

Online Appendices (referred to in the methods section) – Martin et al. 2019

Appendix 1: Flexible Interview Guide for Participants

1. Can you give me some background on your career since leaving medical school, especially your career as a consultant? If you've had experience in different Boards or healthcare systems, how would you compare them?
2. There are a number of changes in the NHS over the years that may have affected your experience of work. I would like to ask you about some of them to see how they accord with your experience
 - What about the changing expectations of patients and attitudes of the general public towards doctors and the healthcare system. Have patients' expectations and attitudes changed during your career? If so, how has this affected you?

What about increasing bureaucracy, routinization of work and the changing role of managers. Have these been an important feature in your experience of work during your career? If so, could you tell me how?
 - What about the role played by medical bodies in exercising control over the profession. Has this been a feature that has impacted on the profession and your work? If so, how?
3. Do you feel your ability to influence key decisions has increased or decreased over the time you have been a consultant? What about the balance of power between consultants and managers? How do you feel about that? To what extent has it affected your ability to do your job well? To what extent do you trust managers here to act in your/ patients' best interests?
4. Do you feel more committed or less committed to your work now than when you began? Why is that?
 - What about your engagement with matters outside of your immediate work. Has that changed over time?
 - Have incentives or the lack of them played any role in your engagement?
5. Do you sense increased tensions between medical consultants and other clinical professions since you began as a consultant? Or are things pretty much as they've always been?
6. Has there been any blurring of the professional boundaries between consultants, nurses and other clinical professions, during your career? If so, how do you feel about this? And has it affected your ability to do your job?
7. How do you suggest the situation can be improved to allow consultants to do their job more effectively and give you a better experience of work?
 - What about getting more consultants into clinical leadership roles and/or into the overall management structure in this Board?
 - What about other ways of improving the work experience and effectiveness of consultants?
 - What do you currently do to cope?
8. Which rationales do you think govern decisions made in your work?
9. Which rationales should dominate decision making?
10. Is there anything you would like to tell us that we would find useful for our research?

Table 3: Data Structure

Empirical themes	Conceptual Categories/ second order constructs	Aggregate codes/ theoretical dimensions
<p>Expanding bureaucracy (e.g. targets) governing day-to-day work</p> <p>Non-clinical managers' lack of respect/understanding for/of doctors' role</p> <p>Expanding power of non-clinical managers</p> <p>Blurring of professional lines</p> <p>Contrasting with the past autonomy</p> <p>Patient care expressed as doctors' overriding concern</p>	<p>Loss of autonomy and control</p> <p>Loss of self-esteem and distinctiveness</p> <p>Continuity with past professional values</p> <p>Efficacy and meaning expressed through patient care</p>	<p>Identity motives for rejecting new logics</p>
<p>Need patient-centred collaboration between managers and doctors.</p> <p>Role as the patients' advocate</p> <p>Professional satisfaction through innovation/influencing the system</p> <p>Changes have been for the benefit of patients</p> <p>Have to overcome the reluctance of the 'old guard' and step up to be counted.</p> <p>Clinical leadership as a way forward / need for training</p> <p>Leading but also being a team player</p>	<p>Efficacy expressed though system-wide effectiveness</p> <p>Meaning through new medical professionalism</p> <p>Distinctiveness by breaking with past</p> <p>Self-esteem through medical leadership</p>	<p>Identity motives for accepting new logics</p>
<p>Expressing the centrality of medical autonomy to effective patient care</p> <p>Focus is on standing up for the patient</p> <p>Frustration at Management's lack of understanding</p> <p>Negative feelings towards new medical regulatory bodies</p> <p>Denigrating the motives and competence of doctors who go into medical leadership roles</p> <p>Denigrating the influence of medical leadership roles in improving patient care</p>	<p>Legitimizing medical autonomy</p> <p>Legitimizing by enhancing existing identity</p> <p>Delegitimizing bureaucracy and managerialism</p> <p>Delegitimizing new professionalism</p> <p>Delegitimizing medical leadership</p>	<p>Identity work processes and tactics for rejecting new logics</p>
<p>Criticising colleagues' narrow views of medical professionalism</p> <p>Criticising colleagues' refusal to move with the times</p> <p>Expressing positive experiences of working with non-clinical managers</p> <p>Promoting the role of medical leadership in improving patient care and 'new' professionalism</p> <p>Expressing positive experiences of medical leaders' agency</p> <p>Expressing positive experiences of new bureaucracy</p> <p>Learning to deal with managers and bureaucracy</p> <p>Avowing patients' rights to participate/ express voice in their treatment by doctors</p>	<p>Legitimizing managerialism</p> <p>Legitimizing medical leadership</p> <p>Delegitimizing traditional medical professionalism</p> <p>Delegitimizing traditional medical professionals</p> <p>Reframing and integrative work</p>	<p>Identity work processes and tactics for accepting new logics</p>

Table 4: Representative data for individual responses to multiple logics, based on desired and feared possible selves

Identity motives		Identity work	
Traditionalist consultants' conceptual categories	Strong sense of wanting to protect their distinctive professional identity arising from a perceived lack of congruence of new logics with medical professionalism		Active identity work to resist integration of multiple logics into consultants' personal and role identities. Driven by motives of continuity, belonging to a profession, distinctiveness and overcoming threats to their efficacy.
Perceived loss of medical autonomy and control as a threat to their efficacy (patient care)	<p><i>The role of the consultant is clearly viewed by management to provide patient care on a shoestring, to do so unsupported, and to take the blame when patient care goes wrong even if the cause is faulty management (FT-LCSurg).</i></p> <p><i>I do like this idea of sharing the power but not at the expense of being disempowered by other elements in the system and I think that's what's happening. (IntC10-LCPhys)</i></p> <p><i>There seem to be a great number of people who could not do my job but feel qualified to tell me how to do my job... (FT-LCSurg).</i></p> <p><i>There is a lack of investment in true consultation... a shift towards line management ...however much you have a sense of vocation and you're committed to your sector and your patients you can't help but feeling a sense of disappointment (IntB1-LCPsyc)</i></p> <p><i>I think unrealistic targets, set by governments ...have led to a shift towards employing more non-clinical staff to come up with ways of meeting targets rather than employing more clinical staff to treat patients (FT-LCPhys)</i></p>	<p>Legitimizing medical autonomy as the overriding logic in patient care.</p> <p>(retaining identity)</p>	<p><i>'In my day, we recruited the brightest and best to medical schools because we often had the life of patients in our hands. We had to because we had a great deal of autonomy in caring for patients, and that's what is required. Nowadays, we still recruit the brightest, but they're not needed – we're no more than 'hired hands'. What's the point? All this is doing is creating a whole generation of p....ed off doctors' (IntC16-LCPhys)</i></p> <p><i>I think what might work better (is) if people would all play their part, which is a big if. If the authority rested more with the clinical leads in the clinical areas. And the general manger was there in support, as opposed to the other way round. (IntA7-LCPhysML)</i></p> <p><i>The health board regularly introduces unproven measures, which harm patients. It's not their fault, the agenda is set by the Daily Mail and scared politicians. My job is to protect the patients from dreadful board policies, but this is increasingly difficult. (FT-MCPhys)</i></p>
Efficacy achieved through patient care	<p><i>It is I realise that ...the bottom line is largely financial, however my bottom line is patient care and ...it's my duty or our duty to ensure that we can deliver both good patient care and we've always been mindful of the financial thing because the NHS is not a bottomless pit as a resource (IntC8-MCPhys)</i></p> <p><i>My motivation is patient-centred not management-centred if you like so I'm quite comfortable as long as I believe I can arrange things in the order that I think's appropriate for my patients. I get frustrated undoubtedly if I feel there are pressures brought to bear which are not related to clinical need. (IntB1-LCPsyc)</i></p> <p><i>The targets and the government standards that the board are set, the health board are set, then the senior managers have things that they're then required to do and the things that they choose to do...but it doesn't translate at all well into patient care, face to face. (IntA12-LCPsycML)</i></p>	<p>Enhancing existing identity by co-opting mutuality</p> <p>(adding to identity)</p>	<p><i>It (Mutuality) wasn't a negative thing, it was quite a positive thing I felt. Generally, I think they (patients) have a very high expectation and I don't mind that. I think that the whole point of being a doctor is that you explain what you're able to do and you do it openly and honestly that's what we've got to do and you need to make that very clear. So I don't mind they had very big demands and they were unrealistic but that's the point of being a doctor is that you can at least educate people as to what's available and what you're able to do and if you can't help them then you would try and find somebody who can and if nobody can help them then that's how it is and you can't change reality (IntD1-MCSurg).</i></p> <p><i>One of the things that I value in my job is the ability to equalise the power dynamics with patients and I think that has revolutionised the way that I practice. (IntC10-LCPhys)</i></p>

<p>Loss of self-esteem and distinctiveness.</p>	<p><i>Consultants have been debased to drones, driven by inappropriate targets, matched with insufficient resources, with the devaluing of time spent on anything other than measurable activity. Time as a clinical tool for patients has been sacrificed on the altar of waiting times (FT-LCPhys).</i></p> <p><i>I'm not valued as a person because I'm just a number you know it just felt very demoralising and devaluing (IntC10-LCPhys)</i></p> <p><i>I have been a consultant for 19 years. During that time, I have seen management expand through self-perpetuating bureaucracy while the position and role of the consultant has been diminished by underfunding, inappropriate policies and ridiculous diktat... (FT-LCSurg).</i></p>	<p>Discrediting the legitimacy of bureaucracy and non-clinical managerialism.</p> <p>(retaining identity)</p> <p>(retaining, strengthening identity)</p>	<p><i>Since I started as a doctor 27 years ago, I have seen an enormous expansion in non-clinical workers in the NHS, many of whom add little or nothing to patient care but count things for political reasons... (FT-LCSurg).</i></p> <p><i>I find there's a coherent management view so you could say that's positive because the management team work well and form a view or you could say it's not inclusive because it's not making full use of the experience and knowledge of the entire professional groups whether it's nursing or medical ...there are tensions ...however much you have a sense of vocation and you're committed to your sector and your patients you can't help but feeling a sense of disappointment. (IntB2-LCPhys)</i></p> <p><i>It is person specific there are some (managers) that I trust and there are some that I wouldn't trust to cross the road without getting hit by a car. (IntD6-LCPhys)</i></p>
<p>Seeking continuity with past professional identities and traditional values of medical professionalism</p>	<p><i>... what you want to really do is to be a good doctor or be thought of as being a good doctor, reliable, trustworthy, respected ... You're a doctor, you're not something that isn't a doctor. (IntA12-LCPhysML)</i></p> <p><i>The way that it is in medicine is that we qualify as doctors because we want to be doctors and we don't want to be managers we didn't set out to do that (IntB5-LCSurg)</i></p> <p><i>There's just not space yes certainly we had the opportunity but as a rule I think the medics ...are less powerful than they were...but in some respects I think people are just less willing to take on leadership and management roles as well there's two sides to that. (IntD5-LCPhysyc)</i></p> <p><i>My experience (of medical leadership) ... personally, I find it a distraction. I found it very hard to do the... the day job ... because of all the harassment ... and that's too conflicting, I think, for me. I think, you're either dumping work on your colleagues who are also busy or you're not doing the work properly and potentially, you're not doing anything properly, and ... that's not good. (IntA7-LCPhysML)</i></p>	<p>Discrediting the legitimacy of new medical elite bodies</p> <p>(retaining identity)</p> <hr/> <p>Discrediting the legitimacy of medical leadership and leaders.</p> <p>(retaining/ stabilizing identity)</p>	<p><i>I think medical bodies have actually made it worse, for example, adding on to appraisal and revalidation and things like that on an already busy and committed workforce without any thought for where is this time going to come from. What does the clinician have to give up to realistically engage with those processes because it is not a simple process, revalidation is a year-long process? (IntD4-LCPhysyc)</i></p> <p><i>I think the whole system of appraisal, and I'm a consultant appraiser, as well as being appraised. If I'm really honest I think it is a huge waste of professional time. I think it is paper chasing. (IntA17-LCPhys)</i></p> <p><i>And then the management chip gets implanted in them and they forget about being a doctor... associate medical director and up... they then cease to be like doctors and then become part of management (IntA2-LCPhys)</i></p> <p><i>I think certain clinicians should go into leadership but not necessarily those clinicians that apply for the leadership roles...(IntA8-LCSurg)</i></p> <p><i>The people that you recruit into a (medical leadership) job that increasingly becomes a full time management job are not the people who actually have medicine at their heart... increasingly people go into these management roles and see their way out of that management role as onwards and upwards in the hierarchy and that therefore makes them feel quite comfortable with the idea of trampling on their colleagues, dismissing all their kind of clinical priorities, forgetting about patient care as they become further and further removed from the clinical frontline. (IntB5-LCSurg)</i></p>

Identity motives		Identity work	
Incorporated consultants' conceptual categories	Strong sense of wanting to create a new meaningful medical professional identity that incorporates new logics and provides efficacy with the system.		Strong identity work to integrate multiple logics into doctors' personal and role identities; emphasis placed on how working together with management can improve effectiveness and enhance the self-esteem, efficacy, meaning they get from work.
Efficacy expressed through positive acceptance of changing logics for system-wide effectiveness.	<p><i>We are able to influence quite a lot...we have been pretty lucky in that respect, so as a department we punch above our weight. But I believe that one of the reasons that we punch above our weight was because we took a novel approach to how (the service) would be delivered here, um and that gave us an immense sense of professional satisfaction. (IntD10-LCPhys)</i></p> <p><i>What they should be doing is removing layers of management and just gently giving more managerial responsibility to clinicians as they mature through their career. So that the clinician becomes a mature manager and leader because at the end of the day they're not going to effect the changes that they need to effect without having the doctors with them. (IntA19-MCPhysML)</i></p> <p><i>Clinicians need to be given control over financial decisions for their team, but also the responsibility for delivery. Only then will clinicians face up to tough decisions and make them in patients' interests (FT-LCPhysML).</i></p>	<p>Reframing the legitimacy of managerialism as a necessary way of reforming healthcare systems.</p> <p>(adding to identity)</p>	<p><i>Managers are an easy target for doctors as they have responsibility for implementing difficult financial and political decisions. I have always found working with them more productive than attacking and undermining them as some colleagues seem to prefer. If we wish to be listened to and earn respect from colleagues, clinical and non-clinical, we need to behave the same way towards them (FT-MCPhys-ML)</i></p> <p><i>I think it's only really when you become a Consultant that you start to realise how much management are involved, and how much bureaucracy there is. ...I must say it does seem to be fairly appropriate. ...I don't feel it's affecting me badly – or at least not, in terms of unnecessary stuff. (IntD13-MCPhys)</i></p> <p><i>I don't mind managers holding power, I'm very happy with that actually, I think they have lots of obligations in relations to all sorts of managerial stuff that we don't want to be bothered with but I do expect them to hold power in relation to being able to listen to clinical experience and take heed to it and that's I don't trust that. (IntC1-MCPhys)</i></p>
Meaning (sense of purpose) expressed through need for new medical professionalism	<p><i>I've got a very good relationship with our general manager though you could argue that I probably cultivate that because it's a useful thing to have you don't really want to fall out with somebody or you know if you're seen as difficult you're not going to get you know what you want without a real struggle (IntB8-LCPhys)</i></p> <p><i>I would like to be able to describe it as a mutually beneficial relationship where people work synergistically to achieve the best aim for the patient ... doesn't seem to work....I think there's a lack of honesty in the conversation from both sides and I think there's a lack of trust ...So what I mean by trust is, I see the managers not giving the full picture to the doctors and I see the doctors not giving the full picture to the managers. There seems to be a real hesitation to have honest conversations with the doctors about the budgets that they work to (IntA19-MCPhysML)</i></p> <p><i>Society, patients in general feel that they should be more involved with their treatment, quite rightly so I believe ... a lot of what the Government does I believe is actually genuinely designed to improve the patients experience, which is I think why we are all here. So in my view the changes that have taken place in the NHS in the last twenty years has been stellar, and they have been very good for patient. (IntD10-LCPhys)</i></p>	<p>Reframing medical leadership as a key element in new medical professionalism.</p> <p>(adding to identity)</p>	<p><i>With more than thirty years in the NHS I enjoy my work as much as ever and feel that working in medical management allows me to influence change positively for the benefit of patients. (FT-LCPsysML).</i></p> <p><i>It was very difficult when I started as a clinical lead ...the way in which we were expected to communicate ... formalised in a managerial way with lots and lots of new language and technical terms that, as a clinician, you just hadn't been trained in. That made communication very, very difficult for a period of time. I would say that it is a lot better now, I guess, because I have learned some of the lingo ... once you get past those barriers, you can actually establish a good working relationship (IntA5-MCPhys)</i></p> <p><i>I'm not really a clinical leader by appointment ... I think I've done a lot of clinical leading by example (IntB10-LCSurg)</i></p> <p><i>Some of my colleagues expect that I should act as an advocate for doctors exclusively but as a manager it is the public, patient safety and the service that supports patients, which must be the priority (FT-MCPhysML)</i></p>

<p>Distinctiveness from traditional medical professionalism.</p>	<p><i>I've now become secretary of two committees because I could see that there was an old guard in our department...There is a newer group of us, and there's an awful lot of people who do just come to work and then go home and they're like a third group. ...The old guard are all in established positions. Sometimes it does feel like you're trying to get things changed and there's reluctance (IntC12-ECPhys)</i></p> <p><i>I definitely feel more engaged in the process as I have a vested interest ... I think the more that you feel you've got buy in and you work together, I think the more committed you become to the job. (IntA19-MCPhysML)</i></p>	<p>Letting go of traditional medical professionalism.</p> <p>(subtracting identity)</p>	<p><i>I think the word deprofessionalization has a kind of for me it has a kind of connotation of we think we're the best and we should be in charge of everything ...there is a historical view of doctors and I think there is still a lot of senior consultants around who do have that approach and those are the people I mean who are struggling with the idea that you can sit in a (specialist) team meeting and for two of the nurses to say we don't like the way you are running your clinics because we don't think it's best for the patients and they find that very challenging...personally that's not an issue for me. (IntB12-LCPhys)</i></p> <p><i>Having worked in the NHS in England, I feel that NHS Scotland has maintained a more healthy culture amongst clinical teams and the relationship with management is more effective and harmonious in (goes on to elaborate the difficult climate). (FT-LCSurg)</i></p>
		<p>Developing integrative solutions and reframing mutuality as a virtue</p> <p>(adding to identity)</p>	<p><i>Deference to consultants is long gone – and that is not necessarily a bad thing; as long as consultants speak out on behalf of patients and not just our historical position, we will continue to have a valued place within the NHS...(FT-LCPhys-ML)</i></p> <p><i>There's the two extremes, I guess. You know, the very critical person, who checks everything that you're suggesting, and then the other person, who is, um, "Whatever you say, Doctor," and just do it. So there is these two extremes of person....That's a very important part to patient care, if you open up an avenue of discussion... we're talking about patient-centred care. You're trying to respect their wishes, as much as you can – and their habits, their character, I suppose. (IntA1-ECPhys)</i></p>
<p>Self-esteem enhanced by being seen as leaders of new medical professionalism and healthcare reform.</p>	<p><i>They wanted somebody who would step up to a leadership role but at the same time wouldn't, would rock the boat but in a nice way, if that makes any sense ... the thing that was important to me was being a team player ...at the same time, I was somebody who wanted, had a very direct vision that I wanted to deliver. (IntA19)</i></p> <p><i>So we're working hard on being more recognised ...we have a good few young Consultants here, who are very dynamic ...One, in particular, is an excellent, um, Manager, you could call him, almost. He's got a very good understanding of the NHS politics, and government politics, and he's a very good advocate (IntA1-ECPhys)</i></p> <p><i>Effective leaders are critical to the way medics relate with managers. What happens to people that we draw in the best school leavers, who have so much leadership potential, and 20 years later this has all disappeared. We need to think much more about how to ensure that medics are trained and enabled to become effective managers. (FT-LCPhysML)</i></p>	<p>Discrediting traditional medical professionals</p> <p>(adding to identity)</p>	<p><i>My eyes have been opened by what I've seen in medical management: huge efforts to engage with consultants and appalling behaviour by doctors (Free text comment, medical leader).</i></p> <p><i>...it was just devastating actually because [senior doctors on a development programme] sat ...it was this tale of woe that nobody was coming to them and asking for their help and support, and they had all of this extra knowledge and nobody wanted to hear it. ... There was this business of waiting to be invited in, whereas my experience had always been, see the problem, map out two or three potential solutions, because if you think you've got the right solution first time you're nutty. Naive probably is the better word to say (laughs). (IntA19-MCPhysML)</i></p> <p><i>You definitely hear all grades of clinical people moaning about managers. ... (but) it's the balance I mean everyone likes to think they make the right clinical decisions but if we're completely left to it and we don't have the checks of the structure, the protocols in place things will get missed (IntC7-MCPhys)</i></p>

Table 5 – Overview Analysis of Traditionalists and Incorporated Interviewees

	Consultant IW Category	Traditionalist	Incorporated	Totals
	Overall Count	44	20	64
Career Stage	Early-career (0-4 years)	5	6	11
	Mid-career (5-9 years)	11	5	16
	Later-career (10+ years)	28	9	37
Broad Specialism	Physician	21	9	30
	Surgeon	12	5	17
	Psychiatrist	7	1	8
	Other	4	5	9
Formal Leadership Experience	Yes	4	5	9
	No	40	15	55
Type of board	A small remote/island board	2	1	3
	Medium-sized mixed board	16	12	28
	Large urban board	24	7	31

**Please note that due to missing data, four of the original 68 interviews were removed from this analysis*