**Social Identity in a Public Hospital: Sources outcomes and possible resolutions**

**Abstract**

**Purpose**: The overarching goal of the current paper was twofold: Its first aim was to investigate how social identities in a multilayered social platform of a public hospital is shaped. Its second aim was to account for the impact of these identities on staff interrelations, patients, and the organization overall ability to meet its challenges.

**Design/methodology/approach:** A qualitative method was used. 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 identified as social identity theory of leadership, it was found that departmental identity was the most prominent social identity associated with the hospital staff, strengthen by prominent in-group management and scantly impacted by the senior outgroup management. Under these conditions, organizational goals were overlooked. Drawing on social identity theory and its extension, the social identity theory of leadership, these findings are discussed, and resolutions for dealing with these adverse impacts on staff patients and the organization ability to meet its challenges are presented.

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

**Originality/value**: Most of the literature on SI dealt with personal and group level antecedents of social identity, overlooking the potential participation of in-group and out-group management in shaping these identities and their contribution to the detainment or achievement of organizational goals. Using a qualitative approach, the current study enables a deeper understanding of the interrelations between senior management and direct in-group management in shaping social identities. Such a comprehensive view was overlooked thus far. However, accounting for these identity shaping forces is essential for understanding the challenges hospitals are facing as well as for understanding their various impacts, some of which lives depend upon.

**Keywords**: Social Identity, Intergroup Relations, Top Management, Qualitative Method .

**Introduction**

In recent decades, market dynamics, driven by digital transformations, and economic challenges, generated a continuous organisational pursuit to increase their ability to compete in a dynamic environment and establish their superiority in a constant struggle over resources (Edmondson 2012).

Similarly, in trying to promote patient-centricity under these conditions, healthcare organisations enable telemedicine, digitalization of patients clinical history, and other services while at the same time they are struggling with decreased budgets and increased social challenges such as COVID-19 that exhaust their resources (Prado-Prado et al., 2020).

All in all, in trying to supply add-value for customers and staff and respond to increased challenges, healthcare institutes are promoting private sector management practices such as lean management (Drotz and Poksinska, 2014), kaizen (Prado-Prado et al., 2020) and others, all of which requires cooperation between departments, professions and, ultimately, individuals with diverse social identities.

Indeed, in a hospital setting, staff members categorize themselves and others according to a range of corporate groups linked to expectations and perceptions about professions (e.g., medicine, nursing, etc.), diverse specialities (e.g., emergency medicine, gastroenterology, etc.), and various statuses (e.g., junior and senior doctors) acting and interacting together (Hewett, Watson & Gallois, 2015). In a public hospital context, where group memberships are hierarchical, firmly role-bound, and at the same time, departmentally based, intergroup dynamics become complex (Riskin, Erez, Foulk, Kugelman, Gover, Shoris, Riskin, & Bamberger, 2015).

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

In such formation, three related challenges are expected. The first, which embed the two others, relate to the organizational need to compete through change management and management practices. These private market practices that are utilized to respond to organizational challenges reduce managers’ centricity and power (Gandomani et al., 2020). Thus, it is expected that ingroup managers who want to maintain their control and status in their groups will resist new managerial practices by strengthening group identity and shape it to detain change (Hogg et al.,2020) which is needed to enable the organization to compete in a dynamic environment.

The second challenge relates to the impact these departmental social identities have on patients, drawing back to the organizational ability to compete and promote patient centricity. Lastly, within a solid ingroup identity, intergroup relations are becoming more conflictual, impacting employees, patients, and the organisation's overall ability to meet its challenges.

Thus, the overarching goal of the current paper is twofold: Its first aim is to investigate how the diverse forces shape social identity in the hospital through an exploration of some of its departments. Its second aim was to account for the impact of these identities on staff interrelations, patients, and the organization overall ability to meet its challenges.

While answering these questions, the current study contributes in several ways. Firstly, most of the existing literature on SI dealt with member and group level antecedents of social identity, overlooking the potential impact of leadership in shaping these identities and their ability to contribute or detain organizational goals. Using a qualitative approach, the current study enables a deeper understanding of the interrelations between senior, out-group management and direct ingroup management in shaping social identities. Such a comprehensive view was overlooked thus far, although its importance in the context of hospitals, (Steffens et al., 2021) in which SI impacts the lives of individuals. Additionally, the social identity theory of leadership utilized in the current study can account for various management levels and their diverse impact on social identities and organizational goals. Still, such a comprehensive viewpoint was overlooked.

**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 SI is shaped, it can explain individuals' feelings, thoughts and behaviours motivated by their group membership following the prototypical attributes of the group (Hogg, 2001, a, b, Hogg, 2005, Hogg et al., 2012).

Both personal identity and its counterpart social identity (SI) comprise a two-fold identity formation (Gallois, McKay & Pittam, 2005),.in which social identity operates as a social cement attaching individuals to their in-group, allowing them to act on behalf of the collective group (Van Vugt & Hart, 2004). When an individual is categorised as a group member, his attributions are overlooked, while 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 also allows us to understand the nexus between the individual and the group that 1)shapes individuals’ perception of themselves and others in terms of social categories and 2) accounts for members’ attitudes and behaviours triggered by a sense of belongingness (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987).

SI also allows a meaningful way to organize one’s social world (Tajfel & Turner, 1979; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) by categorizing individuals in a simplified in-group (“us”) or out-group (“them”) dichotomies formation, in 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 differentiating them from others within their group.

Indeed, SIT was utilized 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, Rubin, & Willis, 2002; LaTendresse, 2000). The underlying motivation of individuals concerning categorization, social identification, and social comparison, all of which are central processes involved in forming social identity, is their desire to boost individuals’ self-esteem (Tajfel & Turner, 1979). In this respect, social identity stimulates group behaviour through two opposing mechanisms: discrimination and cooperation, utilized in congruence with the context in hand, to maximize self-esteem (Kreindler, Dowd, Star, & Gottschalk, 2012).

Studies focusing on the positive contribution of social identity suggest that social identity enhances group cohesion and motivation (e.g., Ellemers, de Gilders, & Haslam, 2004), collaboration, altruistic behaviours, and positive groups evaluations (Ashforth & Mael, 1989).

 Other studies that addressed the positive impact of social identity on the individual level found that it increases job satisfaction, health and wellbeing (Haslam, Jetten, Postmes, & Haslam, 2009). Similarly, recent longitudinal research highlighted the positive long-term impact of social identity on individuals’ health, wellbeing, and morale. These scholars attributed the positive effects to groups’ support and appreciation, two mechanisms that protected group members from burnout during demanding periods (Haslam, Jetten, & Waghorn, 2009).

Other studies focused on the adverse implications of social identities. Social identity, under several circumstances, can potentially increase in-group bias toward others (e.g., McGarty, 2001) by stereotyping the outgroup or discriminating against it (Tajfel, 1978). In turn, under these conditions, social competitiveness (Amiot & Sansfacon, 2011) and conflicts can foster.

**Social Identity in the Health Context**

Professional identity also comprises individuals’ social identity, a broader view of social identity based on the same desire to belong to a larger group with shared professional attributes (Ashforth, Harrison and Corley's,2008). In health care, healthcare providers from various professions must collaborate to provide patient care during work. For that purpose, individuals from diverse professional, specialities, and cultural backgrounds are teamed in multi-cultural and professional teams consist of individuals who differ in language, rules, and norms that shape their distinct professional identities (Watson, Hewett, & Gallois, 2012).

Professional identity consists of a well-constructed set of attributes, values, motives, and experiences that define ones’ professional role (Warren & Braithwaite, 2020). The professional sub-cultures such as medicine, nursing, and administration, shape professional identity in a hospital setting. In turn, these sub culturs impact individuals’ well-being and their feelings, thoughts and behaviours towards the organization (Callan et al.,2007).

Taking a broader perspective, Hewett, Watson, Gallois, Ward, and Leggett (2009) investigated the impact of physicians' professional identity on the communication between diverse healthcare professions and, as a result, on the quality of medical care given to patients. The authors found that speciality was the primary source of group identity. Their illuminating findings went beyond the internal properties of identity, informing the external impact on patients. The authors indicated that these identities triggered biased patient charts that reflected inter-group competition. Moreover, patient charts were biased to enhance in-group identity. The study also revealed that inter-professional competition over-diagnoses and ultimately patient owning could threaten patient’s lives. The authors argued that these dysfunctional communication patterns could not be mitigated through interpersonal skills training since it was rooted in group identities rather than lack of skills (Hewett et al., 2009).

While these studies investigated the formation and impacts of social identities on individuals, groups, and external steakholders such as patients, only scant attention was given to the interactive relations between power as an antecedent of social identity and social identities, which can enhance or decrease individuals’ power. In this respect, 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. giver and receiver), an identity shaped by not only but also power differences. Despite these exciting findings, the authors overlooked an integration of leadership, a representation of power, with SI theory and their interrelations (Hogg, 2001a,b; Hogg, 2005), namely social identity theory of leadership

**The social identity theory of leadership**

In his illumination work, centring 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 SI, to preserve their own power. This groundbreaking theory is structured on the foundations of the social identity theory of leadership presented a few years earlier (Hogg, 2001a; Hogg and Knippenberg 2003) by the author. In the extension of SI to social identity theory of leadership, the author posits that the representation of groups is based on prototypes – members that can represent the essence of the group and its distinctiveness from other groups through their properties. Prototypical in-group members are a reliable source for in-group norms, and as such, they can influence the identity and behaviour of other group members. Leaders who are also in-group members are expected to hold prototypical characteristics of the group more compared to other group members or out-group leaders (Hogg et al., 2012; Steffens et al., 2021.‏). Thus, such leaders are more 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 properties to highlight their own prototypicality, preserve their power, and increase their and their group members’ distinctiveness from outer groups. Indeed Rabbie & Bekkers (1978) found that insecure leaders are prone to promote conflicts with other groups, sharpening the differences between the groups and thus the prototypicality of themselves and other in-group members resulting in their increased power (Hogg, 2005).

While the author accounted for contextual threats on group SI and thus on group leadership, he overlooked the premise that in-group leadership and out-group leadership are jointly shaping the group SI in a delicate fabric of relations in which out-group senior management leadership can serve as a contextual threat to in-group departmental leadership. Specifically, due to market dynamics, healthcare institutes are promoting private sector management practices such as lean management (Drotz and Poksinska, 2014), kaizen (Prado-Prado et al., 2020) aimed to respond to organizational challenges, but at the same time, these trends are threatening to reduce in-group managers’ centricity and power (Gandomani et al., 2020). As senior management is considered outgroup leadership, it is highly dependent on in-group leadership to utilise these practices. Yet, these internal leadership forces are threatened and are prone to enhance their group prototypicality and ultimately their power to overcome their identity threats.

**The Present Study**

The overarching goal of the current paper is twofold: Its first aim is to investigate how the diverse forces, including in-group and out-group leadership, shape members' social identities in a public hospital in Israel. Its second aim was to account for the impact of these identities on staff interrelations, patients, and the organization's overall ability to meet its challenges. An exploratory qualitative inquiry was utilized to seek rich, in-depth perceptions of social identities expressed in differentiating feelings and behaviours.

**Method**

**Research Design and Sample**

We conducted a qualitative research study to comprehensively examine 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). The interviews provided descriptions and examples that comprehensively revealed the phenomenon's complexity, including its causes and consequences.

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 included members of different religions and ethnic groups. The hospital is a peripheral hospital, typically catering to middle and lower class populations.

 In accordance with previous guidelines (Bowen, 2008; Kerr, Nixon, & Wild, 2010), data saturation was reached after 30 interviews, when main themes related to the study (such as the dominant social identity, the perception of outgroups and issues related to contact) were repeated. Furthermore, and more generally, a sample of 30 has been acknowledged as being more than adequate for qualitative research (Mason, 2010).

The interviewee sample was drawn from various departments and sectors in the hospital (medical, nursing, administration and para-medical), and was intended to provide a wide as possible examination of the various levels of social identity. The interviewees were randomly sampled by the hospital administration in accordance with this qualification, and the research team ensured 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.

Thus, the respondents were managers and employees from different departments and ward levels as specified 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 for open-ended questions, structured and based on the literature review and aiming to explore the role that social identity and contact play in the hospital context, were used. 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 thematic interview guide included the following themes: strengths and weaknesses of the hospital and department; feelings about the hospital and the hospital’s image; the employee’s main identities; the relationships within the department; and the contact and relationships between the departments. Each interview lasted about one hour and was conducted during working hours in a private room in the hospital. The interviews were conducted by the three researchers.

Permission to conduct the study was obtained from the hospital’s vice-CEO, the chief doctor, and department heads. All participants were required to sign informed consent forms. Before submitting these forms, the researchers assured participants 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) by encoding central themes and identifying patterns that emerged from them, and which were related to the respondents’ perceptions of social identity and its consequences. The data analysis process included 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 performed transverse analysis that identified general patterns of themes and provided a comprehensive picture of perceptions and concepts. In order to maintain inter-rater reliability, was measured through Cohen's Kappa interrater reliability that outreacher the threshold of 0.60 resullting in K=0.63

**Results**

**Social Identity in a Public Hospital: Sources, outcomes and possible resolutions**

Findings:

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

1. **Social identity**

Several social identities emerged from the analysis: organizational (the hospital versus other hospitals); role (doctors, interns, nurses, maintenance); seniority (senior doctors, junior doctors, and interns); and cultural groups. Firstly, participants spoke about “their” hospital, its uniqueness, advantages and its challenges in comparison to other hospitals: “*the atmosphere, the family-like feeling, everyone is ready to help and comntribute. It is a small hospital. In other hospitals you can get lost”* (a nurse). Participants also 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 but also the sometimes-harsh approach towards interns, junior doctors and nurses, the relations between senior nurses and junior nurses, and the attitudes of different role holders to maintenance staff, such as cleaners.

Participants further spoke of cultural aspects of their identity, although less. This included groups of employees speaking different languages within the hospital (such as Arabic or Russian) which exclude others from the conversation, or mentioned their own cultural identity, for example being Arab Israelis, or being immigrants who came to Israel at an older age from different countries. One physician share that *“when I got to the hospital I set in the middle: Russian speaking from one side and Arab 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 describing themselves 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, much more than any other group identity. Few main sub-themes emerged regarding departmental social identity: the department as an ingroup, other hospital departments as outgroups, hospital’s management as an outgroup.

 ***The department as an ingroup***:

Being the main social identity, the department emerged to be the participants’ main source reference and they tended to describe themselves mainly 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 by high in-department **solidarity**. The often described the uniqueness, importance and quality of their department, conveyed a sense of **pride** in their department and promoted it within and outside the hospital. For example one neonatal nurse said: “*I tell every pregnant woman to come to us at [name of hospital]. I know she will get excellent care in our department. 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).* Their departmental identity was also expressed by their expressed wish for the department to flourish and their aspiration to develop and advance their career within the department.

Beyond it, the department emerged to provide the majority of participants with a **sense of belonging**, which was very important to the majority of them. Belonging was expressed by the discussion of their shared specialy, as well as the frequent use of the term “family-like” and the description of the close relationship within the department, within and across roles. Different participants described daily life routines such as coffee during 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 memer).*

Social identity was also expressed in **cooperation** within the department, above professional roles, and overcomes hierarchy and status boundaries. The participants described cooperation between department members of different roles, expressed in mutual help, support, learning and teaching and consulting . One doctor said that: “*There are excellent relationships between the physicians and the nurses; we include them in morning rounds….* *We (the doctors) also give them (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 morning meetings, and there is a nurse on morning rounds”. The nurses conveyed a similar view. For example, one nurse said: “there is open relationship between us, we share, consult. Our head of repartment is somethins special, we can all express our opinions freely, he counts on us..”.* This perceived cooperation was accompanied bya sense of **support:** A para-medical leader for example said: “*we support each other. We help each other , we ask on WhatsApp: do you need help?* **A** maintenance staff member for example described receiving support from her department and its head when she was mistreated by one of the departments, being left outside in the rain, including complaining to management about the way they treated her.

***Other departments as outgroup***

The ingroup identification and solidarity was contrasted with the other departments which were perceived as the outgroup, by that strengthening the ingroup social identity. This reference to the outgroup was based on comparisons and expressed by a few subthemes: quality, professionalism, and availability of resources.

Regarding **quality**, different departments highlighted different qualities that outperform those of other departments, being it the perceived importance of their specialty and its status, the quality of staff or of their patients care, workload and hard work, values and relations. They tended to contrast their perceived strengths with those 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 by saying*: There is no ego in our department. You however see ego in many departments”.*

At the same time, the department’s identity was often defined also by its perceived **professionalism**: expressed by either a sense of superiority over other departments accompanied by a sense of entitlement, when the specialty or department had perceived high statuesm, or a sense of inferiority when comparing themselves to other, better or more prestigeus departments.

Such a perceotion was accompanied by the perception of the **availability of resources** compared to other departments, serving as social identity glue. While for some it was the feeling of being invested in and being able to develop, for others it was a sense of 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 outgroup***

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, by that being perceived as an outgroup which operated as a factor contributing to departmental social identity. In this, the department’s social identity was formed and expressed by the mutual feelings of its members regarding their place and status in the hospital’s leadership view and actions, expressed, among other things.

The participants from different departments and roles often described hospital management with power and influence regarding decisions and as a force responsible for resources, support and attention external to the department. The discussion of top management often centered on their view of and approach to the department: of its perceived status and appreciation or its lack of, of providing or denying resources from the department, and as having preferences regarding their decisions. The findings indicate that the various departments described competing for the management’s support, material and emotional, which was viewed as external to the department and its goals. The perceived differential management attitude was found to operates as a source supporting the deparmental social identity and their distancing from other, outgroup 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 told: “*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”.*

**B. 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 main sources: specialty and its general status, the status of the department within the hospital and outside it, and department leadership.

**Specialty status:** Beyond the sense of belonging and pride of department members in their department, and closely related to it, 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, among themselves, and in their perception of hospital’s leadership eyes. Consistent with SIT, respondents made intergroup comparisons and categorized specialists from other departments as out-group members.

**Perceived quality of the department:**

Throughout the interviews, and as mentioned earlier, it was evident and agreed upon by members of all departments that*” We have’ flag*ship*’ departments, some of the best in the country, that work admirably while other do not” (a department nurse).* This view, whether belonging to the higher or lower prestigious groups contributed to the departments’ social identities.

The reputation and evaluation pf quality of the department work within the hospital and outside it, which were interrelated, was not identical to the general status of the specialty and was formed based on their performance in the hospital and their prestige outside it. Their performance, in turn was related to the quality of their staff, the country and institution from which they obtained their degrees, the departments’ ability to attract staff from high status hospitals and new interns, staff retainment, available resources and technological advances, and future prospect in terms of development and resources. The criteria used by the participants to evaluate the quality of the department were the departments’ reputation within and outside the hospital and among management, the perceived quality of the doctors, including whether they studied in Israel or abroad (and if not, what country or institution) and whether they have previously worked at the center of the country, and their ability to attract interns.

**Department leadership 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, view, highlighting their uniqueness, expressing and sharing their disrespect (when strong departments were involved), or their sense of envy and deprivation compared to other departments with their staff , and cultivating competition with other departments.

Highlighting the attempt to accentuate departmental uniqueness, a nurse working in nursing administration told: *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 priority of the medical center a step forward: “*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. One of them said that “*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 expressing disrespect towards 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 of some departments as superior to others, as well as the perceived distribution of resources to the more successful departments, and the competition of other departments over it, can serve to the ability of department heads to preserve and maintain their power through departmental social identity processes.

In particular, some spoke about the tendency of some department leaders to take as little work as possible to their department, especially when this work comes from another department, with the aim to conserve their resources within the department. As one physician told: *“. Some department leaders, when you turn to them asking for patient’s admition, say: why are you “throwing” a patient at me? Their attitude is that we (from other departments) bother them…and they project this attitude to their teams”*

**C.Outcomes of departmental social identity**

The focus on the department as main social identity was found to come with an organizational price tag. Those prices center around three main themes: negative intergroup relations between in- and outgroups typified with hostility, competition, lack of cooperation and ego fights, Difficulties in promoting organizational goals and driving organizational change and growth, and impact on patients and

**Negative interpersonal relations between in and outgroup:**

The dominance of the departmental social identities was found to create negative inter-group relationsexpressed by lack of communication, hostility, competition, biases, and negative feelings and defiant behaviors towards other departments which impacted their 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 can not succeed”*

**Stereotypes and biases:** Stereotypes were used to describe members of the out-group as additional evidence of the superiority of the departmental identity vs. the professional one. In describing other departments, homogeneity of the outgroup was evident. 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”.*

***A sense of hostility between the departments*** Hostility was also found to center over perceived extra workload because of other departments’ low prefessionality or commitment, their superior status in the eyes of hospital’s management or perceived superior resources, or their overarching negative impact of their bad reputation on other departments: *“Other departments are less professional and to 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 (Head of department); “it projects…Someone says in a wedding to its relatives: I have been in X department in the hospital and they were terrible. Everyone here it and will then not want to come to the hospital, to all departments” (a physician).*

Those perceptions were found to often create negative climate and sometimes resulted in real actions as another nurse told:: *The offices 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 administrative office”.*

***Competition and lack of cooperation*:** Furthermore, the superiority view of some departments was found to cultivate competition and make cooperation between departments difficult. This was expressed by concealing information, competition over resources and crefit. 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 actual low resources or relative deprivation. Participants often felt that patients are admitted to their more crowded departments, or given less be operation room time, or later operating hours. *Credit* fights were among the described outcomes of those processes: *for example, when we work on protocols, which a few departments have to cooperate, there is a friction over who will present the findings and will get the credit.* *There is a big identification with the department*” (department nurse)

**Difficulty to promote organizational goals**

The hospital as a whole was described as investing a lot of effort in improvement and innovation of hospital’s services and service, provide a better care for patients and compete 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 department;s focus on narrow goals, competition and lack of cooperation, was found to often contrast organizational goals and departments and negatively impact 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 ER”.*

This proess was enhanced by department leaders who reject the organizational changes in order to preserve their power. As opserved by a para-medical staff member : “*despite management efforts*, *some departments have a lot of power and reject the change, thus holding the change, and the hospital, back”.* In particular, those objections were related to investing in other departments.

Another organizational goal, which was noted by some participants to be hard to achieve within the current social identity was to improve organizational culture and leaders’ attitudes towards staff and patients. This aim, too, was found to be hard to achieve when department leaders were more concerned with maintaining their power within the department. 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 patients’ care**

References to the negative relations, and preference of department goals over organizational ones suggests impact on patients care. As emerged from the interviews, those can be attributed to the lack of cooperation and the sharing of information regarding patients, low resource sharing- for example admitting patients into less crowed departments, sharing operation rooms based on needs rather than rigid departmental schedule, and improving the flow between departments- such as from ER to 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 were the level is not high so overall I am not sure they do”.* A nurse added: *”I would like to thing 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 me that what I am asking is not suitable and that he can not do it…often I an convinced that it is just from not wanting to do the extra mile for another department*”. Regarding resources, a nurse said*: “ If I find three packs of…and I cannot use them because I a 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 the lack of cooperation, the head of physiotherapy expressed her frustration from not having a multi-disciplinary discussion over patients’ needs: “ *If I was allowed to be present in their (other departments) meetings and to explain them what we are doing and what we can do, patients would have gotten a much better care”.*

**Discussion**

Within the framework of SIT and its extension to the social identity theory of leadership, this research aimed to investigate social identities and intergroup relations in a hospital, a highly heterogeneous group context with many different aspects of identity. The overarching goal of the current paper was twofold: Its first aim was to investigate how the diverse SI forces, including in-group and out-group leadership, shape members' social identities in a public hospital in Israel. The current investigation aimed to reveal the infrastructure of social identities in the hospital where identities can be driven by diverse sources such as departmental, professional, organizational, ethnic or seniority.

Its second aim was to account for the impact of SIT on staff interrelations, patients, and the organization's overall ability to meet its challenges. In-depth perceptions of social identities expressed through feelings and behaviours were accumulated for that purpose, seeking rich qualitative data.

**Social Identity theory of leadership and organizational goals**

All in all, data revealed that departmental identity was the most prominent identity in the hospital. Strengthen by department heads serving as prototypical representations of identity, the departmental identity was the source of pride, belongingness and cooperation (Hogg, 2001a; Hogg and Knippenberg 2003; Hogg et al., 2012). At times, the departmental identity was strengthened by two distinct forces- departmental ingroup leadership that promoted an ingroup/out group relations, and senior management out-group ledership that differentiated various departments regarding attitude and resource allocation.

Such ingroup leadership behaviour is well documented in the social identity theory of leadership, especially in Hogg (2005) documentations of misuse of power. The author noted that prototypical ingroup leadership would promote conflicts under threatening conditions and highlight group prototypicality to enhance their own leadership power. Precisely, senior management willingness to encourage centricity customers requires decentralization of leadership in a way that decreases -group leadership power (Drotz and Poksinska, 2014; Prado-Prado et al., 2020). Indeed, department heads were prone to protect their power without considering the hospital needs and impacting the SI of in-group members.

The selective treatment of senior management toward the different departments nourished these departmental identities.

**Social Identity theory of leadership and Intergroup Relations**

Our findings indicated that all interviewees classified their social identity based on the department to which they belonged. Differential top managerial attitudes contributed to forming their departmental social identity, which was strengthened by department heads attitudes and behaviour. This means that members of the highly-valued departments wanted to preserve their esteemed professional image and differentiate themselves from less appreciated and less professionally valued departments, which affected their attitudes and behaviours towards these outgroups. Previous studies have similarly shown that preserving a high professional image leads to intergroup conflicts (Cuhadar & Dayton, 2011; Rubin & Hewstone, 2004). The perception of the 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, indicating that the differentiation is aimed at maintaining the department’s professional image.

Furthermore, the high costs of medical care create struggles over budgets and resources in hospitals. Under these conditions, the present study shows that hospital management’s support of the various departments is essential and is a predictor of social identity. SIT theorizes that when individuals identify with their group, their wellbeing is intertwined with the group’s wellbeing (Van Vugt & Hart, 2004), and the group’s status is significant for their wellbeing. Senior management’s selective attitude toward various departments creates an experience of a particular hierarchy among the departments, which is reflected in feelings of rejection, discrimination, and superiority among those departments and their members shaping their SI. An insight provided by SIT in this context relates to the social structure of the groups, seen in status and power differences between them. It is one of the elements of social categorization (Kreindler, Dowd, Star, & Gottschalk, 2012).

Additionally, it seems that these drivers shape intergroup relations. A frustration-aggression effect could be identified in departments that felt other departments stood the way of their professionalism, creating further conflict among departments. While there was increased and positive contact within departments (both within and across professional roles and statuses), which was manifested through solidarity and an in-group bond, the opportunity for between-department connection was found to be minimal, artificial and mostly conflicted. These conflicts could be either actual or relative. For the most part, they nurtured the departmental social identity, prevented cooperation between the groups, and evoked mutual negative behaviours and feelings. These findings also demonstrate a lack of shared goals. Previous results have supported the proposition that such a lack of shared goals impacts the quality of relationships (Lloyd, Schneider, Scales, Bailey & Jones, 2011).

**Social Identity theory of leadership and patients**

In the healthcare sector specifically, and consistent with this notion,

Thomson et al. (2015) found that focusing on one’s specific sector’s goals instead of the patient’s or the team’s goals affects the quality of communication between teams and their overall ability to provide the best care for patients. Indeed, evidence found in this study supported previous findings illustration that SI impacts patients and thus should be managed.

While outgroup threats to departmental prestige and leadership strength followed by in-group leadership efforts to maintain their power can be predicted and are well documented, senior leadership selective treatment strengthens the conflicts and prejudice between departments inhibiting the organizational goals. Such findings are more meaningful considering the ethical gap between employees across departments. This gap could nourish the SI of employees (Klein et al., 2019) yet be inferior to the forces mentioned above.

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

**Spotlight on the utilization of Contact Theory to resolve the challenges**

The lack of shared goals, the divisive managerial attitude, the emergence of prejudice and the differentiation of status based on professionalism and prestige are evidence that some building blocks upon which contact is based according to contact theory principles (Dovidio et al., 2011; Visintin et al.,2017), can be utilized to improve

As part of contact theory, Allport (1954) specified four essential conditions that can help overcome the challenges as mentioned above: equal group status within the situation – 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 authorities, law or custom, which establishes norms of acceptance (Pettigrew, 1998; Pettigrew, Tropp, Wagner & Christ, 2011) that will shape a more favourable structure of intergroup relations (Dovidio, Eller, & Hewstone, 2011).

Given the evidence and these guidelines, it seems that implementing direct contact strategies might reshape the departmental identity into a comprehensive hospital identity. Accordingly, to achieve hospitals’ goals, it improves department relations and patient care.

First, shared goals, such as mutual responsibility for patient care, should be identified and emphasized by senior management. Senior management should maintain equality between departments, and support to lower status departments should be given. 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 establish a shared identity.

Interdepartmental cooperation should be embedded in daily practice, encouraged and rewarded, promoting direct contact. The likelihood for positive contact will be greater if, through HR practices and internal communication, management promotes situations in which intergroup contact is made and allows and encourages these situations through staff exchange. In this respect, these opportunities for intergroup contact could be advanced through HR projects in which employees from different departments join other departments for short periods. All in all, senior leadership should understand and defuse the automatic mechanism that strengthening departmental identity triggered by external threats instead of nourishing departmental identity through selective treatment and attitude given t0 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 the sectors – medical, nursing, administration and para-medical – has not yet been studied.

An additional contribution of this study is extending SIT to analyze its external causes and outcomes utilizing the social identity theory of leadership, in contrast to previous studies which focused on the internal factors and implications of social identity. Existing literature has detailed intergroup factors that create social identities, such as group characteristics and motivation to belong (Amiot & Sansfaçon, 2011; Brown, 2000; Callan et al., 2007), and has also noted its in-group consequences, such as affecting the individual’s sense of self-worth in the group and group cohesion (Brown, 2000). The present study added to these the effect of out-group elements on the social identity formation in an organizational context, such as the management’s selective attitude and the interrelations between in-group and out-group relations

**Limitations**

One limitation of this work is that it was performed in one hospital, i.e., one organization. On the one hand, this limitation can help preserve data homogeneity and ensure control of various contextual variables. On the other hand, it raises the question of whether the findings were the result of the organizational culture of this specific hospital or perhaps due to inter-sectorial relationships unique to this hospital. Future research could investigate other medical centres and organizations, such as schools, universities, etc., to enrich the data and enable more conclusive statements.

 **Conclusion**

This study has revealed the layers of social identity in the hospital, which serve as different circles of belonging for the employees. It also demonstrated the need to expand the employees’ circle of belonging from the department to the hospital level to improve the hospital’s daily work and achieve the organization’s goals in a dynamic -competitive environment. For the first time, to the best of the authors’ knowledge, it allowed a comprehensive view on the delicate relations of out and in-group leadership and their impact on members’ SI.

Future studies might examine how organizational social identity could be instilled in the employees to enhance identification with the organization, thereby bridging departmental social identities. Rovio-Johansson and Liff’s (2012) paper showed how to achieve greater cooperation in a multi-professional team through verbal abilities. The investigation of organizational communication mechanisms in our research context could significantly contribute to understanding and bridging the individual departmental identities if utilized efficiently by senior management that currently used her 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 analysed during the current study are available from the corresponding author on reasonable request.

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