**Social Identity in a Public Hospital: Sources, Outcomes, and Possible Resolutions**

**Abstract**

**Purpose**: The overarching goal of the current paper is twofold: to investigate how social identities in a multilayered social platform of a public hospital are shaped, and to account for the impact of these identities on staff interrelations, patients, and the organization’s overall ability to meet the challenges it faces.

**Design/methodology/approach:** In this qualitative study, data from 30 employees working in a medium-sized public hospital in Israel were collected using a semi-structured interview guide.

**Findings:** Using a thematic analysis approach and drawing on social identity theory and its extension (the social identity theory of leadership), it was found that the most prominent social identity associated with the hospital staff was departmental identity. This identity was strengthened by prominent in-group management and hardly impacted by senior out-group management; under these conditions, organizational goals were overlooked. Discussion of these findings leads to recommendations for dealing with the adverse impacts of this departmental identity on staff, patients, and the organization’s ability to meet the challenges it faces.

**Research limitations/implications:** The study provides a qualitative viewpoint on the formation and implications of social identity in healthcare, building on the social identity theory of leadership and its contribution to understanding social identity in the context of hospitals.

**Originality/value**: Most of the literature on social identity has dealt with personal- and group-level antecedents of social identity, neglecting the potential participation of in-group and out-group management in shaping these identities and their contribution to the achievement or nonachievement of organizational goals. By adopting a qualitative approach, the current study provides a deeper understanding of how interrelations between senior management and direct in-group management can shape social identities, a perspective that has been missing from previous research. Accounting for these identity-shaping forces is essential for understanding the challenges that hospitals face and their various (in some cases, life-or-death) impacts.

**Keywords**: Social identity, Intergroup relations, Top management, Qualitative method.

# Introduction

In recent decades, market dynamics, driven by digital transformations and economic challenges, have prompted continuous efforts on the part of organizations to increase their ability to compete in a dynamic environment and establish their superiority in a constant struggle for resources (Edmondson, 2012). In trying to promote patient-centricity under these conditions, healthcare organizations have implemented telemedicine and digitalization of patients’ clinical histories while struggling with lower budgets and ongoing social challenges, not least COVID-19, that exhaust their resources (Prado-Prado et al., 2020). In their attempts to add value for customers and staff and respond to these challenges, healthcare institutions are promoting private-sector management practices, such as lean management (Drotz & Poksinska, 2014) and kaizen (Prado-Prado et al., 2020), which require cooperation between departments, professions and, ultimately, individuals with diverse social identities.

In a hospital setting, staff members categorize themselves and others into a range of corporate groups according to expectations and perceptions about professions (e.g., medicine versus nursing), diverse specialties (e.g., emergency medicine versus gastroenterology) and various statuses (e.g., junior versus senior doctors) acting and interacting together (Hewett et al., 2015). In a public hospital context, where group memberships are hierarchical, firmly role-bound and, at the same time, departmentally based, intergroup dynamics are complex (Riskin et al., 2015).

The management of members nourishes this complexity in an effort to shape the social identity of a group. Direct managers, who are considered to be those who best represent the group identity, are expected to be deeply engaged in shaping the identities of their followers. In contrast, senior management members are not likely to be considered in-group members, and thus they will have less impact on group members’ social identities (Dalton & Chrobot-Mason, 2007; Hogg et al., 2012).

In such a situation, three related challenges arise. The first, in which the other two are embedded, relates to the organizational need to compete through change management and management practices. These private-sector practices, which are used to respond to organizational challenges, reduce the power and centrality of managers (Gandomani et al., 2020). Thus, it is expected that in-group managers who want to maintain control and status in their groups will resist new managerial practices by strengthening the group identity and shaping it in ways that impede the change that is required for the organization to compete in a dynamic environment (Hogg et al., 2020). The second challenge relates to the impact of these departmental social identities on patients, which concerns the organization’s ability to compete and promote patient-centricity. The third challenge is that, given a solid in-group identity, intergroup relations become more conflictual, which impacts employees, patients, and the overall ability of the organization to cope with challenging circumstances.

The current paper has two main aims: first, to investigate how diverse forces shape social identity in a hospital through an exploration of some of its departments; and second, to account for the impact of these identities on staff interrelations, patients and the overall ability of the organization to deal with the challenges it faces.

In addressing these questions, the study makes two primary contributions. First, most of the existing literature deals with member- and group-level antecedents of social identity, overlooking the potential impact of leadership in shaping these identities and their ability to contribute to or impede organizational goals. The current study, using a qualitative approach, provides a deeper understanding of the interrelations between senior (out-group) management and direct (in-group) management in shaping social identities. This comprehensive view is novel, despite its particular importance in the context of hospitals, where social identity impacts the lives of individuals (Steffens et al., 2021). Second, the social identity theory of leadership utilized in the current study (and neglected in previous studies) can account for various levels of management and their diverse impacts on social identities and organizational goals.

# Literature Review

## Social Identity Theory (SIT)

Social identity is defined as “part of an individual’s self-concept which derives from his [*sic*] knowledge of his membership of a group (or groups) together with the value and the emotional significance attached to the membership” (Tajfel, 1978, p. 63). Once social identity is shaped, it can explain individuals’ feelings, thoughts and behaviors motivated by their group membership and following the prototypical attributes of the group (Hogg, 2001a, 2001b, 2005; Hogg et al., 2012).

Personal identity and its counterpart social identity represent a twofold identity formation (Gallois et al., 2005) in which social identity functions as a cement that attaches individuals to their in-group, allowing them to act on its behalf (Van Vugt & Hart, 2004). When an individual is categorized as a group member, his or her other attributes are overlooked, and a greater emphasis is given to their commonalities with the group (Hogg et al., 2012).

Social identity theory (SIT) accounts for more than a broader view of the self. It allows us to understand the nexus between the individual and the group that (1) shapes individuals’ perceptions of themselves and others in terms of social categories and (2) accounts for members’ attitudes and behaviors as triggered by a sense of belongingness (Turner et al., 1987).

Social identity also offers a meaningful way to organize one’s social world (Tajfel & Turner, 1979; Turner et al., 1987) by categorizing individuals in terms of a simplified dichotomy of in-group (“us”) or out-group (“them”), within which individuals strive to maximize their positive distinctiveness. When social identity is salient, people tend to focus more on unified attributes than on the distinctive personal properties that differentiate them from others within their group.

Accordingly, SIT has been used to explain individuals’ motivation to identify themselves as part of a group and at the same time to account for their desire for distinctiveness (Hewstone et al., 2002; LaTendresse, 2000). The underlying motivation of individuals concerning categorization, social identification and social comparison, all of which are central processes involved in the formation of social identity, is their desire to boost their self-esteem (Tajfel & Turner, 1979). In this respect, social identity stimulates group behavior through two opposing mechanisms, namely discrimination and cooperation, which are used in congruence with the context in hand to maximize self-esteem (Kreindler et al., 2012).

Studies focusing on the positive contribution of social identity suggest that it enhances group cohesion and motivation (e.g., Ellemers et al., 2004), collaboration, altruistic behaviors and positive group evaluations (Ashforth & Mael, 1989). Studies that address the positive impact of social identity at the individual level have found that it increases job satisfaction, health and well-being (Haslam et al., 2009). Recent longitudinal research has highlighted the positive long-term impact of social identity on individuals’ health, well-being and morale. Scholars attribute these positive effects to the support and appreciation of groups, two mechanisms that protect group members from burnout during demanding periods (Haslam et al., 2009).

Other studies have focused on the adverse implications of social identities. Social identity, in many circumstances, can increase in-group bias (e.g., McGarty, 2001) by stereotyping the out-group or discriminating against it (Tajfel, 1978). Under such conditions, social competitiveness (Amiot & Sansfaçon, 2011) and conflicts can flourish.

## Social Identity in the Healthcare Context

Professional identity includes individuals’ social identity, which involves the similar desire to belong to a larger group with shared professional attributes (Ashforth et al., 2008). In healthcare, providers from various professions must collaborate to provide patient care. For that purpose, individuals from diverse professional specialties and cultural backgrounds, who differ in the language, rules and norms that shape their distinct professional identities, are grouped into multicultural teams (Watson et al., 2012).

Professional identity consists of a well-constructed set of attributes, values, motives and experiences that define one’s professional role ([Warren](javascript:;) & [Braithwaite](javascript:;), 2020). Professional subcultures, such as medicine, nursing and administration, shape professional identities in a hospital setting. These subcultures impact individuals’ well-being and their feelings, thoughts and behaviors toward the organization (Callan et al., 2007).

Taking a broader perspective, Hewett et al. (2009) investigated the impact of the professional identity of physicians on the communication between diverse healthcare professions and on the quality of the medical care given to patients. The authors found that specialty was the primary source of group identity, but their findings went beyond the internal properties of identity to shed light on the external impact on patients. They found that these identities triggered biased patient charts that reflected intergroup competition; moreover, patient charts were biased in ways that enhanced in-group identity. The study also confirmed that interprofessional competition can lead to overdiagnosis and may ultimately threaten patient’s lives. The authors argued that these dysfunctional communication patterns cannot be mitigated through interpersonal training, since they are rooted in group identities rather than in lack of skills (Hewett et al., 2009).

Although previous studies have investigated the formation and impacts of social identities on individuals, groups and external stakeholders such as patients, relatively little attention has been paid to the interactive relations between power as an antecedent of social identity and social identities, which can enhance or decrease the power of individuals. In this connection, Miles et al. (2021) recently showed that the content of feedback given by healthcare professionals depends upon the social identity of the participants in the process (i.e., the giver and the receiver), an identity that is shaped, albeit not exclusively, by power differences. Although these findings are valuable, the authors did not integrate leadership, a representation of power, with SIT and its interrelations (Hogg, 2001a, 2001b, 2005), namely the SIT of leadership.

## Social Identity Theory of Leadership

In his illuminating work, which focuses on leaders’ misuse of power in the framework of SI, Hogg (2005) accounted for differences between in-group and out-group leadership and the diverse contextual conditions in which in-group leaders can utilize their social power and personal attributes to shape their group’s social identity and preserve their own power. This groundbreaking theory is structured on the foundations of the SIT of leadership presented by the same author a few years earlier (Hogg, 2001a; Hogg & Knippenberg, 2003). The extension of the concept of social identity to the SIT of leadership posits that the representation of groups is based on prototypes, that is, members who represent the essence of the group and its distinctiveness from other groups. Prototypical in-group members are a reliable source of in-group norms, and as such they can influence the identity and behavior of other group members. Leaders who are also in-group members are expected to hold prototypical characteristics of the group more than other group members or out-group leaders (Hogg et al., 2012; Steffens et al., 2021.‏). Thus, such leaders are influential and trusted, which allows them to adjust the group’s identity without being criticized. Hogg (2005) suggests that, under certain conditions, these leaders can direct the group’s properties to highlight their own prototypicality, preserve their power, and increase their and their group members’ distinctiveness from other groups. Rabbie and Bekkers (1978) found that insecure leaders are likely to promote conflicts with other groups. As Hogg (2005) noted, this allows them to sharpen the differences between the groups, emphasizing their own prototypicality and that of other in-group members, and resulting in their increased power.

Although Hogg accounted for contextual threats to group social identity and thus to group leadership, he overlooked the fact that in-group and out-group leadership jointly shape the group’s social identity; thus, in a delicate fabric of relations, out-group senior management leadership can serve as a contextual threat to in-group departmental leadership. In the healthcare sector, because of market dynamics, healthcare institutions are promoting private-sector management practices such as lean management (Drotz & Poksinska, 2014) and kaizen (Prado-Prado et al., 2020) in response to organizational challenges. These trends threaten to reduce the power and centrality of in-group managers (Gandomani et al., 2020). As senior management are considered to be out-group leadership, they are highly dependent on in-group leadership to implement these practices. However, when under threat, internal leadership forces seek to enhance their group prototypicality and, ultimately, their power.

## The Present Study

The overarching goal of the current paper is twofold: first, to investigate how diverse forces, including in-group and out-group leadership, shape members’ social identities in a public hospital in Israel; and second, to account for the impact of these identities on staff interrelations, patients and the organization’s overall ability to meet the challenges it faces. An exploratory qualitative inquiry is used to provide rich, in-depth perceptions of social identities expressed in the differentiation of feelings and behaviors.

# Method

## Research Design and Sample

We conducted a qualitative research study to examine comprehensively the social identity of staff in a hospital work environment. Qualitative research frameworks require researchers to study phenomena in their natural settings, understand and interpret the world-constructs of individual participants, attach considerable importance to personal knowledge, views and perspectives, and note the meanings attributed by participants to personal experiences (Creswell, 1998; Patton, 1990; Sabar Ben-Yehoshua, 1999; Shkedi, 2004). Interviews provide descriptions and examples that can reveal the complexity, causes and consequences of the phenomenon under study.

Between January and March 2017, semi-structured in-depth interviews were conducted with 30 participants in a medium-sized general hospital in Israel. The hospital employs about 890 employees, including doctors, nursing and paramedical workers, and administration and maintenance workers. The staff include members of different religions and ethnic groups. The hospital is a peripheral hospital that caters mostly to middle- and lower-class populations.

As guidelines anticipate (Bowen, 2008; Kerr et al., 2010), data saturation was reached after 30 interviews, at which point main themes related to the study (such as the dominant social identity, the perception of out-groups and issues related to contact) began to be repeated. A sample of this size has been acknowledged as more than adequate for qualitative research (Mason, 2010).

The interviewees were drawn from various departments and sectors in the hospital (medical, nursing, administration and paramedical) to provide as broad a perspective as possible on the various levels of social identity. The interviewees were selected at random by the hospital administration, and the research team ensured that the sample reflected the sought-after diversity. Eleven medical departments, about half of the administrative departments and about half of the paramedical departments were represented in the sample. The respondents were managers and employees from different departments and ward levels, as shown in Table 1. Fifteen of the participants were women and 15 were men. Job tenure ranged from 6 months to 40 years.

[Insert Table 1 here]

## Data Collection and Interview Design

Common guidelines were adhered to for the use of open-ended questions, which were structured and based on the literature review with the aim of exploring the roles that social identity and contact play in the hospital context. The interviews were flexible with regard to the order of the questions, the time allocated for each question and the discussion of emerging topics. The interview guide included the following themes: strengths and weaknesses of the hospital and the department; feelings about the hospital and its image; the employee’s main identities; the relationships within the department; and the contact and relationships between the departments. Each interview lasted approximately one hour and was conducted during working hours in a private room at the hospital. The interviews were conducted by all three researchers.

Permission to conduct the study was obtained from the hospital’s vice-CEO, the chief doctor and department heads. All the participants signed informed consent forms, having been assured by the researchers that participation in the study was voluntary, that refusal to participate would have no effect on their careers, and that confidentiality and anonymity would be maintained throughout all stages of the study. All references to personal data were omitted from research records.

## Data Analysis

Data were analyzed using thematic analysis (Weber, 1990), encoding central themes and identifying patterns that emerged from them and that were related to the respondents’ perceptions of social identity and its consequences. The data analysis process consisted of two stages. In the first stage, each researcher reviewed the interviews that she or he had conducted, performed lengthwise analyses and encoded central themes. This stage is vital for preserving the context and content of the interviewees’ statements. In the second stage, all the interviewers carried out transverse analysis to identify general patterns of themes and provide a comprehensive picture of perceptions and concepts. Inter-rater reliability was measured using Cohen’s kappa and exceeded the threshold of 0.60 (κ = 0.63).

# Results

The analysis of the interviews clarified the nature of social identity in the hospital, its sources, and its impacts on the department, the staff and the hospital as a whole. The findings are described using three main categories: social identity within the hospital, sources of departmental social identity and outcomes of departmental social identity. A few main themes emerged in each of the categories.

## Social Identity within the Hospital

Several social identities emerged from the analysis: organizational (the hospital versus other hospitals), role (doctors, interns, nurses, maintenance), seniority (senior doctors, junior doctors, interns) and cultural groups. Participants spoke about “their” hospital, its uniqueness, and its advantages and challenges in comparison to other hospitals. As one nurse put it, “The atmosphere, the family-like feeling, everyone is ready to help and contribute. It is a small hospital. In other hospitals you can get lost.” Participants spoke about their role group and its unique attributes, role responsibilities and challenges, as well as interrelations with other role groups such as senior management mentoring. They also mentioned the sometimes harsh approach toward interns, junior doctors and nurses, the relations between senior and junior nurses, and the attitudes of different role holders to maintenance staff, such as cleaners.

To a lesser extent, participants spoke about cultural aspects of their identity. For example, they mentioned groups of employees speaking different languages (such as Arabic or Russian) within the hospital, which excludes other people from the conversation; or they mentioned their own cultural identity, such as being an Arab Israeli or an immigrant who came to Israel at an older age. One physician told us that “When I got to the hospital I was set in the middle: Russian-speaking from one side and Arabic-speaking on the other. I didn’t understand a thing. I think this is disrespect, to exclude people.”Personal cultural identity was discussed mainly in personal terms and did not emerge as an issue within the hospital.

Departmental identity, however, was found to be an especially significant social identity factor, serving as the participants’ main identity and outweighing any other group identity. A small number of subthemes emerged regarding departmental social identity: the department as an in-group, other hospital departments as out-groups, the hospital management as an out-group and the department as an in-group. Being the main social identity, the department emerged as the participants’ main point of reference, and they tended to describe themselves in terms of their department and its specialty: “I am a nurse in the geriatric department … I love working with this age group.”

Identification with the department was expressed as high in-department **solidarity**. The participants often described the uniqueness, importance and quality of their department, conveying a sense of **pride** in it and promoting it inside and outside the hospital. For example, “I tell every pregnant woman to come to us at [name of hospital]. I know she will get excellent care in our department” (a neo-natal nurse); “I am proud to be part of this department, proud of the relationships between the staff” (a junior doctor); “We are very professional and family-like and there are great doctors here” (a nurse). Departmental identity was also expressed in terms of a desire for the department to flourish and an aspiration to develop and advance one’s career within the department.

The department provided the majority of participants with a **sense of belonging**, which was very important to most of them. Belonging was expressed through discussion of a shared specialty, as well as the frequent use of the term “family-like” and descriptions of the close relationships within the department (both within and across roles). Different participants described daily life routines such as shared coffee breaks, celebrating holidays or sharing private events with their colleagues: “We celebrate holidays, and personal events, bring food to meetings and share it” (a paramedical staff member).

Social identity was also expressed in **cooperation** within the department, in ways that went beyond professional roles and overcame hierarchy and status boundaries. The participants described cooperation between department members with different roles in the form of mutual help, support, learning and teaching, and consulting. One doctor said, “There are excellent relationships between the physicians and the nurses; we include them in morning rounds … We [the doctors] also give them [the nurses] lectures, share information.” Another doctor added, “We respect each other. There is no ego … we all know everything and everyone and do things together. The head nurses sit in on morning meetings, and there is a nurse on morning rounds.” The nurses conveyed a similar view. For example, one nurse said, “There is an open relationship between us, we share, consult. Our head of department is something special, we can all express our opinions freely, he counts on us.” This perceived cooperation was accompanied by a sense of **support**.A paramedical leader, for example, said, “We support each other. We help each other, we ask on WhatsApp: do you need help?”Amember of the maintenance staff described receiving support from her department and its head when she was mistreated by another department (being left outside in the rain), and how they complained to management about the way she had been treated.

### Other Departments as Out-groups

This in-group identification and solidarity was contrasted with other departments, which were perceived as the out-group, thereby strengthening the in-group’s social identity. References to the out-group were based on comparisons and expressed in a few subthemes: quality, professionalism and availability of resources.

Regarding **quality**, departments highlighted different ways in which they outperformed other departments, including the perceived importance of their specialty and its status, the quality of their staff and of the patient care they provide, their workload and hard work, and their values and relations. They tended to contrast their perceived strengths with the perceived weaknesses of other departments. For example, one doctor said, “We insist on professionalism, that everyone in the department knows all the patients, unlike other departments.”Another doctor supported this view, saying,“There is no ego in our department. You however see ego in many departments.”

At the same time, a department’s identity was often defined by its perceived **professionalism**. This was expressed either as a sense of superiority over other departments, and accompanied by a sense of entitlement based on the high perceived status of the specialty or department, or as a sense of inferiority in comparison to other (better or more prestigious) departments.

Such perceptions were accompanied by perceptions of the **availability of resources** compared to other departments, which served as social identity glue. While some participants reported a feeling of being invested in and being able to develop, others experienced relative deprivation. “There are many things we need but do not get. We have not received new employees for three years. Either there are no job vacancies available, or they go to other departments … We talk about it among ourselves often” (physician, head of a department).

### Hospital Leadership as an Out-group

As the main social identity was the department rather than the hospital as a whole, the hospital leadership was typically referred to as external to the department. Thus, the hospital leadership was perceived as an out-group, and this contributed to departmental social identity. In this respect, the department’s social identity was formed and expressed by the mutual feelings of its members regarding their place and status in terms of the hospital’s leadership view and actions.

Participants from different departments and roles described hospital management as having power and influence regarding decisions and as a force responsible for resources, support and attention external to the department. Discussion of senior management often centered on their view of and approach to the department: its perceived status and appreciation (or the lack thereof), the provision or withholding of resources, and preferences regarding decisions. Participants from various departments described competing for the management’s support, both material and emotional, which was viewed as external to the department and its goals. The perceived differential management attitude was found to operate as a source supporting the departmental social identity and distancing it from other (out-group) departments. One department nurse, for example, expressed the view that “In general, hospital staff are being heard here, but in my department, we feel rejected. They [hospital management] give more to profitable departments. That is how our top management works …” Another nurse from a different department added, “We feel that they do not remember us, that we are abandoned up here. They remember us only when they need us … to sign off on someone’s rehabilitation.” Similarly, a physician from a third department said that, “Management is not attentive to my needs, for instance, regarding equipment. I sometimes get the impression that we do not get priority. For instance, the refrigerator of the patients’ families … a cooler … Management never says to us, ‘Tell us what you need, and we will fix it.’”

## Sources of Departmental Social Identity

Beyond the social identity created by belonging to the same group and working together in close contact, the formation of the department as the main social identity was found to rely on a number of sources: the specialty and its general status, the status of the department within the hospital and outside it, and department leadership.

### Status of the Specialty

Beyond but closely related to their sense of belonging and pride as department members, participants had a strong sense of their disciplinary and professional memberships. Specialization was the most salient professional identity for them, and its quality affected the department’s prestige, both among themselves and in the views they attributed to the hospital leadership. Consistent with SIT, respondents made intergroup comparisons and categorized specialists from other departments as out-group members.

### Status of the Department

Throughout the interviews, and as mentioned earlier, there was a clear consensus among members of all departments that, in the words of a department nurse, “We have ‘flagship’ departments, some of the best in the country, that work admirably, while others do not.” This view, regardless of whether it was expressed by more or less prestigious groups, contributed to the departments’ social identities.

The reputation and evaluation of the quality of a department’s work (both within the hospital and outside it) was not identical to the general status of the specialty, and was instead formed on the basis of the department’s performance in the hospital and prestige beyond it. That performance, in turn, was related to the quality of the department’s staff and the country and institution from which they obtained their degrees, the department’s ability to attract staff and interns from high-status hospitals, staff retainment rates, availability of resources and access to technological advances, and future prospects in terms of development and resources. The criteria used by the participants to evaluate the quality of the department were its reputation within and outside the hospital and among management, the perceived quality of its doctors (including whether they had studied in Israel or, if not, in what country or institution) and whether they had previously worked in the center of the country, and the department’s ability to attract interns.

### Department Leaders as Drivers of Social Identity

Department heads were very often found to support and enhance the departmental sense of identity.As emerged from the interviews, they cultivated the departmental social identity by looking at their work from a narrow, departmental perspective, highlighting their uniqueness, expressing and sharing their disrespect (in strong departments) or their sense of envy and deprivation (in weaker departments) with their staff, and cultivating competition with other departments.

Highlighting such attempts to accentuate departmental uniqueness, a nurse working in nursing administration said, “Many heads of departments see their department as unique.” A physician in the medical center’s administration took the priority of the department over the medical center a step further: “Department heads are not always committed to the organizational spirit, but rather to their department. They are committed to their patients on the department level and not at the whole hospital.” Department heads themselves supported this view: “As head of [X] department, I am less interested in what goes on in other departments. What interests me is that my department develops. I see other departments such as Cardiology and others, which are successful, and I want mine to develop too.” Expanding this view to express disrespect toward other departments, a head of another department said, “What I do not like about my job is all that thing about working with other departments, because we are on a completely different level than they are, and it is hard to work with less professional staff.”

The view that some departments are superior to others, as well as the perceived distribution of resources to more successful departments and the competition between departments over this, can help department heads to maintain their power through departmental social identity processes. In particular, participants spoke about the tendency of some department leaders to accept as little work as possible for their department, especially when this work comes from another department, with the aim of conserving the department’s resources. As one physician said, “Some department leaders, when you turn to them asking for a patient admission, say: Why are you ‘throwing’ a patient at me? Their attitude is that we [from other departments] are bothering them … and they project this attitude to their teams.”

## Outcomes of Departmental Social Identity

The focus on the department as the main social identity comes with a price tag for the organization. There are three main costs: negative intergroup relations between in- and out-groups, typified by hostility, competition, lack of cooperation and ego fights; difficulties in promoting organizational goals and driving organizational change and growth; and adverse impacts on patients.

### Negative Interpersonal Relations between Groups

The dominance of departmental social identities was found to create negative intergroup relationsexpressed in the form of lack of communication, hostility, competition, biases, and negative feelings and defiant behaviors toward other departments, all of which have a negative impact on the ability to cooperate and achieve mutual goals. As one physician said, “This issue of communication between departments is of prime importance. As medical staff we have a calling, and if we will not work on our communication, we cannot succeed.”

#### Stereotypes and Biases

Stereotypes used to describe members of the out-group provided additional evidence of the superiority of the departmental identity over the professional one. In describing other departments, the homogeneity of the out-group was emphasized. Describing the biases between departments and their negative impacts, a nurse said, “Our relationships are not ideal. Everyone thinks that the other department does not do anything. If someone comes by and says, ‘All you do here is drink coffee all day’ it upsets me, and I want to be rude back.”

#### Hostility between Departments

Hostility was found to focus on perceived extra workload because of a lack of professionality or commitment from other departments, superior status in the eyes of hospital management or perceived superior resources, or the overarching negative impact of a bad reputation: “Other departments are less professional and do things in a less professional way, or do not do a good enough job, and we have to deal with it and fix their mistakes” (a head of department); “It projects … Someone says in a wedding to their relatives: ‘I have been in X department in the hospital and they were terrible.’ Everyone hears it and will then not want to come to the hospital, to any department” (a physician).

Those perceptions were found to create a negative climate in many cases, and they sometimes resulted in negative actions. As one nurse explained, “The office corridor, where there are many general nurses and nurses with other roles, accreditation, has been given the name ‘The Pure Souls Street.’ They play dirty games, lots of ego wars” (a nurse in the administrative office).

#### Competition and Lack of Cooperation

Furthermore, the view some departments have of their own superiority was found to generate competition and make cooperation between departments difficult. This took the form of concealing information and competing for resources and credit. As one nurse described, “The nurses here in nursing administration are competitive. They do not give all the information or do not help, so that I am less successful.”

Participants described conflicts between departments over resources (such as rooms, operating rooms, materials and time), which reflected either absolute low levels of resources or relative deprivation. Participants often felt that patients were admitted to their more crowded departments, or that they were given less operating room time or later operating hours. Fights for credit were described as the result: “For example, when we work on protocols, for which a few departments have to cooperate, there is friction over who will present the findings and will get the credit. There is a big identification with the department” (a departmental nurse).

### Difficulty in Promoting Organizational Goals

The hospital as a whole was described as investing a lot of effort in improvements and innovation in services, provision of better care for patients and competition with other hospitals: “The hospital is developing, renewing itself. It develops new services such as MRI, blood vessel department, rheumatology. It is very impressive” (a physician).

However, the department identity, manifested through the mechanisms of a department’s focus on narrow goals, competition and lack of cooperation, was often found to distinguish between organizational and departmental goals, thereby having a negative impact on the hospital’s performance and reputation: “We cannot go on like this. There is competition over patients among hospitals and we are losing in it. There needs to be a profound change in some departments, we do not perform complicated surgeries and there is chaos in the ER.” This process is exacerbated by department leaders who reject organizational changes in order to preserve their power. As a member of the paramedical staff explained, “Despite management efforts, some departments have a lot of power and reject the change, thus holding the change, and the hospital, back.” Such objections related particularly to investment in other departments.

Another organizational goal, which was noted by some participants as hard to achieve within the current social identity, was to improve the organizational culture and leaders’ attitudes toward staff and patients. This objective, too, was made difficult to achieve by department leaders being more concerned with maintaining their power within the department. As one physician said, “They [management] are trying to change department leaders’ attitudes … There is one department head in particular, who also projects his attitudes to the staff … They even brought him a counselor. So far it doesn’t work very well. He keeps shouting, speaking disrespectfully, not cooperating.”

### Impact on Patient Care

These references to negative relations and the prioritization of department goals over organizational ones suggest a negative impact on patient care. As the interviews showed, this impact can be attributed to a lack of information sharing regarding patients and a lack of resource sharing between departments (for example, admitting patients into less crowed departments, sharing operation rooms according to need rather than rigid adherence to departmental schedules, and improving the flow between the ER and other departments). As one paramedical staff said, “Do patients get the care they need and deserve here? I don’t know. There are very good departments and departments where the level is not high, so overall I am not sure they do.” A nurse added, “I would like to think that our lack of departmental cooperation does not negatively impact our care, but I am not sure about it anymore. I ask something from a doctor from a different department and he explains to me that what I am asking is not suitable and that he cannot do it … Often I am convinced that it is just from not wanting to go the extra mile for another department.” Regarding resources, a nurse explained, “If I find three packs of [X] and I cannot use them because I am not sure they belong to the department and therefore hesitant to use them, and then I wait a long time for my order to get through, the patients are negatively affected.”

Attributing this impact on patient care to a lack of cooperation, a head of physiotherapy expressed her frustration at not having multidisciplinary discussions about patients’ needs: “If I was allowed to be present in their [other departments’] meetings and to explain to them what we are doing and what we can do, patients would have gotten much better care.”

# Discussion

Within the framework of SIT and its extension to the theory of leadership, this research investigated social identities and intergroup relations in a hospital, a highly heterogeneous group context with many different aspects of identity. The overarching goal was twofold. The first aim was to investigate how different forces, including in-group and out-group leadership, shape members’ social identities in a public hospital in Israel. The current study therefore sought to clarify the infrastructure of social identities in a hospital context, where identities can be driven by diverse considerations, such as departmental, professional, organizational, ethnic or seniority factors. The second aim was to account for the impact of SIT on staff interrelations, patients, and the organization’s overall ability to meet the challenges it faces. Rich qualitative data, in the form of in-depth perceptions of social identities expressed through feelings and behaviors, were gathered for these purposes.

## Social Identity Theory of Leadership and Organizational Goals

The data show that departmental identity was the most prominent identity in the hospital. Strengthened by department heads seeking to be prototypical representations, departmental identity was a source of pride, belongingness and cooperation (Hogg, 2001a; Hogg & Knippenberg 2003; Hogg et al., 2012). At times, departmental identity was strengthened by two distinct forces: departmental in-group leadership that promoted in-group/out-group divisions, and senior management out-group leadership that differentiated among various departments regarding attitude and resource allocation.

This type of in-group leadership behavior is well documented in the social identity theory of leadership, especially in Hogg’s (2005) findings on the misuse of power. That author noted that prototypical in-group leaders promote conflicts under threatening conditions, highlighting group prototypicality to enhance their own leadership power. The willingness of senior management to encourage customer-centricity requires a decentralization of leadership that is likely to decrease group leadership power (Drotz & Poksinska, 2014; Prado-Prado et al., 2020). In the present context, this was evident in the willingness of department heads to protect their own power without considering the needs of the hospital or the impact on the social identity of in-group members. By treating departments differently, senior management nourished these departmental identities.

## Social Identity Theory of Leadership and Intergroup Relations

All the interviewees in the present study classified their social identity on the basis of the department to which they belonged. Differential senior managerial attitudes contributed to the formation of that departmental social identity, which was strengthened by the attitudes and behaviors of the department heads. As a result, members of highly-valued departments sought to preserve their professional image and differentiate themselves from less-appreciated and less-valued departments, which affected their attitudes and behaviors toward those out-groups. This finding is in line with previous studies, which have shown that preserving high professional image leads to intergroup conflicts (Cuhadar & Dayton, 2011; Rubin & Hewstone, 2004). The perception of a department’s professionalism forms its appearance, which was also found to predict discrete social identity. The SIT framework helps to elucidate the motivation of groups to distinguish themselves, making it clear that the differentiation is aimed at maintaining the department’s professional image.

Furthermore, the high costs of medical care generate struggles over budgets and resources in hospitals. Under such conditions, the present study shows that the support of hospital management is essential for a department and is a predictor of social identity. SIT theorizes that when individuals identify with their group, their well-being is intertwined with the group’s well-being (Van Vugt & Hart, 2004) and the group’s status is significant for the individuals’ well-being. Senior management’s selective attitudes toward various departments create an experience of a particular hierarchy among departments, which is reflected in feelings of rejection, discrimination or superiority among those departments and their members, which in turn shapes their social identity. An insight provided by SIT in this context relates to the social structure of the groups as expressed in status and power differences between them. This is one of the elements of social categorization (Kreindler et al., 2012).

Moreover, it seems that these drivers shape intergroup relations. A frustration-aggression effect was identified in the departments that felt that other departments stood in the way of their professionalism, creating further conflict. Although there was positive contact within departments (both within and across professional roles and statuses), which was manifested through solidarity and an in-group bond, the opportunities for between-department connection were found to be minimal and artificial, and in most cases involved conflicts. These conflicts could be actual or relative, but for the most part they nurtured the departmental social identity, prevented cooperation between groups, and evoked mutual negative behaviors and feelings. The present findings also identify a lack of shared goals, in line with previous studies that claim that a lack of shared goals negatively impacts the quality of relationships (Lloyd et al., 2011).

## Social Identity Theory of Leadership and Patients

In the healthcare sector specifically, Thomson et al. (2015) found that focusing on the goals of one specific sector instead of the goals of the patient or the team affects the quality of communication between teams and their overall ability to provide the best patient care. The evidence found in the present study supports previous findings that social identity can have a negative impact on patients and should therefore be managed carefully.

Out-group threats to departmental prestige and leadership strength followed by in-group leadership efforts to maintain power can be predicted and are well documented. Nevertheless, selective treatment by senior leadership exacerbates conflicts and prejudice between departments, making organizational goals even more difficult to achieve. Such findings are all the more significant given the ethical gap between employees across departments, which can nourish social identity (Klein et al., 2019) but remains inferior to the forces mentioned above.

In light of these findings and the presence of prejudice between departments, contact theory and contact strategies should be used to remedy negative intergroup interpersonal relationships, enhance patient care and promote organizational goals.

## Spotlight on the Use of Contact Theory to Resolve the Challenges

The lack of shared goals, the divisive managerial attitudes, the emergence of prejudice and the differentiation of status based on professionalism and prestige are evidence that some principles of contact theory (Dovidio et al., 2011; Visintin et al., 2017) could usefully be applied to improve the situation. As part of contact theory, Allport (1954) specified four essential conditions that help in overcoming the challenges described above: equal group status (that is, contact between those sharing a similar status); commonly shared goals with an active, goal-oriented effort; intergroup cooperation without intergroup competition; and the support of the authorities, laws or customs, which establishes norms of acceptance (Pettigrew, 1998; Pettigrew et al., 2011) and shapes a more favorable structure of intergroup relations (Dovidio et al., 2011). Given these guidelines and the evidence presented above, it seems that the implementation of direct contact strategies could reshape the departmental identity into a comprehensive hospital identity. Therefore, to achieve the hospital’s goals, it is important to improve department relations and patient care.

First, shared goals, such as mutual responsibility for patient care, should be identified and prioritized. Senior management should maintain equality between departments, and support should be given to lower-status departments. Based on the understanding that all departments are equal and vital for the hospital, these steps can serve as the basis for cooperative status and help to establish a shared identity.

Second, interdepartmental cooperation should be embedded in daily practice, and encouraged and rewarded in order to promote direct contact. The likelihood of positive contact will be greater if, through HR practices and internal communication, management creates situations in which intergroup contact is made and encourages these situations through staff exchange. In this respect, opportunities for intergroup contact could be advanced through HR projects in which employees from different departments join other departments for short periods. Senior leadership should take active steps to understand and defuse the automatic mechanism of strong departmental identities triggered by external threats, and should avoid nourishing such identities through selective treatment of departments.

## Contribution

The results of this study contribute to the literature in several ways. Although previous research has examined social identity in hospitals (Penman, 2015; Thomson et al., 2015) and among specializations in the medical sector (Hewett et al., 2009), to the best of our knowledge the departmental social identity that emerges from the investigation of all sectors – medical, nursing, administration and paramedical – has not been investigated until now.

Another contribution of this study is its extension of SIT to leadership in order to analyze external causes and outcomes; this is in contrast to previous studies, which have focused on the internal factors and implications of social identity. The literature has detailed the intergroup factors that create social identities, such as group characteristics and motivation to belong (Amiot & Sansfaçon, 2011; Brown, 2000; Callan et al., 2007). It has also noted the in-group consequences, such as effects on the individual’s sense of self-worth within the group and on the cohesion of the group (Brown, 2000). The present study adds the effect of out-group elements on social identity formation in an organizational context, including in-group and out-group interrelations and selective attitudes on the part of management.

## Limitations

A limitation of this study is that it was carried out in one hospital, that is, in a single organization. Although this approach can help to preserve data homogeneity and ensure control of various contextual variables, it raises the question of whether the findings are due to the organizational culture of this specific hospital or some unique characteristics of the intersectorial relationships there. Future research should investigate other medical organizations, such as schools and universities, to enrich the data and improve the generalizability of the findings.

# Conclusion

This study has clarified the layers of social identity in a hospital context and how they serve as different circles of belonging for employees. It has also demonstrated the need to expand the employees’ circle of belonging beyond the department to the hospital level in order to improve the hospital’s daily work and achieve the organization’s goals in a dynamic-competitive environment. To the best of the authors’ knowledge, this study offers the most comprehensive perspective to date on the delicate relations of in- and out-group leadership and their impact on the social identity of their members.

Future studies can usefully examine ways of instilling organizational social identity in employees to enhance their identification with the organization and bridge departmental social identities. Rovio-Johansson and Liff’s (2012) paper has shown how to achieve greater cooperation in a multiprofessional team through verbal abilities. Similar investigation of organizational communication mechanisms in the present research context could significantly contribute to better understanding and bridging of departmental identities if used appropriately by the senior management figures who currently use their leadership power to fuel departmental identity.

\* The corresponding author states that there is no conflict of interest.

\*\* The corresponding author confirms that the study was approved by the institute ethics committee (the name is added to the title page for blind review purposes).

\*\*\* The corresponding author confirms that datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

\*\*\*\* Informed consent was obtained from all individual participants included in the study.

\*\*\*\*\* The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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