Narrative identity work in a medical ward - A study of Diversity in health care identities

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ABSTRACT

A recent debate in identity studies is about gender of health care professions arguing that the feminization of health care professions will diminish diversity as well as status in the field. The paper argues that even in health care professions of many females, such as within public rehabilitation, there is still diversity in the creation of professional identity. This paper argues that the fundamental part the identity of rehabilitation professionals is not formed by educational values, gender and knowledge, but is created in the everyday work with patients and other professionals. Drawing on narrative interviews with rehabilitation professionals, the paper illustrates how rehabilitation professionals construct their identities and what kind of identity work is emerging. The findings illustrate hybrid identities and tensions in the attempts of becoming identities in the interaction with patients and colleagues. Key words: Identity work, heath care professions, hybrid identities.

INTRODUCTION

There is a large body of research attempting to describe the educational values of health care professions, and the combats over different kinds of health care values. A recent issue is gender in the health care professions arguing that the feminization of health care professions will diminish diversity as well as status in the field. The paper argues that even in health care professions of many females, such as in public rehabilitation, there is still diversity in the creation of professional identities.

Recent studies of organizational identities have applied a narrative approach to understanding the construction of identities that reaches beyond organizational formalization and concerns both individuals and organizational identities (Gabriel 2000, Czarniawska 1997, EGOS book, Brown & Humphreys 2002). The paper is an attempt to bridge a personal and interpersonal focus of identities by illustrating multiple organizing identities.

In a hospital context, identity research has primarily focused on the identity of individual health care professionals. This research has supported a formal identity formation influenced by education, knowledge and moral authority (Freidson 2001, MacDonald 1995). Earlier identity studies have traditionally focused on the identity of either physicians (Jespersen 1996, 2003, Hunter, 1991, Kleinman, 1980; Loewe, 1998; Sharf, 1990), nurses or other health care professionals (Sehested 2002; Burrage & Torstendahl 1990). Few narrative studies have focused on patient stories and identities (Bury, 2001; Frank, 2000; Garro, 2000). Even fewer studies have focused on how group identities are relating to each other (Mattingly, 1998a, 1998b; Mishler, 1984, Eggy, 2002). Despite of all the identity studies conducted in the context of hospitals, we lack identity studies focusing on the multiple and informal ways of creating hospital identity that highlight relation between the personal and organizational identities.

I want to expand the existing body of work on identities by focusing on the how both organizational and personal genre stories contribute to create identity work in hospital settings. The argument is that professional identity is a not a given position based on education or status but is created in an ongoing

identity work. The research question in this paper is: what kind of identity work is going on during the everyday working life of rehabilitation professionals when interacting with patients and other professionals? The contribution of this study is thus to elucidate the process of identity work of health care professionals and extent the understandings of identity work as a creative, never ending process that does not function as a control instrument.

NARRATIVE IDENTITY STUDIES

The theoretical framework of this study is rooted in theories of organizational sociology and in theories of identity construction (e.g. Albert and Whetten, 1985; Albert et al., 2000; Pratt and Foreman, 2000; Gioia, Schultz and Corley, 2000) and, more specifically, theories on narratives (Czarniawska, 1999; Gabriel, 2000; Boje, 2001).

Identity bears a great power. Whetten and Albert (1985) ask a very simple, but important question: who are we, and what kind of firm is this. Since then this has been one of the core questions of many identity studies in organization literature. Whetten and Albert characterize organizational identity as a self-reflective question of tree main features: Organizational identity is what organizational members take to be central to the organization, and what makes an organization distinctive from others organizations, and third what the members perceive to be enduring and continuing feature linking the organization with the past and the future (Albert & Whetten 1985; Goia 1998). Thus, some of the first studies of organizational identity mainly focused on the internal life of the organization in terms of organizational culture, and how it created certain values and norms shaping the organizational identity.

A narrative approach to identity studies tries to understand how specific actors discursively position themselves through specific conditions of possibility and constraints. Instead of assuming that organizational identity is exclusively about that, which is central, enduring, and distinctive, the paper emphasizes the work efforts involved in the performance of identity stories. The purpose of applying a narrative perspective is to achieve two goals: 1) to get away from an essentialist view on identity that may be read into the three defining characteristics where you easily get the impression of a core, of a substance that is somehow at the bottom of what an organization 'really' is, and 2) to draw attention to the performative aspect of identity construction and to the notion of narrative identity as an ongoing and never ending process of construction. In this view, the answer to what we are and who we are as an organization is to be understood in terms of the way in which the ongoing narration proceeds. With the ambition of coming to an understanding of professional identity in contemporary society that understands itself as fluid, there seems to be a great need for working towards a conceptualization of an approach to identity that is thoroughly processual.

The idea that narratives matter in understanding organizations and organizing has already been emphasized in various organizational studies (Martin, 1982; Martin, Feldman, Hatch and Sitkin, 1983; Weick and Browning, 1986; Boland and Tankasi, 1995; Fineman and Gabriel, 1996; Czarniawska, 1998, 1999; Gabriel, 2000). Gabriel (2000) explores the idea of narrative genres and poetic tropes and how these can be used as an interpretive device in trying to understand the ways in which different members of organizations make sense of events in everyday organizational life. Many narrative researchers in the field of organization and identity have been analyzing narrative the genre of comedy, tragedy and romance (Downing, 1997; Gabriel, 2000; Grant, Michelson, Oswick, & Wailes, 2005) in their work with organizational stories.

In his work, Gabriel (2000) contributes with knowledge about interaction between managers and employees, and how they are making sense of the workplace and how stories reflect emotions. One of Gabriel's examples of

this is a kitchen assistant who commits suicide in the workplace. This tragic event affects his colleagues; they gradually incorporate the event into their stories about poor management and thus make the latter responsible. The example demonstrates how myths flourish in organizations and co-construct the storyteller's understanding of the identity of organizations. Gabriel defines organizational stories as types of sense-making devices; focusing on storytelling in a narrow sense with simple, but resonant plots and characters, involving narrative skills, poetic tropes, entailing risk and aiming to entertain, persuade, and win over (Gabriel, 2000:22). Gabriel is arguing for the simultaneous uniqueness of organizational stories that are embedded in a specific organizational context and their similarity to other forms of storytelling[8]. Throughout life, Gabriel argues, we are socialized into specific ways of telling stories that are determined by our upbringing and cultural values.

Recent studies of identity have been suggesting that identity is not a given position. In post-industrial times, there are far fewer identities given, but more identity options and more tolerance of identity diversity, which results in processes where identities change over time (Albert, Ashforth and Dutton 2000). In effect identities are negotiated both inside and outside organizations.

Different issues that reflect this kind of identity formation have been unfolded in the recent literature on organizational identity. One of the important topics has been the multiplicity of identities (Pratt & Foreman 2000), focusing on how managers handle multiple organizational identities. The organizational researcher David Boje has also investigated this theme through his idea of *multiple voices* that has also informed my design. Boje points out how stories reflect the organizations in which they exist. Emerging and dynamic organizational forms, for instance, create incomplete stories: "People are only tracing story fragments, inventing bits and pieces to glue it all together, but never able to visit all the stages and see the whole," (Boje, 2000:5). Boje installs in his work the idea of multiple voices, when he argues that a story should not necessarily be based on the wholeness of the event. Organizational stories often differ from the classic literary ones that are the focus of narrative studies: organizational stories are often oral, and they are highly colored by the organizational context in which they are told.

It is the very dialogic and becoming aspect of identity that makes it so obvious why identities are so much more fragile and potentially ephemeral than we usually take them to be. For this purpose, the paper suggests the notion of narrative identity work. Thus, identity-work connotes the belief that there is a whole lot of story work involved in performing an identity. Identity is not simply there, ready to be unfolded, discovered, or whatever metaphor one might use to suggest that the essential identity is already there, whether hidden or not. On the contrary, there is a lot of story work involved in the production of identity.

RESEARCHING REHABILITATION PROFESSIONS

The empirical material is from a European context, more specific collected in one of the Nordic countries, Denmark, which is characterized by large public welfare institutions. Professionals have played a crucial role in the development of the welfare state populating administrative bodies and institutions (Johnson 1995). Professionalism and bureaucratization have been intertwined in order to avoid conflicts and to secure stability, continuity and consensus in the production of welfare services (Sehested 2002; Jespersen 1996; Burrage & Torstendahl 1990). The professional bureaucracy thus became the institutional framework for professional work.

Over the last 10 years professionals have witnessed significant changes with the numerous waves of reforms in Danish public

institutions. New Public Management is one example, but its influence is moderate in Denmark compared to other countries. The traditional professional and functional bureaucracy as an institutional basis for the autonomous professions is challenged. One challenge is entrepreneurial management models e.g. auditing and controlling mechanisms for professional work (Klausen & Michelsen 2004; Dent 1999, 2003, Halford 1999, Moos *et al.* 2004). Another is democratic models that increasingly involve politicians, users and citizens in the principle matters of the institutions (democratic reforms, e.g. through user boards and political management by objectives) (Sehested 2002; Jespersen 2005; Laursen et al. 2005).

Qualitative and quantitative studies of professionals in Denmark document that there are common trends in the development of professional identity. Professionals have generally transformed their identity, shifting focus from the profession-bound identity to a more fragmented identity discourse characterized by loyalty towards both management reforms and traditional autonomy, thus new hybrid professional discourses are forming, where professional identities are not given, but are narrated and negotiated (Jespersen 2003). This study is following the described tradition and is trying to illustrate the new roles of the professionals. The stories presented in the following section were gathered during field studies in a physical rehabilitation ward in a Danish hospital, Esbønderup (located in the countryside north of Copenhagen). The ward is responsible for the rehabilitation of patients after treatment in orthopedic, rheumatologic, medical and neurological wards. The patients are often amputees, arthritis patients, those coping with cerebral hemorrhage, or injuries sustained in a fall. The ward is staffed by a head nurse, a physician, nurses, social assistants and assistant nurses, approximately 20 employees in total. The employees also include a counselor and a number of occupational therapists and physiotherapists; these are located in other clinics, and only attend the rehabilitation ward when required.

The fieldwork included observations and interviews over a six-month period. The first part included three months of observing participants' everyday life in the ward, following day and night shifts and meetings. The idea of spending so much time in the ward before the interviews was to become familiar with the employees, their daily routines and uncover organizational themes bottom-up (Bogason & Sørensen 1998).

The data concerned twenty in-depth narrative interviews with the employee groups at the ward. Observations and daily conversations with employees were also used to help select the interview persons. These included four nurses, two social workers, an occupational therapist assigned to the ward, two patients, two managers of the ward, the two physiotherapists, the social counselor, a developing nurse assigned to the ward, one physician, and four nurses coordinating discharge meetings with the ward on behalf of the municipality. All interviews were taped and transcribed.

The table below gives an overview of the narrative interviews:

Theme Interviews	*Amount of Ward interviews*
Personal identity stories	Social workers 2 Nurses 2 Physician 1 physiotherapists 2 Ergo therapist 2 Social counselor 1
Interpersonal identity stories	Physicians 2 Nurses 2 Social workers 2 physiotherapists 2 Ergo therapist 2

The table illustrates the sample of stories about the identity work and the number of people interviewed in the two sections.

The narrative interviews addressed ordinary events in the everyday life of the

employees, who determined all the interview themes. The opening requirement was: "tell us about your day, from when you meet in the morning". The interview technique served to induce storytelling (Czarniawska, 2003).

We identified two types of identity stories:

Types of identity stories at the ward:	Stories of the workers and patient relationship	Stories of colleagues and interpersonal relations
Events:	Encounter with patients	Meetings with colleagues
Relational dimension	Personal	interpersonal

Observing the daily life of the staff two events we identified to be of greatest importance as all interviewees referred to them: meeting the patients – this might be in training sessions, rounds or when washing them or just talking them to lunch; meeting colleagues at formal conferences, multidisciplinary meetings or management meetings; meeting people from outside the ward at e.g. discharge conferences with municipality representatives or communicating with staff in another local hospital.

The findings were verified and reported during a meeting with the ward staff. This meeting confirmed and expanded the understanding of identity work. The briefing was not a formal research meeting, but rather an informal dialogue with the employees.

In each of the following sections several stories are presented to illustrate the findings. The stories are typical and therefore representative for the stories collected in the study. In the first section all the stories of the health workers refer to Mary. Mary is a fictional name - a representative of the concrete patient they are talking about. In many of the stories Mary is the same patient, and the stories thereby illustrate that there are many different ways of relating to the same patient. In the second section all the stories refer to the multidisciplinary meetings in which we participated as observers several times.

The last story appears in Appendix 1. It's an observation story about the first days of a patient's (Mary) life in the rehabilitation hospital. The aim of this story is to open up the black box of all the meetings and details of everyday life in a rehabilitation ward.

BEING PROFESSIONAL BY BEING "UNPROFESSIONAL" WITH THE PATIENTS

Previous narrative studies of relationships between professionals and patients have traditionally focused on either physicians (Hunter, 1991) (Kleinman, 1980; Loewe, 1998; Sharf, 1990), or patient stories (Bury, 2001; Frank, 2000; Garro, 2000),). Few studies have focused on how these groups relate to each other (Mattingly, 1998a, , 1998b; Mishler, 1984) (Eggy, 2002). Garro & Mattingly are arguing that within a narrative approach it becomes possible to understand how individuals acquire narrative skills and how theses skills are culturally embedded. (Garro & Mattingly, 2000:25).

In Esbønderup Hospital the meetings with patients are very informal. It is not only the physicians who meet with the patients during the day, but also nurses, therapists, and other professions (social chancellor about home equipment) in order to uncover training problems and social problems due to rehabilitation programs. During the first days, the patient talks with several professionals, in training sessions, and in the ward trying to cope with everyday actions (eating, washing, etc.). The meetings with the patient form the basis for storytelling work among the employees in the ward and how they make sense of these meetings. The following short stories are showing different kinds of story work, allowing employees to make sense of their professional identity related to their relations and interactions with patients.

Jane's (therapist) story:
If I were to characterize the good professional in a few words it would be revealing to the patients who you are. I

don't mind if the patients know where I live, how many children I have, and what I am doing in my leisure time. I find that sharing your life with the patients gives you a particular knowledge that may prove beneficial both to yourself as a professional and to the patient. This does what some psychologists call constitute a shared third. Sharing, for instance, my love of music with Mary means that when she is being discharged I can tell her where and how she can attend concerts even though she is walking-impaired. I have thus been able to help Mary with something that I think is of great importance to her, but which we would never have discussed had I not shared my interest in music with her. If I had only spoken with her about how to get dressed, cooking, shopping and such things that most physiotherapists discuss with their patients, I would never have learned about Mary's interest in music – it would never have emerged as a theme for discussion. However, others would probably call me rather unprofessional, especially when it comes to patients that I am treating over longs periods. I share my thoughts and life with the patients, and I know that some of my colleagues find it a bad idea. But for me it is important to reveal who I am and to integrate the many aspects of my personality into the relationships that I am part of. I could not be physiotherapist Jane Petterson without telling my patients about myself. If I did not I would no longer find the job exiting.

Sofia's story:
My meeting with the patients differs from that of other professional groups as my approach to the patients is social while that of the other professional groups is physical. I am always careful to speak with the patients in private as social issues are very delicate and some patients are coping with so great problems that they are hardly capable of participating in a rehabilitation program. Therefore it is important to clear away some of the problems and enable them to relax. Professionally I find it important to keep patients at arm's length. You have to adopt this professional attitude as you are the patient's straw, and if this straw sways with the patient it is of no support to him or her. However, keeping emotional distance is not equal to being disengaged or reserved. It merely means that I do not voice my sympathies and antipathies to the patient, because such expressions may impede the patient's development process. Making friends with your patient may result in situations in which the patient experiences a loyalty conflict toward the relations she is part of. In such situations you would not be able to help her to go on – you would keep her from it. If I had not kept a reserved attitude toward Mary, but had agreed with her stories about her husband and their relationship, it would probably have been difficult for her to return to me and tell me that she had decided to make it work. She would have experienced a conflict between keeping a relation to me at the same time as she had changed her mind. I think that you learn this art over the time.

Peter's story:
Meeting the patient is about spaciousness. I think that it is important to be kind, open and accommodating toward the patients, recognizing that the situation is difficult for them at the same time as we focus the interviews on their resources. With spaciousness I mean a special attitude like the one that Karen, for instance, displays towards Mary. I am sure that Mary feels that Karen is listening to her which is why Karen soon establishes a relationship of trust with her, which is a good start on the future training. I also think that the ways in which we have arranged the dining facilities contribute to the good relations among the patients in the ward. It is my experience that when patients have overcome their scruples about dining with the others in

the dining room, they can also do other things that they did not think capable of. They flourish and discover that they have much to give to others. When I talk with the patients over the dinner it is a way of learning about them. I try to identify the kind of resources reflected in what they are saying or doing in order to find strengths that can be used. It is in social situations in particular that it is easy to detect the patients' resources, and I think this is telling of how the patient manages his or her situation and how he or she will manage when returning home.

Inge's story
I regard the concrete meeting with the patient as closely tied to my experiences within the profession. Being a senior and experienced nurse who has met many different patients and their different problems over the years, enables me soon to recognize and define problems with new patients. They remind me of something I have seen before, and I use my experiences actively when meeting new patients. Spending time with the patients and being attentive to their problems no matter how big or small they are is for me the core of being professional. Today I involve myself much more than when I was younger and over the years I have become much better at advising and guiding the patients. In my opinion a good professional must have the courage to talk with patients about things that are inappropriate. For example, I find the economic relations between Mary and her husband highly unfortunate. I would not be taking properly care of Mary if I neglected her remarks on the pretext of this being none of our business, she must decide herself, it is a private matter, etc. Medication, for instance, is a very sensitive issue both among patients and among nursing staff as patients reacts very differently to pains and to medicine. In my view it is not enough, as a nurse, just to give the patients the medicine they are asking for. I would not give in to Mary's request before having tried other solutions to alleviate pains. I let the patient know that I feel sorry for his of her pains in the back, and that we must find a way of alleviating the pains, as more medicine will not help. In that way I tell the patient, without giving in to her request for medicine, that I understand the request and her pains. This may result in that she feels stronger when she experiences that we can relieve her pains in other ways than by medicine.

In Esbønderup hospital story work is, as Boje argues, emerging when people are tracing fragments of stories, inventing bits and pieces, which they glue together. However, they are never able to grasp all stages and see the whole (Boje, 2000: 5). In the same manner, all these stories represent different understandings of professional identities. None of the stories are grasping all stages of becoming a professional, by relaying to management discourses (entrepreneurial /bureaucracy or governance) or educational discourses (medical discourse, or illness discourse). They are all telling about how they meet the patient in a way that works for them in their everyday working life.

The identities reflected in these stories are not based on educational backgrounds. We have stories like the one Janne tells from both physicians, nurses and social workers, and we have stories like the one Inge tells from therapist, physicians and social workers. Across educational background the study identifies four different kinds of identity stories:

Identity work between professional and patients
Intimacy stories
Distance stories
Spatial stories
Supportive stories

The table illustrates the different kind of stories we meet in the ward. The four types are not generic genre. Some professionals used the

term nearness to describe their professional relations with the patients. Others used distance to become professional partners, and a third group used the term space to illustrate their professional identity. Yet others focused more on their decision making for the best of the patient, not only listening to them, but also advising on difficult issues, such as medicine abuse. The four themes should not be seen as contradictions, but as different elements in a larger multi-voiced professional discourse.

BEING THE "RIGHT PROFESSIONAL" BY TELLING ABOUT OTHERS' IDENTITIES

At multidisciplinary meetings, health care professionals attempt to plan and coordinate patient treatment. The premise of interaction at such meetings is that all dialogues and all participants are important in creating patient plans and identities. In rehabilitation hospitals, multidisciplinary collaboration is playing a crucial role, due to the patients being treated by different professionals: physicians, nurses, and therapists.

The multidisciplinary meetings at the rehabilitation hospital were structured according to the number of patients and case records addressed during the week, focusing on the patients' treatment plans. The meetings always included the ward nurses and nursing staff, the physicians, and therapists, in total ten to fifteen people. A senior nurse, the head of the ward, was the informal chair of the meetings. She started the meeting by presenting the patients of the day. When each treatment plan had been discussed, one of the physicians would record the medical plan.

The weekly meetings became the visible interacting and story-making place for the different professionals at the hospital ward. According to Weick, meetings are one way in which the organization can render itself visible to its members. At the same time, meetings also furnish individuals with an opportunity for making sense of what they are doing and saying (Weick, 1979:133). So meetings offer organizational members an opportunity for making sense of what they are doing.

Nurse story
Sometimes I get really upset with these meetings. The physiotherapists are forcing their opinions on us while we in the nursing group try to collect our thoughts and contemplate what to say. We are far from being good enough at bringing our professional reflections into the dialogue at the multidisciplinary meetings. On the other hand, we cannot drag out the meetings because we find it difficult to voice our opinions. But it is difficult to penetrate the dialogue once the physiotherapists have started to talk. Sometimes it is as if they are merely delivering their opinions to the physician whereupon they rush out of the door with the excuse that they have to attend to patients. I sometimes find that the physiotherapists are uninterested in the tasks of the nursing group and our contact with the patients. I sometimes get the feeling that they see our efforts as 'a dumb job'.

Physician's story
In some situations, this behavior is rooted in the remains of old power struggles between the physiotherapists and the nursing group, but you also see it in other contexts. A few persons are carrying on this old struggle. It is not a question of different attitudes toward the patient. It is a genuine struggle over the power to decide according to the patient plan. You feel this power-struggle at the meetings where is becomes a question of who is capable of getting the upper hand – of pressing his or her opinion through and getting the others to bite the dust. Power struggles are devastating for the good spirit of collaboration.

Nurse story
In the wards where I used to work, the physicians always had the last word at the meetings, and they were extremely

domineering compared to other professional groups. But in this hospital, attention is paid to all professional groups and their views taken into consideration. However, multidisciplinary (organization) entails more then merely listening to one another; it requires close dialogue, which is not yet the case at our meetings. The problem is not only one of different attitudes toward the patients, but also of ownership – who owns the patient? If you ask the physician, it is his or her patient, because she has the right to prescribe treatment, rules over the patient record and possesses the general view of the patient. If you ask the nurse, the patient is hers because she is taking care of him or her all day long like a mother. If you ask the physiotherapist, she or he has ownership as the patients come to this group for rehabilitation, which is the major issue. Perhaps the reason why we cannot join in a common dialogue is that we are thinking too much in terms of ownership and each of us want to do different things for the patient.

Physiotherapist story
I find the nurses rather weak at the meetings, and I think it has to do with their tradition of leaving it to the physicians to speak. However, this weakness prompts the physiotherapists to take the lead, which renders collaboration extremely difficult when we have to reach common decisions. This situation is highly regrettable as the nursing group could contribute with many valuable observations from the daily interaction with the patients. These observations are extremely important to our work. For example, when discussing amputation patients at the meetings, the nursing group often leaves it to me as a physiotherapist to tell the patients about the size of the stump, training with the artificial limp, and different dressing, while other issues, such as personal hygiene or removal are not discussed. In effect it is my contact with the patient that comes to represent the major input at the meeting. But in most cases, the nursing staff is actually spending much more time with the patient and presumably has a better knowledge of him or her.

In the stories, the authors are referring to "the nurses", "the physiotherapists" and "the physicians" as three different interpersonal identities. The table below illustrates the identity work:

	Traditional stories of therapist	*Battle stories of physician*	*Status stories of nurses*
Nurse identity	Passive nurses due to historically conditions	Old battle with therapist about the patient	We have the least valued job
Therapist identity	Therapist in command because no one else is	Old battle with nurses about the patient	Tell their stories to the physician, rush out of the door.
Physician identity	Are used to leading the conversation at meetings	Trying to listen to all arguments and include all professions	Appears as main audience of therapist stories.

The table shows how "they" and "we" are constructed and retold in different stories, where different group identities are at stake. The nurse presents one identity in terms of nurses performing the least valued jobs and status. The physiotherapist describes another nurse identity: nurses have difficulties in

voicing their opinion, because they are traditionally and historically used to being subordinated the physicians. The physician describes the nurse identity in relation to a old power battle with therapist. The silence of the nurses is thus related to three different nurse identities: performing the least valued job, historically being silence and as the result of a power struggle. All find the silence regrettable and resulting in deficient information about the patients.

When stories relate to other stories they also relate to other constructions of identities. The identity work in and after the meetings are related to the groups of participants in the meetings and thereby the interpersonal identity work.

The stories illustrate how different identities act at these meetings and allow different kinds of identity work emerge from the meetings. The identity work is not based on reaching a common understanding of one's own profession, but is used to created story work about other professions and explains how and why they interacted.

Each professional group feels that they play the leading role in treatment of patients and is thus deaf to the voices of other groups and their perspectives on the care and treatment of patients. Thus the identity work is presented as a likely battleground. Abreu et al. (2002) support this conclusion in their description of the collective identity of patients that emerges from the discussions among professionals during the meetings. Because the patient is only represented in the form of a case record, and cannot present his or her own identity, the dialogue risks turning into a battle over whose professional identity is most appropriate for helping and understanding the patient. The combatants are representatives of the groups of physiotherapists and of nursing respectively. The stories illustrate how identity is relational, meaning that nurses, physicians and therapist define identity differently. Identity work is thus a relational process through which colleagues negotiate and do story work.

DISCUSSION OF DIVERSITY AND IDENTITY WORK

Often more traditional studies of identity are focusing primarily on the organizational identity or the formal professional identity. The contribution of this study is to enlighten the process of identity work that goes beyond these distinctions and illustrate how organizing identities are constructed through many processes of personal and interpersonal relations. The concepts of organizing identities are thereby supporting a view of identity as a relational process, that bridges collective as well as personal identity work. This study supports Gergen's argument that identities are never individual but relational phenomena (Gergen: 1994: 209).

The findings show that even if a profession is characterized by predominantly women or men, there is room for diversity in the identity process. The study thereby rejects the arguments that more female employees in health care are leading to similar values and identities and thereby creating constrains on identities work. The study illustrates how even in a small hospital and in a ward with only female employees, there is still a great deal of informal identity work going on.

Identity work	**Becoming personal identities**	**Becoming interpersonal identities**
Interacting with	Me and Patients	We, them and colleagues
Place and time	The patient room	The internal meetings
Hybrid stories	Personal stories of becoming professional by intimacy, guidance or distance and trust.	The interpersonal stories of becoming professional by battle, tradition and status.

The table also illustrates how several identities are emerging: the intimacy stories, the distance stories, the trusting stories, and the guiding stories.

There are also different characters in the stories; the patients and the colleges and "me" and "us". They are using words: I and Mary in their personal stories and "they" and "us" in relation to meetings with other professionals. The personal stories unfold identity work by personal relations with patients about. The

colloquial stories unfold identity work through group relations with colleagues using us and them.

The stories also highlight the role of the dimensions time and space in identity work. Thus the patient encounters and the formal meetings in the medical ward are not just routines, but important sense making events during the employee's working day, demonstrating how identity work is linked to the dimensions time and space in organizations.

The analysis furthermore illustrates how employees' identity work are hybrids including, for example, having personal intimate relations with the patients, considering the job to be menial, or guiding patients by personal experience and being at war battle with other professions. These storylines are not contradictory; they support an understanding of identity as an ongoing performative process. This paper argues that there is a need for moving beyond attempts to describe professionals as stable, homogenous groups with the same identity based on educational background and gender.

In the stories of the rehabilitation professionals several factors contribute to their identity diversity. The same patient will talk about professionals showing warmness and intimacy and being reserved and keeping distance. The stories suggest that some rehabilitation professionals fell that they have to become "unprofessional" to be professional in their interaction with the patients. Others describe how multidisciplinary meeting are important organizing events during the workday that make space for relational identity work among professionals. These results show that we should not ask; what is the stable and unique identity of rehabilitation professionals, but rather ask how rehabilitation workers are becoming professionals through their hybrid identity work.

CONCLUSION

While we know a great deal about organizational identity and image (Gioia, Schultz, Coley 2000) the every day narrative aspects of work identities in organizations are unexplored. This is especially the case within the hospital field where previous analyses have paid little attention to narrative identity formation (Borum 2000). This paper has suggested an empirical analysis of the narrative identity work in a hospital ward. The argumentation was that the notion of narrative identity work provides a useful approach for narrative analysis of professional identity work. The analysis has demonstrated how this approach helps focus on the personal as well as relational aspect of identity formation in storytelling, and revealed the dynamic process of identity work that previous research has described in primarily theoretical term.

In particular the analysis demonstrates the two dimensions of stories: the personal and interpersonal relations. Paying attention to these different dimensions allows us to see the ways in which work identities are created and produced at the ward level through employees' relationships with patients and collogues. This perspective adds to previous studies that have not specified how concrete identity stories are emerging in hospital settings. Revealing the story work also makes is possible to uncover elements in the stories which are specific to context, time, and space, concepts to which previous studies have paid little attention. Furthermore, the analysis helps understand the fragmentary nature of identity stories, and that health care workers have many different ways of relating to patients, showing the importance of subjectivity where the formal education and the professional affiliation (doctor, nurse..) have no influence on the relationship with patients and colleagues. These stories are thus illustrating the unmanaged space in the hospital where the workers are free to relate in different ways to patients and to tell informal and creative stories about their relationship with patients and colleagues disregarding the official discourse.

One limitation of the study is the neglect of the role of identity work going on outside the hospital. Mishler and others have illustrated how identity work also is being made in life stories and embrace life conditions outside the hospital context. Another limitation is the focus on only one hospital ward and the identity work taking place here. Similar studies could be made in other hospitals in other countries or regions to compare the everyday negotiations and conditions that influence identity work.

While the paper has specified the role of narrative identity work, there are issues that need be scrutinized in the future research. The paper does not include and discussed the performative role of the storytellers or at the importance of time and space in the stories. In some of the stories the author's name is presented but no information is given about the performative ways in which the stories are being told. This is an element of storytelling that is very important, but about which we did not write down any data. This paper has, however, opened up the analytical view of narrative identity work that could be extended further in theoretical papers on the influence and importance of narrative time and the performative storyteller.

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APPENDIX 1

An observation story of Mary's first days in the hospital

This morning nurse Karen welcomes a new patient. Mary is in a wheel chair and has been hospitalized several times in different hospitals before coming to Esbønderup for rehabilitation. Karen greets and welcomes Mary who returns her greetings. They enter the sitting room and Karen closes the door behind them in order for them to talk in private. She asks Mary to tell what has happened so far. Mary tells that sometime ago she fell and broke one of her elbows. Currently her hip is giving her great pains. Mary is very attentive to what is going to happen with her in the rehabilitation ward and she complains about the way in which the hospital has treated her. Karen lets Mary talk and occasionally ask her for information that she needs for filling in the reception papers. She does not interrupt Mary even though she is repeating herself over and over as she seems to be in need of talking. In the end of the conversation, Karen tells Mary that later that day Sofia, the councellor, and the physician Connie will come to see her. The following day she will start ergotherapy with Jane.

The next morning nurse Inge rouses Mary. Inge is attending to Mary during her first week at the rehabilitation center. She listens to Mary and is attentive to some of the small signs of problems. While Inge potters about in the room and helps Mary getting dressed, Mary remarks that she would love to get a magazine from the kiosk. 'But my husband did not give me any money', she says, 'but he will probably come on Sunday'. Inge reflects on this remark.

After breakfast Mary is starting ergotherapy with Jane. Jane receives her with a smile saying, 'hello Mary, good to see that you made it. We are located a little away from the ward'. She tells Mary that before they start, she wants to see how much Mary can do with her arms. 'Try to raise your arms as far as possible above your head', says Jane and watches carefully. Mary is now going to train with small dumbbells and a double pillow which makes her tired and short of breath. 'Is it too much?' Jane asks but Mary says that it is ok. Jane notices that something is wrong with Mary's wheel chair – one of the arm rests has been turned around. Jane asks Mary if she feels comfortable with the arm rest, and Mary says 'no, but I did not know what was wrong'. 'I will fix it', Jane says. Mary gets the double pillow with her back to her room so that she can continue training outside the hours she spends in the ergotheraphy. Jane asks Mary if she has any problems or there is anything that she needs. Mary tells her that yesterday she spoke with the councellor about aids and she cannot understand why she has not been given the aids that she has applied for as some of the other patients that are not worse off than she is have been granted the aids. Jane tells her that the rules for receiving aids differ depending on which municipality you are living in. Jane promises to look into the matter, which makes Mary happy. The ergotheraphy is over for today and Mary and Jane say goodbye.

When Mary returns to the ward, she rings the bell and Inge arrives in her room. While Inge helps Mary visit the lavatory and asks her about the day, Mary once more says that she hopes her husband will turn up on Sunday, as she would like to get some money.

Inge recommends Mary to tell her husband that she would like to get some money as there are things that she would like to buy in the kiosk. 'If you want to, I can be here and help you talking to your husband about it, as I know that it might be a delicate issue. Mary says that it is not necessary, but talking it over again they agree that it might be a good idea for Inge to talk with him.

Mary soon settles down in Esbønderup. Most of the patients get to know each other as they are spending a long time in the place. Especially during the meals – and in particular the dinner at 6. p.m. – you feel that the patients are familiar with each other. They sit in small groups at the round tables, and usually it is the same people that join each other and talk over the

dinner. While the patients find their tables, the nursing staff is busy bringing in bread and cold cuts and serving the warm dishes or soup to those patients that prefer this. It is important that the patients eat properly if they are to have sufficient energy to manage training, and Peter, the head of the ward, is very attentive to what and how much the patients eat.

How much the patients talk during dinner differs. At one of the tables are Per, John, Bent and Jelene. They are not talking much, but are quietly eating. At another table are Mary, John, Terry and Lulu talking. The nurses are now finished helping the patients at sit down at the tables to get something to eat. They talk with the patients about what has happened during the day, how their families are at home and about things that are particularly difficult.