tied to the researcher at a given time, repeating the research is troublesome. For example, the requirement for intuition at analysis step 4 sets boundaries for repetition. Concerning the limitations of generalization, participants with diverse or uniform personal backgrounds (e.g. age, gender, years of work experience) were not sought, so the results cannot be generalized by these criteria. Related to that, possibly divergent experiences attached to age, for example, are not presented as age-related results when only a few participants were of a certain age.

To foster further understanding of healthcare leader identity development, phenomenologically oriented research on leader identity development should also be conducted in the private sector, where work cultures and management systems affecting identity development may differ from the public field.

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