From Lone Wolves to Members of the Pack: Exploring interpersonal identity work within identity workspaces

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Summary

Individuals can experience the urge to realize their desired work selves, inspired either by the 'roads not taken' in the past or positive images of the self in the future. Based on a qualitative study of healthcare professionals working in Italian community hospitals, we develop a process model of how communities of individuals who are unable to enact their desired work selves in their current occupations, create new entities to act as identity workspaces to host their identity work. They may do so even if they hold different desired work selves, engaging in interpersonal identity work. The processes of identity work and collective creation of an identity workspace are intertwined since the identity work of one individual is in an ongoing dynamic relation with the identity work of other individuals. People converge to play out their desired work selves in an identity workspace which is supportive. However, the heterogeneity of the desired work selves involved can lead to the individual's identity work encroaching on the identity work of the others, and this heterogeneity results in impasse. This impasse is resolved only when individuals engage in interpersonal identity work, through mutual exploration and enactment of expanded work selves in an enabling identity workspace.

Keywords: *alternative self, desired work self, possible self, collective processes, interpersonal identity work, identity workspace, identity co-construction*

1. Introduction

The pervasiveness of the experience of work in people's lives means that people hold beliefs about what they should achieve in their work and the way they should develop as professionals throughout their careers (e.g., Wrzesniewski & Dutton, 2001; Wrzesniewski, LoBuglio, Dutton, & Berg, 2013). In turn, how people define and develop themselves has positive consequences for their wellbeing and performance. As a result, scholars have long been interested in understanding how people construct their work identities and engage in identity work processes, i.e., the activities that people carry out to attain, repair, sustain or strengthen a coherent sense of self (Snow & Anderson, 1987; Sveningsson & Alvesson, 2003), and the various types of social relationships, resources, and contextual conditions that may support or constrain them in this endeavor (e.g., Ibarra, 1999; Pratt, Rockmann, & Kaufmann, 2006; Snow & Anderson, 1987; Sveningsson & Alvesson, 2003). As contemporary careers become more fluid and the influx of emerging occupations increases, individuals are able to envision repertoires of desired work selves which they are driven to enact (e.g., Barley, Bechky, & Milliken, 2017; Murphy & Kreiner, 2020; Obodaru, 2017; Petriglieri, Petriglieri, & Wood, 2018; Strauss, Griffin, & Parker, 2012). This is making a better understanding of these issues especially relevant. Individual identity work has been documented extensively in prior research, and ranges from identity customization strategies which occur through verbal, physical, and cognitive tactics (e.g., Caza, Vough, & Puranik, 2018; Lepisto, Crosina & Pratt, 2015; Pratt et al., 2006), to leveraging identity workspaces or holding environments (e.g., Petriglieri & Petriglieri, 2010; Petriglieri et al., 2018). Along this line of reasoning, scholars acknowledge that people develop through relationships with others, and identity work unfolds via interactions with others (e.g., Ibarra, 1999; Lepisto et al., 2015; Petriglieri & Obodaru, 2019).

Despite general agreement that social relationships play a fundamental role in identity work processes, and therefore, that identity work is inherently relational, there are several relevant issues which remain unaddressed. For instance, extant theories of self and identity work focus primarily on individuals' agentic efforts to progress toward their desired work identities within the constraints and resources provided by their social context. Although it has been acknowledged that individuals engaged in identity work need to relate to others who variously can validate, question, ignore, or resist their efforts (Brown, 2017), 'others' are rarely treated as real interaction partners. Thus, although the process of identity work is deemed relational (Lepisto et al., 2015), there is scant research on how desired work identities are formed and negotiated relationally and dynamically through interactions (Brown, 2020; Petriglieri & Obodaru, 2019). This is problematic for a number of reasons. First, this oversight hides part of the fundamental relational dimension of identity work theories. The current models risk overlooking the fact that the identity work undertaken *simultaneously* by multiple parties may be critical to the enactment of the focal individual's desired self. In addition, not fully acknowledging the interpersonal nature of identity work makes it more difficult to assess the range of possible cross-level consequences that it entails for processes of everyday organizing.

To address these issues and theorize about how desired work selves may play out interpersonally, we conducted a qualitative field study of healthcare professionals who participated in the creation and management of new organizational arrangements, specifically community hospitals, to facilitate their own identity work.

With our data, we show that the processes of collective creation of an identity workspace and identity work are intertwined since an individual's identity work is in an ongoing dynamic relation with the identity work of others inside the identity workspace. More specifically, if the individual cannot enact her desired work self in the current occupation,

there is the option to join with peers and participate to the collective ideation of a new identity workspace that is perceived as potentially conducive to individual identity work. However, if participants have different desired work selves, the established identity workspaces can turn from being perceived as supportive to challenging for people's ability to enact their own desired work selves. When people can appreciate how the performance of others' desired work self can fit into their own progression, the identity work becomes truly interpersonal and the identity workspace finally becomes enabling. Ultimately those two elements allow the participants to enact their desired work selves and to incorporate elements of others' desired work selves into their work self.

Our research contributes to the literature on identity work in a number of ways. Unlike studies of individual identity work which put the changes induced in a focal individual through negotiation of her desired identities center stage, studying how desired work selves play out interpersonally inside identity workspace enables an understanding of the processes of co-construction which allow multiple parties to change their self-concept. In particular, we theorize about some of the ways that people's identity work potentially can intersect and interact with the identity work being undertaken simultaneously by different others so that identity work becomes an ongoing interpersonal process involving self and others. In addition, we extend the current literature on identity workspaces by proposing that the identity workspace, its defining features and organizational processes may be co-constructed as the people within it progress towards their desired work selves.

2. Theory informing the study

2.1 Self-concepts and the motivational impact of desired work selves

The term self-concept refers to a dynamic self-knowledge system consisting of the entirety of a person's self-representations (Markus, 1977, 1983). It comprises thoughts, images,

prototypes, schemas, tasks, and goals related to the self (Cooper & Thatcher, 2010; Markus & Wurf, 1987). By showing that self-representations can refer to who the person is in the present or the 'actual self' (Higgins, 1987), who the person was in the past or the 'past self' (Albert, 1977), and who the person may become in the future or the 'possible self' (Markus & Nurius, 1986) research has revealed the diversity and complexity of self-knowledge. Images of potential future or possible selves encompass the selves that a person would like to become, could become, or fears becoming. Building on counter-factual thinking, Obodaru (2012: 34) extends our understanding of the content of the self-concept by proposing that it includes self-representations of who the person 'could have been if something in the past had happened differently'. Obodaru labels these self-redefining counterfactuals as 'alternative selves' since they describe an alternative reality. She notes that although we can generate numerous counterfactuals simultaneously, not all will represent alternative selves because alternative selves are self-representations about which the individual frequently thinks and talks.

In this paper we are interested specifically in the content and consequences of self-representations related to work. Possible selves are a broad construct which includes both hoped-for and feared selves. Strauss and colleagues (2012) proposed the concept of future work self to refer to individuals' future representations of their work lives that reflect their career hopes and aspirations. An example of a future work self is a family doctor who wishes to become a professional able to care for her patients more holistically including psychologically. Thus, the future work self addresses a possible positive future and can be regarded as a desired work self. Alternative selves can be perceived as worse or better than the actual self. A better alternative self is described by one of Obodaru's (2017) informants who, having decided to abandon the professional path to becoming a judge, entered as employee in a company and spent the rest of her life pondering on the road not taken.

Better alternative selves and future work selves influence the individual's professional life and help to explain the individual drive to change. Both alternative selves and future work selves share the assumption that they represent an evaluative context for and a point of comparison to the current self. They thereby influence the individual's affective, cognitive, and motivational states. For instance, Strauss and colleagues (2012) observed that future work selves extend the aspirations of professionals, broaden their creative thinking about future possibilities, keep them focused, and lead them to shape their careers through engagement in proactive behaviors. A better alternative self can also increase the individual's understanding of a more appealing future, favoring development of a desired work self whose content has considerable overlaps with the alternative self. It thus reinforces the motivation to modify the work experience to enable progression toward it (Obodaru, 2012). We use the term 'desired work self' to include both the future work identity to which the individual aspires and the identity that derives from a better work-related alternative self.

Research suggests that pursuing the desired work self may prompt engagement in proactive career behaviors such as skill development or networking (e.g., Strauss et al., 2012). Also, during work or leisure time, some may engage in making changes to task and relational activities to manifest the desired identity (e.g., Berg, Grant, & Johnson, 2010; Burgess, Colquitt & Long, 2020; Obodaru, 2017; Wrzesniewski & Dutton, 2001) and receive social validation (Bartel & Dutton, 2001). If these changes are successful, the expected positive outcomes will include an altered perception of the work identity, an enhanced meaning of work, and greater enjoyment.

2.2 Enacting desired work selves: Identity work and identity workspaces

The activities and efforts directed toward enactment of the desired work self can be interpreted as a type of individual identity work. Among the different proposed perspectives

on the processes of identity construction, identity work studies (e.g., Brown, 2015, 2017; Knights & Clarke, 2014) highlight that these processes are characterized by a provisional nature. This strand of work emphasizes individuals' continuous and often difficult engagement in establishing, maintaining, or altering their identities, within the boundaries of given social contexts (Sveningsson & Alvesson, 2003), and how they relate to others throughout this endeavor. Thus, research on identity work not only stresses agency (Gecas, 1986), it also acknowledges that agentic processes are rooted in social interactions (Brown, 2015).

Identity work has proven salient for work and career transitions, and for particularly demanding work circumstances such as assuming a new role, facing involuntary career transitions, or taking up an emergent occupation (Ibarra, 1999; Kulkarni, 2020; Murphy & Kreiner, 2020). It is salient also if the individual perceives that what is required in the role does not match with who she is or would like to be (Brown & Coupland, 2015; Mattarelli & Tagliaventi, 2015; Pratt et al., 2006). Several identity work tactics can be initiated to claim a role, ranging from the development of repertoires of provisional selves (Ibarra, 1999), to identity customization strategies (e.g., Mattarelli & Tagliaventi, 2015; Pratt et al., 2006), to managing occupational boundaries in order to craft a sense of identity legitimacy (Murphy & Kreiner, 2020). Alongside elucidation of identity work tactics, scholars have investigated the paramount function of role models or role partners for providing validation of the newly formed identity. Since identities are constructed during social interactions, fruitful identity work efforts are anchored in the judgements of others, and especially in social validation which demonstrates the individual's success in fulfilling the expectations related to an identity (Ashforth & Schinoff, 2016; Swann, Johnson, & Bosson, 2009).

Scholars have also investigated 'where' identity work processes take place in order to understand how different contexts provide individuals with diverse resources and

encouragement as they craft their desired work identities. Although most of this research is focused on corporate environments, Petriglieri and Petriglieri (2010: 44) theorize about the concept of identity workspaces, defined as the 'institutions that provide a holding environment for identity work'. Identity workspaces turn out to be especially significant if the connection between worker and employer becomes fragile, compromising the former's ability to progress toward the desired work self. The authors suggest that institutions which offer sentient communities (communities that individuals feel they belong to, can identify with and invest in), a coherent set of social defenses (collective frameworks and routines created to protect from external threats and internal conflicts), and vital rites of passage (rituals aimed at facilitating major role transitions) are more likely to be regarded as identity workspaces. Examples of identity workspaces are business schools and leadership programs (e.g., Berghout, Oldenhof, van der Scheer, & Hilders, 2020; Corlett, Ruane, & Mavib, 2021; Petriglieri & Petriglieri, 2010; Petriglieri et al., 2018), and fellowship programs (Haynes, Grugulis, Spring, Blackmon, Battisti & Ng, 2014). They are established institutions which participants acknowledge as identity workspaces, and whose value is associated partly to the opportunity to gain access to communities of peers. For instance, participation in an Action Learning Set space supported senior executives in learning how to be different in relation to the dominant leadership discourses traditionally claimed inside organizations, and to feel comfortable in manifesting vulnerability (Corlett et al., 2021). Perceiving this space as characterized by trust, confidentiality, openness, honesty, and social support encouraged executives' engagement in identity work based on expressing their emotions, experiencing disorienting dilemmas, and expressing their vulnerability. In the case of the physicians studied by Berghout and colleagues (2020), participation in a medical leadership development program and interactions with the other participants and the instructors allowed them to construct a new professional identity focused on collaborative leadership and better aligned to

the changing organizational and institutional requirements. Overall, this evidence has provided valuable insights into how, in sentient communities, people obtain support from similar others as they navigate the difficult process of transitioning to a new identity; it represents a productive avenue for our work.

A few contributions underline the need to revise identity work models suggesting that identity work processes should be considered truly intersubjective (Moore & Koning, 2016) or relational (Lepisto et al., 2015), which shifts attention from the focal individual to the mutually influential relationships between the individual and her interaction partners.
In spite of these compelling hints, we know still little about how identity work is undertaken relationally and how desired work selves are negotiated interpersonally also inside identity workspaces (Brown, 2020; Petriglieri & Obodaru, 2019). Extant studies investigating the role of others in identity work show that in complex social interactions, others may agree and facilitate the process (Ibarra, 1999, 2004) or, more likely, may try to negotiate (Swann et al., 2009) or contest progress towards enactment of a desired work self (Brown, 2018; Goffman, 1967). The description provided by Petriglieri and colleagues (2018) of the function of interaction partners for people joining a temporary identity workspace emphasizes that others can play a role as a source of either feedback or emotional support. In this body of work, others are often ascribed unique and somehow static roles (e.g., as enablers or constrainers), and unique functions ranging from normative (acting as sources of norms) to comparative (providing standards against which to evaluate one's own standing), to supportive (offering advice or access to opportunities: Grote & Hall, 2013). This focus may hide part of the relational component of identity work theories. This seems particularly puzzling in today's context. Studies of identity work in contemporary careers highlight that, on the one hand, individuals can envision a large repertoire of desired work selves (Obodaru, 2017), and on the other hand, can leverage identity workspaces to build their identities and progress toward the

desired work selves (Petriglieri et al., 2018). As containers of the identity work of a plurality of people, identity workspaces can become arenas for identity work dynamics among members which have received little attention so far. Therefore, in our research we aim to investigate how desired work selves are played out interpersonally, and how identity workspaces can influence the process.

3. Research context and methods

3.1 Research setting

In this research we adopted a grounded theory approach (Strauss & Corbin, 1998). Our field work was initially informed by the broad research question of how processes originating in individuals' efforts to deal with professional identity challenges influence the emergence of new organizational arrangements. The focus was then narrowed to how desired work selves play out interpersonally inside identity workspaces.

The research context is the Italian healthcare sector, in particular healthcare organizations called community hospitals (CH) which emerged from the joint efforts of a range of professionals including family doctors, nurses, social workers, nurse aids, and health managers. CHs are regional healthcare facilities originally conceived as a territorial solution to the problems brought by an increasingly ageing population. They provide short-term treatments mostly for elderly patients who are not self-sufficient and are affected by chronic, degenerative pathologies (e.g., Parkinson's disease). CHs are neither classical hospitals nor nursing home structures. They target patients who do not require hospitalization but cannot be treated effectively at home. CHs have represented a revolution in the healthcare sector; they are managed by family doctors with the help of other healthcare professionals (nurses, social workers, social aids, and local healthcare managers).

In Italy, the first CH, which we will call Care, opened in 1996 in the north of the country, and 65 more CHs have opened since 2000. The decision to open a new CH facility is taken at the

regional level and requires the region to provide the necessary economic, structural, and professional resources. This results in variations in the size, composition of professionals, and locations of CHs. Family doctors contribute to CHs on a voluntary basis, and those who decide to take responsibility for running a CH are not required to quit their regular general outpatient practice.

This context is relevant for our research for several reasons. Previous studies have documented how changes in healthcare delivery are related strictly to the processes of role identity construction and reconstruction among the professionals involved (e.g., Chreim, Williams, & Hinings, 2007; Reay, Goodrick, Waldorff, & Casebeer, 2017). In addition, the multiplicity and heterogeneity of the professionals participating in CHs allow us to capture differences in desired work selves and the ensuing interpersonal dynamics.

We decided to start our investigation by studying the professionals working in Care (the first Italian CH). When we began our research in 2012, Care's founders (five family doctors and a head nurse) were still working there, which allowed us to discuss the birth of the CHs and their motivation to participate. Initial analysis of our interviews with two of the doctors and the head nurse suggested an intriguing theme: the motivation for participating in the launch of Care was related to a desire to enact professional selves which they had been unable to play in their previous or current jobs. This is evocative of the theoretical concept of desired work self. Initial coding suggested that the desired work selves also were heterogeneous across individuals, and that Care was considered the outcome of a collective effort. Consequently, in further data collection, we used the following dimensions to guide our theory building (i.e., theoretical sampling, Glaser & Strauss, 1967): (1) examining other CHs to explore interpersonal dynamics; (2) choosing CHs whose founders were still working in the facility to investigate desired work self as a motivator; (3) selecting CHs whose founders were heterogeneous professionals (doctors, nurses, managers, social workers, etc.).

Since we were aware that our data would be largely retrospective, we exploited the potential benefit of including older and younger organizations to investigate the processes in both settings that had been operating for several years and newer CHs. Thus, we invited participants from Arcmed (established in 1999), Mediteam (opened in 2000), and Hospmed (founded in 2003). The most recent CH to which we were granted access was Health, which opened at the end of 2010.

All the family doctors involved in our study had continued work in their original outpatient practice after joining the CHs. They devoted between 6 and 20 hours a week to the CH. The monetary incentive for working at a CH is limited. Family doctors are paid per patient admitted or per hour spent in the CH depending on the facility, but all highlighted that the payment barely covered their travel expenses. Some of the CHs (Care and Health) employ full-time nurses. In other CHs (Hospmed and Mediteam) nurses work there part-time, combined with work in other organizations (e.g., nursing homes) or in delivering home care. Arcmed had a mix of part-time and full-time nurses.

3.2 Data sources

We used multiple data sources—semi-structured interviews and archival data—for our theory building process.

Semi-structured interviews. We began the interview process in June 2012 by conducting five preliminary interviews with a healthcare district general manager and four family doctors. These interviews provided an initial overview of the birth, histories, and functioning of the CHs, in relation also to the broader regional network of healthcare services. We conducted other interviews (November 2012 to April 2013) with most of the members of staff in the five selected CHs. Eight additional interviews with key informants from various CHs were conducted later as member checks on the tentative grounded model. Table 1 presents details of the interviewees and the informants' desired work selves derived from data coding.

INSERT TABLE 1 ABOUT HERE

The interviews were aimed at obtaining informants' recollections about the events surrounding the emergence of the CHs, and the reasons why, in their view, certain decisions and actions were taken. First, we asked the interviewees about what characterized their profession, whether certain features had changed over time, what their expectations had been when joining the CH, and why they had continued to work there. Second, we asked about the CH's core features, how it operated, how professional responsibilities fitted with daily CH activities, and what the interviewees appreciated and what they did not like about the CH experience. In the initial interviews, we also asked about the wider institutional context characterizing the birth of the CHs (including the healthcare system more broadly, significant stakeholders, and type of support received from various constituencies). As the importance for our informants of the concepts of past professional choices and better possible selves became clear, we made the notion of desired work self a central theme. We modified the interview protocol for the subsequent interviews. In particular, we included questions about relevant turning points in the informants' professional lives, their professional aspirations before joining the CH, how these aspirations had influenced their desired images, how these aspirations were linked to their participation in CH, and how these aspirations matched daily CH practices and functioning. Appendix 1 provides the initial and the revised interview protocols.

Interviews lasted between 60 and 90 minutes and were conducted face-to-face at the CH sites. With the permission of interviewees, we audio-recorded the interviews and later transcribed them.

Archival data. Our interviewees made frequent reference to various types of documents that they deemed relevant, and often gave us copies of archival documents. These included

guidelines for patient admissions, exam requests, clinical record templates, and admission forms related to Health, Mediteam, and Care CHs, and an internal document describing Arcmed's features and operations. Health and Mediteam interviewees gave us copies of internal statistical analyses which the professionals used to explain their activities to local and regional authorities (e.g., aggregated clinical data on patient admissions, how many and what kind of patients were treated, what types of exams were undertaken, cost per day, etc).

We consulted also healthcare journals, proceedings of national conferences, newspapers, and books including a coauthored text on Care (2002), a coauthored book celebrating Arcmed's history and activities published for its 10th anniversary (2009), proceedings comparing the Mediteam experience with the experience of other CHs in Italy (2002), two articles describing CHs as part of a medical review (2011-12), and two books on Italian CHs (2008, 2009).

To understand the normative context within which the CHs were created, and capture professionals' constraints and degrees of autonomy, we consulted the normative acts expressed at national and regional levels by healthcare institutions (national ministry and regional departments). We analyzed national healthcare plans (PSN - Piano Sanitario Nazionale) from 1998 to 2014, the Department of Health and Social Policies and the National Agency for Regional Healthcare Services (2009) official guidelines, the bi-annual regional healthcare plans for 18 Italian regions, documents outlining doctors' national collective contracts, and related comments and analysis produced by professional associations and unions. Overall, the archival data relevant for the study amounted to approximately 700 pages of material.

3.3 Data analysis

To analyze the qualitative data, we adopted an iterative grounded theory coding process in which the data, the emerging grounded categories, and the literature are intertwined (Glaser &

Strauss, 1967). Through a process of continuous comparison (Gasson, 2009), we compared analytical codes, attributes, and relationships across the fieldnotes and additional data to understand how the theoretical model we were building was supported or modified by new evidence. Figure 1 depicts the data structure that emerged from our coding process.

INSERT FIGURE 1 ABOUT HERE

Elaboration of the categories required several iterations and discussion rounds. The process began with the three researchers independently reading interview transcripts and documents, and then generating first-order concepts (see figure 1, column 1). We highlighted phrases and paragraphs to identify similarities and differences across informants, and met regularly to analyze sets of two or three transcripts and discuss our independent coding. Wherever possible, we used in-vivo codes derived from our informants' descriptions of their experience. For example, 'all-round doctor' was the label used by Doctor 3 to describe the type of professional he aspired to become. We used differences in coding as the basis for discussion to reach agreement on first-order concepts. We then grouped these first-order concepts at a higher level of abstraction to identify second-order themes which we discussed in joint meetings (see figure 1, column 2). In this stage, we confronted emergent themes with concepts in the literature. For instance, our informants talked about incorporating in the self-concept elements of other CH members' desired work selves. This is the case of a nurse stating that she had become 'some kind of a shrink' or of a physiotherapist talking about developing some elements of a social worker in her inpatient care. Looking at studies on changes in the self-concept, we grasped that what we had initially called an 'encompassing desired work self' resonated with the concept of identity expansion in dual-career couples employed by Petriglieri and Obodaru (2019). Consequently, we adopted the label 'enacting expanded work selves'. Over the course of several more meetings, we assembled the second-

order themes at a more abstract level to identify aggregate theoretical dimensions and then debated the dimensions identified, discussed inconsistencies, and developed a common interpretation (see figure 1, column 3).

As a final step, we detected the relationships between second-order themes and aggregate theoretical dimensions in order to build our model. For example, we acknowledged that the processes of identity work and collective creation of identity workspace were interwoven, and employed a temporal bracketing strategy to turn 'a shapeless mass of process data into a series of more discrete but connected blocks' (Langley, 1999: 703). This strategy involved temporal decomposition—i.e., splitting the process data into 'phases' based on a certain continuity within each period and some discontinuities between periods. Thus, phases are usually not presented as categories in the data. In our case, phases referred to the ideation, the set-up, and the evolution of the CHs as identity workspaces. The evaluation of continuity/discontinuity between phases was based on the different ways in which an individual's identity work interacted with simultaneous identity work undertaken by others. We identified three phases: convergence, impasse, and mutual exploration (described in detail in the findings section). We refer to them both in the data structure and in the model using different colors (i.e., white, light grey, and dark grey).

4. Findings

To better illustrate the empirical evidence, we anticipate here Figure 2 that presents our model. The following sections are structured around the temporal decomposition of data into phases and, within each phase, around the aggregate theoretical dimensions and second order themes of our model. Table 2 presents additional quotes.

The model conceptualizes the identity work processes through which individuals realize their desired work selves within an identity workspace.

INSERT FIGURE 2 ABOUT HERE

INSERT TABLE 2 ABOUT HERE

In particular, our model develops along three phases. In the convergence phase, those individuals unable to enact their desired work selves in the current work environment collectively design new entities (in our case CHs) to act as identity workspaces and facilitate their identity work. However, in the impasse phase when the CH starts operating, initial enactment of desired work self-congruent behaviors reveals differences among the various professionals' desired work selves. It becomes evident that playing out some desired work selves might encroach on the ability of others to enact theirs, and the possibility for people to develop professionally within the CH is challenged.

Differences across desired work selves-congruent behaviors engender a diffused perception that CH practices are inefficient. CH usefulness is questioned and unsmooth operations can undermine its chances of survival. When faced with the real possibility of being unable to enact the desired work self in the CH, CH members engage in mutual exploration. They understand that it is necessary to negotiate a common vision of the workspace. Interestingly, this adjustment is rooted in a reflection on the extraordinary pathway leading to the creation of a new entity which allows individuals to see it as a place allowing experimentation and being open to change. In this phase of mutual exploration, the emergent rhetoric is coupled with the negotiated construction of practices that sustain the enactment and co-existence of different desired work selves.

Collective verbal and performative work helps our informants to understand that the trajectories of other individuals might be in line with their own efforts. Individuals then undertake an unexpected expansion of the self-concept to include elements of others' desired

work selves. In particular, in the mutual exploration phase identity work becomes interpersonal in an enabling identity workspace.

Overall we show that the processes of collective creation of an identity workspace and identity work are intertwined, and that the identify work of a focal individual must accommodate and adapt to the identity work of others in the same social context. The model emphasizes that desired work selves are played out through a dynamic process that starts as an individual endeavor and leads ultimately to interpersonal identity work. Below, we describe in detail each phase and how the desired work selves are enacted and the identity workspace is experienced.

4.1 Convergence phase

In the convergence phase, individuals realize that they need a new entity to enable their identity work. The phase unfolded as our informants strove to play out, often unsuccessfully, their desired work selves in their current roles. Dissatisfaction with their attempts pushed them to join with peers and form a community. Forming a community nurtured the idea of a new space (the CH) to be set up in order to host and sustain their identity work.

4.1.1 Identity work: Aspiring to the desired work self

When asked about their motivations for taking part in the CH project, several informants mentioned career trajectories and past work choices perceived as missed chances which often were compared in positive terms to the current work self. Other informants underlined the unease they experienced at work, and their constant thinking about a different work self which would reflect their hopes and aspirations. This pondering on the desired work self impelled them to value and search for opportunities to enact it. Table 3 presents some of our informants' desired work selves, their main features, and representative quotes.

INSERT TABLE 3 ABOUT HERE

For instance, in Mediteam, Nurse 7 described how she faced a major turning point when having to decide to remain a nurse or enter medical school and train as a doctor. She told us that becoming a psychiatrist would have satisfied her inner belief in and desire for compassion: '*I have always believed that I could give more to others and I used to tell myself: If I had kept studying, if I had become a [psychiatrist] doctor, I could have helped needy people better'*.

In contrast, a colleague of hers, Nurse 6 (Mediteam), envisioned a desired work self characterized by managerial responsibilities as an option that would *'bring out [my] inner vocation'* as a healthcare manager. Yet another colleague, Doctor 9 (Mediteam) had a desired work self that he labelled as evidence-based doctor. It implied improved treatments on the basis of careful data collection, data analysis, and data sharing. This desired work self had made him '*obsessed by data collection*' to become '*a doctor of the future, not of the past*'.

Our informants revealed also how they strove to play out their desired work selves in their current roles, mainly by trying to expand what they did and with whom they interacted. For instance, Doctor 9 (Mediteam) who wanted to become an evidence-based doctor, described how he had created a software to allow data sharing among family doctors to foster research applicable to family practices:

> *I'm a computer geek since the '80s and I have always been a strong believer in more order and rigor in medical profession as well as in sharing data and experiences with colleagues […] I created a program that I gave to my colleagues to exchange data. […] If you do not share the epidemiological data, the evolution and improvement of the treatments, the effectiveness of your interventions, how can you enact evidence-based medicine?*

However, Doctor 9 admitted with disappointment that his colleagues only exchanged data three or four times a year, mainly if they changed offices or locations, and that this did not equate with evidence-based medicine.

The professional paths not taken influenced the thinking, reasoning and actions of interviewees from other CHs. For instance, in Care, Doctor 2 described his inability to continue a career as a hospital doctor as a major turning point in his life:

> *A salient event in my life…After I graduated, I had to join the Army for a 18-month compulsory service and so I burnt every chance of getting a hospital position. […] I then tried in a small hospital in a town nearby. […] Once again, there weren't any opportunities ahead. That's how I started my career as a family doctor, because there was no opportunity for me in a hospital.*

Some of his colleagues at Care emphasized that the increasing administrative requirements forced them to leave patients behind to fill in bureaucratic forms (Doctor 3 and 4). Doctors 3 and 4 had a desired work self as an 'all-round' doctor which would involve caring holistically for their patients in every phase of their sickness, from diagnosis to contact with specialists, to post-acute care in patients' homes. Doctor 4 described her image of an all-round doctor as follows:

> *We should see the person as a whole, someone who carries all of her disease with her, who finds a global response in you. […] I wanted to give my patients my expertise, my goodwill, always remembering that they are not just a broken leg or an aching heart, they are not just a protocol, but first and foremost persons.*

However, even in this case, the attempt to achieve the desired work self was unsuccessful. For instance, we learnt that doctors that wanted to be all-round physicians had tried hard to relate to specialists in different ways to enable joint diagnoses and joint definition of treatments in line with the desire to support the patient through all the different phases of their lives. However, family doctors found involvement in specialists' diagnostic and therapeutic plans to be near impossible since '*they [specialists] were used to reading our*

requests for tests rather than collaborating with us' and accordingly felt '*hopeless'* (Doctor 3, Care).

Doctor 3 explained in eloquent terms:

> *Our dreams did not fit in regular situations. […] [We felt like] Sometimes a major breakthrough is needed to achieve recognition of one's aspirations, such as when one changes look or starts a new sports activity to signal that they are undertaking a significant inner change.*

This extract synthesizes our informants' recognition that, following many individual failed attempts to achieve validation, progress toward their desired work selves required a different social context.

4.1.2 Collective creation of an identity workspace: Identity workspace as supportive

Our informants aggregated with other professionals with prospective visions about healthcare. They elaborated and discussed the idea of a new workspace, i.e., the CH, that could facilitate enactment of their desired work selves. Family doctors, nurses, social workers, and other healthcare staff in each location were familiar with working together to provide healthcare services to the local population. Some interviewees referred explicitly to being in '*syntony'* or '*in tune*'. For instance, Doctor 8 (Mediteam) stressed the frequency of interactions with his colleagues in spite of their independent practices:

> *We were used to working together even before [the opening of CH]. We would collaborate a lot with each other for replacements, vacation, institutional engagements, and conferences. We had an excellent integration among us [family doctors] and we gave ourselves the chance to do this thing [creation of CH]. We told each other: 'Let's join forces, let's build something from scratch'.*

When talking about the early days of the CH project, almost all our informants showed agreement about the attributes they believed should characterize a CH, and what the new organization should stand for especially compared to the overall regional healthcare services offers. Initial attributes resonated with the debate that had started to appear in the professional associations' documents. The three most frequent statements were about CHs intended to be

family doctors' hospitals, planned to serve mainly the territory in which they were located, and meant to provide non-acute patients with high-level care without separating them from their families.

Within this overarching framework, people aggregated to realize their desired work selves. At Care, Doctor 1 recalled that *'Going back to those years, each of us had a dream of their own, saw themselves differently in the time to be, and sought a chance to live to the fullest'*. One of his colleagues, Nurse 1, echoed this view, stressing that individual professional aspirations were intertwined with a shared belief that health care services could be enriched and improved:

> *There was a diffused unease among colleagues working in the area, alongside the common perception that we could better serve our community […] We needed a chance, a place to test our visions.*

Our informants carved out time to informally discuss the implementation of CHs during late afternoon meetings and over dinners. Doctor 1, when recounting the ideation of Care, used the metaphor of being part of a movie by Ettore Scola. The famous Italian film director and screenwriter used to narrate the interconnected life stories of people belonging to communities such as families or regular customers at restaurants:

> *Healthcare Manager 1 came up and said: they are closing a hospital, just give me a hand and we will come up with something […] Care was born from the bottom, in a restaurant. It was like in an Ettore Scola's tale*.

Health shows similar dynamics. Doctor 6 described how he contacted colleagues who he thought might be interested in translating a potential different view of self at work into a reality:

> *That is one of the few letters that I have ever written [He shows it on his laptop]. I used a mailing list where I wrote that we had an opportunity [opening of CH] to regain our profession, which had got lost in daily practice in our offices, where we were overloaded with administrative work that had little to do with our medical mission and vision.*

Consistently, Doctor 7 from Health (with a desired work self as hospital doctor) told us that he decided to join the CH initiative because:

> *There was debate, there were information, a pooling of experience, and a lot of studying together. We were all determined to try to be more adequate, even more updated, if we consider that we would also have to talk with hospitals' doctors.*

In discussions about how to improve healthcare practice, subtle references to the interviewees' desired work selves surfaced. Healthcare Manager 1 described the link between participation in the ideation of Care and the possibility for experimenting and consolidating a desired work self, as follows: *'We were all there because we had a professional dream that could not be fulfilled in our regular work conditions, and we were convinced that the population would benefit from our visions'.* In her repetition of the word 'together', Manager 2 from Health evoked the joint effort to conceive Health as a space to provide a supportive social network and sustain a potential transformation: '*We started all together, nurses included. Nobody knew anything about CH, we simply rolled up our sleeves together, to grow together.'*

To sum up, the opportunity to participate in the CH project had formed or reinforced a community which our informants perceived was central to enact their desired work selves.

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4.2 Impasse phase

Following convergence, the CHs were finally established as part of the regional healthcare pools of services. Our informants then worked on setting up the CHs. In particular, as the CHs began operating, their members found themselves involved in the start-up of operational practices such as the definition of patient admissions policies, management of in-site visits, and definition of clinical records formats.

Our documental analysis shows that how CHs fit within the overall network of regional healthcare services provision was broadly described in the official national and

regional documents. However, documents did not provide specifications of the roles of CH professionals. As a consequence, roles, practices, rules, and procedures had to be defined by each facility. Our informants described the high level of autonomy they were endowed with to set up CH operations. The professionals involved in the oldest CHs such as Care and Arcmed had no benchmarks to work on. They had to define all of the CH functions. Doctor 5 from Care told us with some pride that:

> *We didn't have any roadmap to follow: we did it all by ourselves. […] There was really nothing that we could turn to, not a single law, not a single experience. We had to create [this structure] out of thin air.*

In the case of the newer CHs such as Health and Hospmed, the already established CHs could be used as a template or as a source of inspiration. Nevertheless, procedures, roles and practices had to be adapted to each territorial context. For example, Nurse 5 from Health told us: *'We had a minimum of training by visiting another community hospital nearby, but that was a different reality. So we created everything by ourselves'.*

As a whole, nascent CHs granted our informants margins of autonomy in the definition of operational practices.

4.2.1 Identity work: Enacting the desired work self

Thanks to the perceived level of autonomy, the informants were able to apply some elements of their desired work selves in their daily activities. Initially, these attempts were conducted in the absence of negotiation with colleagues. Individual professionals took advantage of the relatively undefined obligations, and tried to endorse the establishment of practices that were coherent with their own desired work self. Doctor 11 from Arcmed told us that: *'There were of course some formal duties that we had to abide by, such as papers to fill in and procurement handling, but, when we started, we had a lot of freedom to fit our aspirations.'*

For instance, in all the CHs we studied, individuals with a desired work self as a hospital doctor endorsed admission of patients discharged from hospitals with post-acute conditions *'At the beginning, I pushed really hard for setting the waiting list so as to give priority to patients just dismissed from regular hospitals because I was there to live my hospital experience'* (Doctor 2, Care). Managing patients with complex and unpredictable conditions that might be unlike those of a typical CH patient was in line with the desire to '*appropriate clinical practice*' (Doctor 10, Arcmed). Similarly, nurses whose desired work self was the hospital doctor proposed adoption of clinical records to report information on patients' conditions, therapy, and examinations requested, using a hospital ward template and justifying it as *'this is the way every hospital works'* (Nurse 5, Health).

All-round doctors and would-be psychiatrists in the various CHs were particularly interested in increasing the interaction with inpatients' families to enable better psychological wellbeing. They believed that admission to a CH should not impose restrictions on families and caregivers (*'I wanted the doors to be open, metaphorically speaking, for people to come in and spend time with inpatients, it would only do them good and was the right way to take thorough care of people '*, Doctor 6, Health; *'I asked my colleagues not to put any time-visit notices on the wall or on the net, that wasn't something in line with the reason why I was there'*, Nurse 14, Hospmed).

Our data suggest that at this stage, individual desired work self-congruent practices and behaviors were associated also to how individuals envisioned some of the defining characteristics of CH. For instance, the abovementioned nurse 14 (Hospmed) projected her desired work self on what the CH should stand for affirming that, in her opinion, CH was a '*relief facility, alleviating families and enabling people to live a normal life* [despite their need to take care of a sick relative]'. Likewise, Doctor 2 tried to shape Care identity based on his hospital doctor desired work self, stating that:

So when we opened CH, it came just naturally to me to deal with the most difficult, borderline cases, and I think this is good for Care […] I saw it [Care] a little bit as a para-hospital [he laughs].

In sum, sponsoring daily practices that reflected desired work selves became the means to make CH the place where individual desired work selves could find their fullest expression.

4.2.2 Collective creation of an identity workspace: Identity workspace as challenging

Despite the common experience of being part of the community giving life to the CH, informants realized that they did not have the same aspirations. While the collective creation of the CH increased the possibility for its professionals to enact their desired work selves within it, an awareness that desired work selves differed and might be conflicting emerged. Now, our informants did not lament the lack of recognition from peers of the new components of their work selves that they were trying to perform. Rather, they acknowledged that their individual attempts were encroaching with the multiplicity of other individual attempts within the CH.

For example, Doctor 2 from Care invited the other family doctors to meet weekly, '*like in a hospital ward',* to discuss clinical cases and evaluate new therapies for acute patients, which, according to him, should be prioritized in terms of admission to the CH. He recalled the resistance to his proposal from some colleagues such as Doctor 4 who held a desired work self as an all-round doctor. He told us that often their discussions revolved around the fact that: *'We are not surgeons, alright, but we are not priests hearing our patients' confessions, either!'*

The recognition that his claims to enact a desired work self as a hospital doctor conflicted with claims of colleagues with different desired work selves, resonates with Doctor 4's concerns. She highlighted that:

> *Originally, I saw Care as an addition to my office where I had the chance to know better my patients and their families […]. I had only 10-15 minutes to visit each inpatient, something like ten people in two hours, because many here were imitating hospitals […] I need time for my patients, I need to talk to them as persons. […] I ended up having no energies left for my patients since I was expected to pay the same attention to all CH inpatients.*

This quote highlights how adhering to some practices sustained by colleagues resulted in Doctor 4 not devoting enough attention to her own patients, which clashed with her reason for participating in the CH and compromised her developmental opportunities.

At this phase, our informants used vivid metaphors—often negatively nuanced—to comment on the effects of divergent individual preferences about daily practices and how the CH was evolving. For instance, Hospmed was compared respectively to a '*Russian salad'*, a '*sea harbor',* and a '*trash bin*' by Manager 4, Nurse 13, and Social Worker 1.

To synthesize, when individuals' thoughts, intentions, and actions (related to individual desired work selves) were played out in the collective workspace, potentially negative interactions emerged, jeopardizing the possibility to fully enact the desired work self.

4.3 Mutual exploration phase

Diverging views about practices ensuing from different desired work selves led to inefficiencies in the services offered by CHs which worried the professionals. For instance, as a consequence of the difficulty to handle admission lists, in particular to manage decisions about what diseases could be treated at the CH instead of being sent straightaway to a regular hospital, some of the unease experienced by the patients was felt also by CH members. Nurse 12 (Arcmed) recounted how patients found the admissions procedure confusing and suggested that this could threaten the credibility of the CH: *'[…] There was a lot of misunderstanding. Seen from the outside, I realized that patients did not receive sufficiently accurate information*

[from us] about the services we were offering and how we were managing them, and this was damaging to the CH's reputation'.

Similarly, Doctor 12 also from Arcmed talked about '*the need to prove that we were really effective as a healthcare facility […] following the many conflicting messages due to our less than clear procedures'.* He continued by saying that CH could not be *'taken for granted'*, and as a relatively new addition to the healthcare scenario a greater consensus was needed on its contribution and operations.

At that time, the effectiveness of the CH in terms of costs and procedures was a major topic as was made evident by a comment from the Care district manager:

> *Doctor 1 keeps telling us that CHs are economically convenient since they allow reduced daily bed costs. Without the CH, however, the patients would be treated in their own homes using or exploit other services. There is no evidence showing that the existence of the CH reduces hospital admission rates. We are going to keep our eyes open on its functioning mechanisms and outcomes.*

CH members were faced with the problem of reconciling divergent views about CH operations stemming from their heterogeneous desired work selves to preserve the identity workspace which they had created.

4.3.1 Collective creation of an identity workspace: Identity workspace as enabling

Faced with the real possibility of a failure to safeguard CH operations, a recurrent theme was that the collective process of creation of an identity workspace had to secure a common vision of what a CH really is and how it functions. At Mediteam, the head nurse recognized, '*We had to find a way to overcome different views, it was a matter of collaborating or failing'*, and Nurse 7 echoed her sentiments saying that '*after all, we all believed in CH. I mean, it is as if the difficulties, which were there, were not impossible to be solved*'.

Reflecting on the amazing journey that had led to the creation of CHs, professionals underlined the remarkable outcomes achieved. Opening a new publicly funded healthcare

facility had been a demanding but rewarding venture that had to be maintained according to our informants. At Arcmed, the rhetoric focused on the capability to launch and run a facility in a mountain area where access was difficult, and how professionals had made the CH accessible. Doctor 10 told us how he had stressed these features after a stormy meeting:

> *We were in the common room having lunch and, looking out of the window, I told Nurse 9: 'This is such a valuable arrangement, a hospital up the mountains, operating to serve a population that would otherwise be abandoned. Of course, this implies that it must be more open and flexible than other facilities'.*

Similarly, a Doctor in Arcmed described the '*impressive endeavor in an unprivileged area*' and pointed to this characteristic as something not to be forgotten when making decisions: '*We cannot send people 30 miles away to get a basic treatment, CH cannot be picky nor too strict in its procedures, we have to go the extra mile*.' At Care, the reasoning focused on its being the first CH in Italy which allowed for continuous novelty, as Doctor 1 recalled:

> *Care had been the first CH in Italy and a benchmark for subsequent initiatives. It was a new type of hospital stemming from an unprecedented effort. It could not be anchored to a fixed way of operating, this can be done, that cannot be done, this patient can enter, the other better not.*

The CHs had become workspaces in which to experiment with unexpected or even complex cases. The '*Russian salad'* and the '*sea harbor*' metaphors were replaced by proud references to engagement with situations that could not be handled elsewhere such as the young woman suffering from eating disorders described in the paragraph below and the patient who had been discharged several times from regular hospitals without any clear diagnoses (see Table 2). Health Manager 2 said: '*We are a facility that is not afraid to handle different cases, day by day, we never stop facing novelty'*. Hospmed Nurse 13 endorsed this saying: '*It was time to cast a new glance on what CH stood for. We cannot wear blinkers.'*

Driven by the interpretation of CH as a workspace open to change, CH members negotiated and co-constructed practices to accommodate a constellation of desired work selves. At Arcmed, a fundraising project was launched by its members to purchase an

ultrasound scanner. The new equipment fitted the aspirations of several CH members, as the same Doctor explained:

> *Everybody is satisfied with the new machine and the process implemented to get it. It serves a lot of different purposes: those who concentrate on the word 'hospital' in community hospitals can elaborate on quick diagnoses without specialists' immediate intervention. Likewise, colleagues who concentrate on the word 'community', can keep patients here, without having to move them to distant locations, away from their families and environment, to get a test.*

The fundraising process was later reiterated to acquire additional resources.

Another example of negotiated and shared practice that we observed in all CHs regarded visits to inpatients and responsibility over treatments. CH members decided that each inpatient should be visited by the doctor who happened to be on site, regardless of her being the family doctor in charge, as in any hospital. Nevertheless, major decisions had to be taken by both the doctor on duty and the doctor in charge, as Doctor 12 from Arcmed recounts below:

> *If I just have to prescribe a blood test or modify the dosage of a drug, I will do it by myself. In contrast, if I think that a patient needs to be brought to the ER because her conditions are worsening or she needs an invasive exam, then I will call her doctor to know her opinion and make a joint decision.*

By doing so this practice accommodates both being a hospital and an all-round doctor. The former applies hospital-like procedures *('In a hospital there is no saying 'This patient is mine, that is yours'*, Doctor 11, Arcmed), while the latter remains in strict control over her patients' wellbeing *('I alone know what can suit them from a 360-degree perspective'*, Doctor 6, Health).

These dynamics were confirmed by the document analysis. In a speech delivered at a workshop on CHs in Italy, Doctor 9 (Mediteam) acknowledged the willingness to experiment as a feature characterizing CHs. At the same time, he underlined how CHs were able to build practices that reconciled and also changed the needs of different professionals:

> *We [CH] are hospitals of a special kind […] Our procedures are not so fixed as you expect them to be in hospitals for acute [patients] […] There are ongoing adjustments as we try to integrate our different views of the healthcare professions. […] I feel that these views have not remained the same over time, they have changed and are still changing*

4.3.2 Identity work: Enacting an expanded work self

Successfully negotiated practices allowed for the simultaneous enactment of different desired work selves. On top of that, the recognition of the need to fit multiple aspirations within the CH made individuals prone to test behaviors that were not necessarily congruent with their initial desired work selves. As a consequence, informants incorporated also elements of colleagues' desired work selves into their own work self in addition to their own initial DWS.

For instance, Doctor 2 from Care told us that in the CH he was finally able to be a hospital doctor because CH admitted patients with a mix of pathologies similar to regular hospitals. He reinforced his claim referring to a longitudinal analysis performed by the regional district. To show that the local CH and the hospitals in the nearby city were comparable in terms of typologies of admitted patients, he told us that:

> *We have been compared, a few years ago, with the other suburban hospitals of the nearby city. They found that we have the same typologies of admitted patients.*

He recognized also that the practice of encouraging families and relatives to visit the CHs at any time, provided it did not interfere with treatments, which was a negotiated procedure, sustained the incorporation of some elements of the all-round doctor and psychiatrist. For example, Doctor 2 recalled his experience with a young woman with an eating disorder who spent a few weeks at the CH. After failed drug therapies and drip-feeding, he decided to talk to her and to her parents who visited frequently. As a result, he identified that the patient's main problem was her relationship with her mother. This was a milestone for his identity as a doctor: *'Curing patients is also about getting to their minds, comprehending their emotions, helping them sort out of their mental traps'*.

Other professionals at Care recognized that they had '*made some room'* for elements from different desired work selves to enter their self-view, while also being able to play out their desired work self. For instance, Doctor 3, whose desired work self was an all-round doctor, synthesized his overall experience in CH as follows:

> *We could not be just prescribers of drugs anymore, we needed to be doctors. Here, we can be doctors. This is another way of working, and, even more important, another way of being a doctor […]. It's so much more rewarding. I finally feel at peace with myself.*

At the same time, Doctor 3 reported the incorporation of some elements of a hospital doctor into the self that ensued from the negotiated CH practices, saying that:

> *If I had been told in the past that I would become a sort of hospital doctor, I would have never believed it, I would have said 'Are you kidding?!' [he laughs] […] In a way, we have become hospital doctors of a special kind, we are hospital doctors who continue using family doctors' practices. […] Here we have the same approach toward patients and their families as we have at their homes or in our offices. [We keep] A total respect of the person, a person is not a number.*

Notably, assimilating some elements of a hospital doctor desired work self did not interfere with the core features of an all-round professional which included thorough care of patients, as the above interview extract explains.

While the above dynamics characterize all the CHs we studied, a few of the professionals involved in the CHs never developed beyond their original desired work selves. Although they believed they had enacted this desired work self, and complied with CH procedures, they remained somehow critical of practices that embodied different views of healthcare professions. For instance, Doctor 5 (Care), although emphasizing that in her view she had realized her professional aspiration to be an all-round doctor at Care, was critical of what she saw as colleagues who paid too much attention to '*mimicking hospital doctors and analyzing data obsessively'*.

In sum, in their determination not to give up on their desired work selves and faced with the possibility of CH failure due to initially inefficient practices, individuals reflected on the history and achievements of the CHs, and discussed and developed a shared vision of the workspace as a place to experiment with. They also constructed negotiated practices that sustained the enactment and co-existence of different desired work selves. This helped our informants see how the development of coworkers could benefit from and provide inspiration for their own development.

Eventually**,** recognition that multiple desired work selves can not only coexist, but also are sustained in an enabling workspace, was described by Doctor 3 (Care) with the metaphor of *'not being lone wolves anymore but members of a pack'*.

5. Discussion

Our research was motivated by an interest in the identity work that can affect the ability to enact desired work selves, whether inspired by roads not taken in the past or by an aspiration to become something different and more appealing in the future. This paper proposes that within identity workspaces, desired work selves play out interpersonally, and theorizes about the various ways in which individual identity work can intersect and interact with the simultaneous identity work undertaken by others. In doing so, this study extends our understanding of identity work as a relational process, shared among a multiplicity of actors, and contributes to identity work and identity workspace theories (e.g., Ashforth & Schinoff, 2016; Brown, 2020; Ibarra 1999, 2004; Petriglieri & Petriglieri, 2010; Sveningsson & Alvesson, 2003), as discussed below.

5.1 Theoretical contributions

A key theoretical contribution of our model concerns the interdependent relationships between the identity work of individuals and the identity work of interaction partners, and how this interdependence may change over time. Interdependence captures the joint identity work activities through which a community of people may co-construct the selves of its members. We argue that this perspective extends our thinking and theorizing about identity work processes.

Although previous research acknowledges identity work as an inherently social process since it requires the individual to position and understand the self in relation to others (e.g. Beech, 2008; Ibarra, 2004; Lepisto et al. 2015), it has not fully engaged with development of an understanding of the interpersonal nature of identity work dynamics in contexts that act as identity workspaces (Brown, 2020; McInnes & Corlett, 2012; Ybema, 2020). Thus, although previous research has identified the important role played by others in affecting the ability to perform identity work successfully and progress toward a desired work identity, it privileges a view of identity construction as an agentic accomplishment even when undertaken under various constraints (Ybema, 2020). We build on and enrich the current literature by proposing that those with whom we interact may likely be engaged in their own identity work, also as a response to our identity work efforts. Viewed through this lens, others can be expected to influence our identity work by favoring it, contrasting with it, or hampering it in the same way as we influence their identity work efforts through a process of identity co-construction whose individual and collective consequences have yet to be fully addressed.

Our work starts to unpack some of the possible ways in which desired work selves are played out interpersonally, and identity work is shared between self and others in the process of organizing. Specifically, our model suggests that individuals who are unable on their own to enact their desired work selves can converge with others to create a new identity

workspace. The impossibility for individuals to fulfill their identity claims (e.g., DeRue & Ashford, 2010) provides impetus for participation in the creation of an identity workspace. This may happen even though they disagree on their desired work selves, since individuals reflect on the meaning and the resources they could draw on by reaching out to others and building an identity workspace that facilitates their own identity work.

However, inside a newly created identity workspace, the identity work of others is likely to affect the ability of the focal actor to develop her identity. Consequently, different desired work selves are continuously negotiated and renegotiated inside the common identity workspace. In particular, within the identity workspace, the community may not only be sentient and supportive, as the literature would claim. It may also be confrontational and require adjustment such that the experience inside the identity workspace could challenge individual development. Our data suggest that we can think of the CH as a metaphorical greenhouse[1], a structure that allows different types of plants to thrive and without which they might die or compete for sunlight and nutrition. Similar to a greenhouse, the CH provides protection and a place for growth. Within the CH individuals engage in identity work to achieve the desired work self which may diverge from the desired work selves of others. In this case, individual exploration and identity work will encroach upon others' identity work. Therefore, the common identity workspace challenges rather than supports identity development.

We argue that a possible mechanism to overcome the impasse caused by the experienced differences might be a collective response thanks to which (to continue the analogy) the greenhouse would allow several varieties of plants to flourish. The extent to which people together can build a new shared understanding of what the identity workspace affords as a collective place imbued with courage will foster progressive experimentation,

[1] We thank an anonymous reviewer for suggesting this metaphor.

development of inclusive practices, and adaptation (e.g., Bojovic, Sabatier, & Coblence, 2020). Drawing on Petriglieri and Obodaru's (2019) theory of secure-base relationships between dual-career couples, we suggest that being able to discuss and experience the essence of inhabiting a place open to exploration helps the individual to recognize other members as both supportive and encouraging of their individual exploratory behaviors, despite existing differences, i.e., the individuals come to regard one another as a mutually secure-base. When this occurs, people's identity work becomes truly interpersonal so that playing out desired work selves also includes others' identity work.

We believe that our study enriches previous research on shared processes of identity construction such as work theorizing collective job crafting. Collective job crafting has been shown to occur among groups of individuals who share the same occupation and/or role (e.g. Leana, Appelbaum, & Shevchuk, 2009; Mattarelli & Tagliaventi, 2015; McClelland, Leach, Clegg, & McGowan, 2014), or the same physical space (Bertolotti, Macrì, & Tagliaventi, 2005). These individuals have similar professional identities, and jointly can foresee and initiate changes to the way the work is undertaken in terms of the task and the relationships needed to include the desired aspects of their work identities. Because of the similarity in expectations, defining the direction of change actions is fairly straightforward. Conversely, our study indicates that identity work can become interpersonal in nature even within communities of people who are heterogeneous in terms of their desired work selves, and can lead to satisfying outcomes, provided the individuals involved are willing gradually to incorporate some elements of others into their self-concept.

Our study contributes also to the literature on identity workspaces. The current conversation (e.g., Berghout et al. 2020; Bojovic et al., 2020; Corlett et al. 2021; Haynes et al. 2014; Petriglieri & Petriglieri, 2010; Petriglieri et al. 2018) centers largely on their positive functions as holding environments able to support individuals in the emotional, cognitive, and

social processes related to experimentation, elaboration, and enactment of desired individual and organizational identities. We argue that this framing may risk assuming that the individuals' journeys within that space will change them, but not necessarily the actual identity workspace. We add to this stream of literature by proposing that if we interpret identity work processes and outcomes as co-constructions, identity workspace functions and roles may also evolve dynamically. For instance, we know that institutions are considered identity workspaces if they provide sentient communities alongside a coherent set of social defenses, and that such resources are supposed to be mutually sustaining. However, if we recognize that identity workspaces may become arenas for a constellation of people engaged simultaneously in identity work in a dynamic interplay with each other, we should expect a more complex morphing of the sentient communities. Under certain circumstances, as our model shows, communities could be enabling or constraining and adversarial. In addition, sentient communities and social defenses which represent the elements constituting the identity workspaces might become substitutes for one another rather than being mutually sustaining such that if the support of the sentient community is perceived as weak then the individuals involved are able to find a stronger anchorage in other resources like, in our case, the rhetoric of the extraordinary endeavor to build the CHs. Therefore, we propose that the identity workspace and its defining features, may be in co-construction with the unfolding identity work. We would suggest that if the interpersonal nature of the identity work inside an identity workspace is really taken into account, and we pay attention to both the verbal and performative dimension of the identity construction within the identity workspace, this would provide a better understanding of the processes of everyday organizing.

These complex dynamics are likely to be emphasized when people do not join already established identity workspaces like those described in the literature, but converge to create a new entity which they envision becoming an identity workspace. In this latter case, the

absence of institutionalized discourses and already established identities, organizational practices, and features may lead to participants experiencing greater latitude, but also more struggles to perform their identity work.

5.2 Implications for practice

This study highlighted the processes able to empower groups of individuals with different desired work selves to co-create work opportunities corresponding to the work self they aspire to. Our findings should be of use to several different organizational actors.

Top managers should identify how best to support employees to fulfill their desired work selves by creating an identity workspace within the organization's boundaries. This might involve a new team, a new organizational program, a new business unit, or an organizational spin-off. Provided that the individuals involved participate in the design of these different organizational arrangements, this might facilitate their pursuit of their desired work self.

Middle managers with responsibility for allocating company resources and managing business process reengineering efforts could also benefit from our findings. Middle managers should more closely examine the dynamics linked to the resources they control. Our study shows that CH professionals gave specific meaning to the resources they were using – meanings which went beyond their straightforward practical use. In other words, the enactment of their desired work selves was imprinted on the use of a particular asset or practice. An ultrasound scanner at the CH (Arcmed) was seen as representing the ability to offer advanced hospital services, and documentation (at Health) related to washing and dressing patients suggested that the CH was a place 'like-home, where we care'. Resources became boundary objects influenced by identity dynamics (Bechky, 2003; Dosi, Mattarelli, & Vignoli, 2020), around which the community discussed collective practices that endorsed the

new organizational arrangement as identity workspace. Managers should assess equipment, documents, routines, and norms not only in terms of conventional criteria—their economic convenience, efficiency, usefulness, but also in terms of the opportunities they offer to the realization of individual aspirations and goals. We believe that if managers disregard these perspectives when making decisions about which resources to activate or dismantle, and which processes and routines to change, they might overlook what it is that underpins employees' reactions, and increases resistance to the proposed changes.

Additionally, this study hints at what those managing the creation of new businesses or entrepreneurial teams should take into account. Start-ups and spin offs could be interpreted by founders or team members as identity workspaces. Our work suggests that investors, tech transfer managers, and incubator managers should understand the convergence or divergence of the founders' desired work selves in order to understand the evolution of the start-up/spin off. First, it suggests that divergence between founders' desired work selves might not be problematic per se although it might have different impact on how the founders envision the new venture. Second, it suggests that divergence requires deeper commitment during the impasse phase, and the identification by spin off/start up founders of shared solutions to allow development towards the mutual exploration phase.

5.3 Limitations and directions for future research

While we believe that this research contributes to theory and practice, it has some limitations. A first concern, common to qualitative research, is related to the trustworthiness of our findings in terms of transferability and credibility (Lincoln & Guba, 1985). We employed certain strategies to address these issues (Gioia, Corley, & Hamilton, 2013; Lincoln & Guba, 1985). For instance, we included in the text extensive excerpts from our field notes to make emerging categories more comprehensible to the reader. We also conducted eight member

checks with key informants to allow them to comment on our model and understand how they perceived the fit between our findings and their interpretations. In addition, we provide rich contextual descriptions to increase the transferability of our findings.

Possible extensions to our study relate to individuals' pursuit of new future aspirations, once accomplished the original desired work self in the identity workspace created. Even if it was out of the scope of the current paper, we learnt that few professionals were already envisaging new desired selves at the time of the interviews, such as manager 2 from Health who told us that, after joining CH, she began thinking that she could become a *'women helper'* in the future and foreseeing the creation of a new center for women support in her town. Interestingly, they raised the issue of undertaking directly a collective endeavor, building on their previous experience. Whether and how this would be possible could be investigated in future research that could benefit from longitudinal studies. By doing so, it would be possible to better capture how desired selves are modified when elements of others' selves are assimilated. At the same time, a longitudinal study could balance the limitations of retrospective data like the ones that we collected.

The possibility of pursuing more than one desired work self at the same time could be taken into account, too. Among the professionals we studied, only one informant (Doctor 3) discussed a possible self as an all-round doctor and an alternative self as a computer scientist. The interplay among multiple desired work selves would be an interesting direction for further research.

Finally, our informants could avail themselves of high-quality connections in order to launch the collective process we described (Carmeli et al., 2015; Dutton & Heaphy, 2003). Previous experience of reciprocal knowledge and trust supported the convergence in new initiatives such as the CHs, thus fostering the growth of the community underlying an identity workspace. In an age dominated by collaborative technologies which offer almost infinite

possibilities to reach like-minded individuals (e.g. through blogs, forums, online communities), it would be interesting to explore whether and how collective creation of identity workspaces occurs and unfolds in the absence of formerly established relationships.

6. Conclusions

Our field study reveals how the roads not taken in our work lives, and our visions of who we could become at work, inspire elaboration of desired work selves whose realization becomes compelling. Enacting a desired work self is not a solitary effort: it may require a new identity workspace in which to interact and negotiate with others to find a way to jointly achieve our heterogeneous desired work selves. The professionals we studied were able to build an identity workspace even when they disagreed on their desired work selves, and to create a new facility that benefited a large community. We believe that understanding the power of desired work selves in triggering interpersonal identity work processes could open up new perspectives for individuals to live multiple work experiences, and by doing so, provide valuable contributions to society.

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Table 1: Characteristics of the interviewees

Number	Informant (Profession)	CH	Founders	Gender	Desired work self
1	Doctor 1	Care	yes	M	Journalist
2	Doctor 2	Care	yes	M	Hospital doctor
3	Doctor 3	Care	yes	M	All-round doctor, Computer scientist
4	Doctor 4	Care	yes	F	All-round doctor
5	Doctor 5	Care	yes	F	All-round doctor
6	Nurse 1 (head nurse)	Care	yes	F	Psychiatrist
7	Nurse 2	Care	no	M	Hospital doctor
8	Nurse 3	Care	no	F	-
9	Nurse Aid 1	Care	no	F	-
10	Nurse Aid 2	Care	no	F	-
11	Manager 1 (district general manager)	Care	no	M	Sports doctor
12	Doctor 6	Health	yes	M	All-round doctor
13	Manager 2	Health	yes	F	Manager
14	Nurse 4	Health	yes	F	Hospital nurse
15	Nurse 5	Health	yes	F	Hospital doctor
16	Doctor 7	Health	yes	M	Hospital doctor
17	Doctor 8	Mediteam	yes	M	Hospital doctor
18	Nurse 6 (head nurse)	Mediteam	yes	F	Manager
19	Doctor 9	Mediteam	yes	M	Evidence-based doctor
20	Manager 3	Mediteam	no	F	Hospital doctor
21	Nurse 7	Mediteam	yes	F	Psychiatrist
22	Nurse 8 (head nurse)	Arcmed	yes	F	Hospital nurse
23	Doctor 10	Arcmed	yes	M	Hospital doctor
24	Doctor 11	Arcmed	yes	M	Hospital doctor
25	Doctor 12	Arcmed	yes	M	Hospital doctor
26	Nurse 9	Arcmed	no	F	-
27	Nurse 10	Arcmed	no	F	-
28	Nurse 11	Arcmed	yes	F	Evidence-based doctor
29	Doctor 13	Arcmed	no	M	-
30	Physiotherapist 1	Arcmed	yes	F	-
31	Nurse 12	Arcmed	yes	F	Hospital nurse

32	Social worker 1	Hospmed	yes	F	Counsellor/ mediator
33	Manager 4	Hospmed	yes	M	Counsellor/ mediator
34	Nurse 13 (head nurse)	Hospmed	Yes	M	Doctor
35	Manager 5	Hospmed	yes	M	-
36	Nurse Aid 3	Hospmed	yes	M	-
37	Nurse Aid 4	Hospmed	yes	F	-
38	Nurse 14	Hospmed	yes	F	All-round doctor
39	Nurse 15	Hospmed	no	F	Lawyer
40	Doctor 14	Hospmed	no	M	Sports doctor

Table 2. Examples of representative quotes

Aggregate theoretical dimension: **Identity work**

Second order theme: **Aspiring to the desired work self**

Thinking and reflecting upon the desired work self lingering in mind

I would have liked to become a doctor, but I had attended a four-year high school that didn't grant access to med school. I should have taken an additional year to enter the school. I chose one of the few undergraduate degrees that would allow me in, i.e., Psychology. I dropped out five modules short of graduation, it didn't suit me. I then taught for a couple of years in primary schools: it was gratifying, but very demanding. I gave up on that, too, and switched to the setting that most resonated with my original dream: the nursing school. [..] I liked my job, I really did, but it used to hurt me when I saw a doctor and thought: 'It could be me'. [Hospmed Nurse 13]

I always believed that I was made to be a counsellor. You must have a certain attitude and personality to be a counsellor and I think I have these attributes. In my professional pathway I always pursued that image of me, first working in the district healthcare management unit, then coordinating international adoption services. I never felt really set, though, as it was more about performing tasks than mediating and coaching daily. [Hospmed Social Worker 1]

Struggling to bring changes congruent with the desired work self to tasks and/or relationships in actual jobs and/or during free time

I struggled to implement group medicine at Z [the town where Care is located]. I meant group medicine to trigger regular exchanges among us, family doctors, about innovative treatments, problem solving tactics, best practices at large, as happens in hospitals. It instead turned out to be just a matter of sharing the rent and making a general practitioner available to the population from 8 am to 8 pm from Monday to Friday, a lot of greetings when crossing a colleague in the hallway, some pleasant chitchat. It was very different from what I had in mind. [Care Doctor 2]

Before Mediteam opened, I tried to collect data about the pathologies handled by family doctors, their patients' socio-sanitary characteristics, to be able to make some forecasts and better plan resources, but it was only a drop in the ocean. Few data gathered in dribs and drabs, as if I were a beggar asking a favor through a mailing list. It was frustrating because that was such a big part of my vision on prospective medicine. [Mediteam Doctor 9]

Second order theme: **Enacting the desired work self**

Promoting practices congruent with individual desired work selves

I scheduled my day so that I could see each inpatient every day, ask them how they are doing, how they were coping with their therapy. I talk to them. [Mediteam Nurse 7]

You are the doctor and you're supposed to interact with your patients, but at home you find also their families who want to have a say. On the contrary, here [at CH] your relationship with patients is immediate, straightforward, there's no mediation by relatives. […] This is what I wanted, a place where it's just my patients and me, that's why I ask relatives to wait for the end of the visit in the hallway, and not stay by the bed. [Health Doctor 7]

Projecting individual desired work selves onto what CH is

CH to me is a place where to devote time and attention to patients. It embodies my idea of the nursing profession […] *To me the most important thing [about CH], and one that I keep reminding my colleagues, is the relationship with the patient. Unlike a hospital ward, here you have more time to spend with patients [...] In fact the first thing that I'd say to them [patients] when they entered the CH was: here you are not in an in-and-out hospital, it is like a family-managed facility where you will be taken care of.* [Mediteam Nurse 7]

I saw Hospmed as an elective setting in which to test and reinforce my willingness to prevent, lessen, and solve conflicts and divergent views. It was opening then, I expected it to be the very place in which issues among healthcare operators, patients, families, and caregivers would be addressed. [Hospmed Social Worker 1]

Second order theme: **Enacting an expanded work self**

Including the core aspects of one's own desired work self into the work self

We were strangled by bureaucratic practices and taking care of patients was almost an accident in our everyday work. [...] I graduated in medicine, not in prescription writing for adult diapers. It used to be just bureaucracy and that's it; you'd write prescriptions all day long. What was missing was a true relationship with patients. […] Things have changed, thanks to my experience in the CH. I can now call myself proudly a doctor [Health Doctor 6]

I see myself as a relational manager [she covers her mouth with her hand to hide a smile]. It's so fundamental to me, I like mediating in complex situations. Here [at CH] it happens frequently: I act as a bridge

between doctors and nurses, between doctors and families, even between doctors or between nurses themselves. [Hospmed Social Worker 1]

Incorporating some aspects of others' desired work selves into the work self

[Throughout my participation in CH] I've gradually realized that talking to patients while teaching them how to use a walker or stand up from a wheelchair is part of my profession. Not just asking them 'Good morning, madame, how are you doing?' out of politeness, but showing them that you are genuinely interested in their state. It makes the difference if you, as a professional, take care of their wellbeing thoroughly. […] *On top of that, it's clear to me that we can't discharge a patient only because some basic mobility goals have been attained. No, you must pay attention to what's lying ahead. Is there anyone looking after them once they're at home? Or even, is their home heated? I can't tell you how many situations like these I've witnessed. You might ask me: why should it matter to you? You aren't a social worker. As a matter of fact, I am, to some degree, it's become my business as well*. [Arcmed Physiotherapist 1]

Working here in CH, I discovered the social component of our work, a component that I did not know before. […] When I first started working here [in the CH], I wondered "How come that all the troubled people are here at the CH, while no one seems to have social problems when I visit them in my office?". But if you begin to go deeper in people's life, you find out that several of your patients are in deep waters. […] From the professional point of view, the idea of taking into account social issues was not meaningful to me [before working at Health]. But now I know this world, it's part of my profession. [Health Doctor 6]

Aggregate theoretical dimension: **Collective creation of an identity workspace**

Second order theme: **Identity workspace as supportive**

Dreaming about a new entity able to support professional transformation

We went fearless to start this initiative. We gave ourselves a chance to become who we wanted to be. [Care Nurse 1]

Aggregating with trusted colleagues

Family doctors would meet every Saturday in a pavilion downtown, those were informal meetings to support professional grow. They then summoned us [other professionals] to discuss about CH. […] It was clear to all of us that CH would be the family doctors' hospital. [Health Nurse 6]

You can't build anything like that (CH) out of your own will. You need to be in tune with other people. At a given time, it occurred to us [future CH members] to be in tune since each of us brought their own idea of how to improve work' [Health, Doctor 6]

Elaborating on what CH might be and might not be during meetings

We just wanted CH to be a territorial facility able to serve the community as an alternative to regular hospitals if, for a variety of reason, local people cannot be treated at home. [Health Manager 2]

From day 1, we agreed that CH would be neither a nursing home nor the annex to the local hospital's general medicine ward [Hospmed Manager 5]

Second order theme: **Identity workspace as challenging**

Developing collective awareness that the heterogeneity of desired work selves can undermine the establishment of CH

I would arrive at CH in the morning to be immediately stopped by a nurse telling me that her colleague had given a patient a painkiller or had modified the anticoagulant therapy on their own […] and that was unacceptable to her, since being a nurse should mean abiding by the rules and thus being 'one and the same' for all patients. […] Then, often within the same day, I would also get the opposite claim. The other nurse would tell me that living by the book is not in line with the mission of being a nurse, which should be about responding quickly to sick people's needs. […] [Mediteam Nurse 6]

When Doctor 2 made a decision about a patient of mine since he happened to be at the CH, and therefore would visit all inpatients, regardless of who their family doctors might be, I'd be nuts. I brought my patients here to follow them better, not to give up on my responsibility. I'm the one who knows them better, I'm often in charge of entire families, know a lot of details about them, even how much money they have on their saving accounts [she smiles]. [Care Doctor 5]

Discussing how practices affect what CH is becoming

We started with taking in patients discharged from the hospital after being treated for acute episodes. Then everything turned out to be messy. We began accepting patients coming from home, sometimes to implement rehabilitation plans, sometimes just to give families relief…'As I'm going on vacation in July, can you please host my mom?'. Social Worker 1 pushed the envelope in this direction. So we became kind of an all-in-one facility: hospital, nursing home, shelter. It had become like a sea harbor. [Hospmed Nurse 13]

CH had become like a loose cannon, as we would admit patients who didn't need it anymore, just because hospitals were full and couldn't keep them. In parallel, we would have terminal patients in the same room,

people who required much care and whom the doctor said we couldn't give up on. It was just confusing. [Hospmed Nurse Aid 3]

Second order theme: **Identity workspace as enabling**

Elaborating on CH history and accomplishments

An interesting conversation developed around what we had been through in our history. […] The amount of people whose social troubles prevail over strictly health issues are frequent. We have introduced a dual pathway, a sanitary one and a social one, and we search a solution for both. We manage a lot of homeless people, both known in town and people who take a train and arrive here by chance. On top of that, we treat some young drug addicted who live nearby. This is really innovative for a CH and it's the outcome of our common trip here. [Health Nurse 6]

There was a time when we'd raise the issue of how far we'd gone at the CH every single day. What a piece of the local history we had written together! […] We have developed a common 360-degree approach: every day we face a new case, it can be one day pneumonia, the other day diabetes, one day a skin problem, then orthopedics. We handle cases in a truly shared way, involving specialists upon need. […] Let me give you an example. We have now a 44-year-old woman who has been in and out of hospitals for months. Nobody was able to find out what she's suffering from and she was always discharged without a diagnosis. Her husband was desperate and begged us to help them. She's been staying here for a month now and things are gradually getting clearer. We have talked to their relatives and friends, analyzed her clinical record, surfed the web. [Health Nurse 4]

Describing CH as a setting in which to tackle novelties

Now we can do a lot of different new things, knowing that we can succeed. Every day brings its novelties and that's so good: we never stop facing new challenges, this is a place where it's possible to push limits a little further, even if we operate within given territorial boundaries. [Hospmed Manager 4]

It was time for us and the rest of the world to see Care from a different perspective: we are a facility in which a lot of different diseases—be they physical or psychological, even relatively unknown to us when patients are admitted—but which touch on the local population, can be treated. [Care Doctor 1]

Negotiating practices to allow for the enactment of a constellation of desired work selves

We carry out Individual Care Plans in which new and old cases are discussed and decisions are made weekly. Technically, I could do them on my own, but a lot of professionals are involved: CH doctors, nurses, manager, but also a psychologist, a nutritionist, a speech therapist if needed. It's a way for all to live parallel lives [she laughs]: family doctors playing to be specialists, nurses playing to be doctors, and so on and so forth. [Hospmed Social Worker 1].

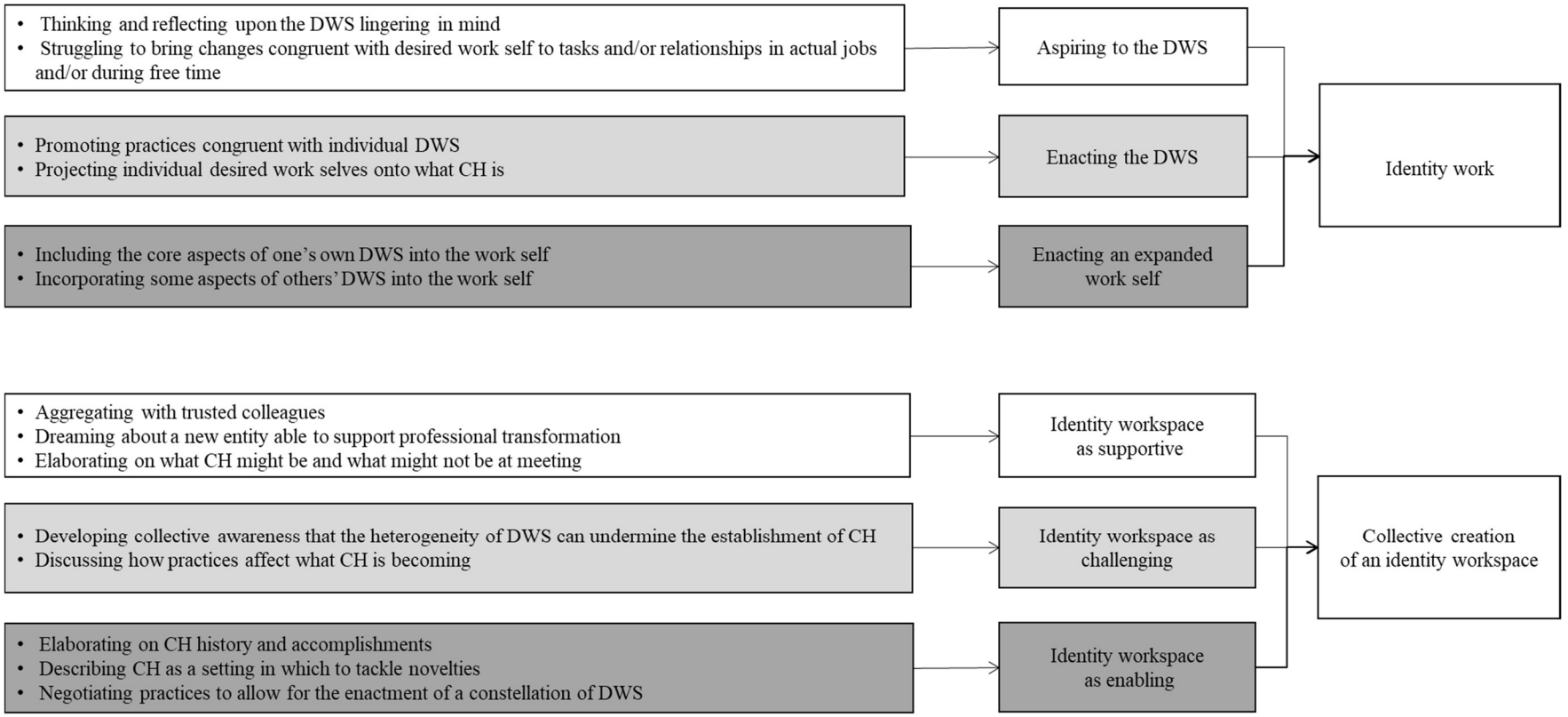
It's been seven years since we have been managing CH patients' clinical records online. We have been pioneers in this field in Italy, long before the debate on this topic even started nationwide. They serve a range of purposes: those who wish to be informed about each and every step of their patients when they are not in CH are satisfied, as well as those who believe that medicine should be also about statistics and those who have strict hospital procedures in mind. [Arcmed Doctor 12]

Table 3: Main features and exemplary quotes of desired work selves

Desired work self	Main features	Exemplary quotes
All-round doctor	Being the main reference for patients and their families for all health-related issues. Taking care of patients from various points of view, ranging from psychological needs to diagnosis, to decisions on treatments.	We should feel the pride to manage all the aspects of medicine: not only treatments, but also the diagnosis of a new disease by ourselves, without always knocking on hospitals' doors. We should roll up our sleeves, exercise our mind, get insightful. [Care Doctor 4]
Evidence-based doctor	Being a knowledge promoter. Fostering research to be applied to family practice. Data collection and analysis as the basis for improving treatments.	Evidence-based medicine is a requisite that was missing in many structures, which are devoted to clinical aspects only. So we are still really stuck to Claude Bernard's nineteenth century medicine. The point is, if you don't show the epidemiological data, the evolution and the improvement of treatments, and the effectiveness of your actions, how can you sustain any new projects? I wanted to be a doctor of the future, not of the past. [Mediteam Doctor 9]
Hospital doctor	Developing and applying protocols and best practices. Curing all patients without exclusive ties. Treating complex cases.	I often thought about it. Freshly graduated, I wanted to be an orthopedist. Back then, however, in order to enter orthopedic residency, you had to be graduated summa cum laude, and I had been engaged in the student protests of '68 . On top of that, at the time, while in the residency program, you had to spend two or three years working in a healthcare center for free, residency was not paid, waiting for God's Grace descending from a Saint Head Physician to save you. [laughing] My family wasn't well-to-do and I couldn't afford working for free, that's why I turned to family practice. Scrubs and the smell of X [hospital disinfectant] remained in the back of my mind, though. [Arcmed Doctor 11]
Manager	Being the contact point for institutional representatives. Setting and handling the organization of work. Assigning the resources to be employed.	I have a double soul: political and sanitary'. [...] Choosing graduate school has been tough for me because at that time I could opt for something coherent with nursing or, alternatively, enter a business school […] I liked what I did, but if I had taken the other road, I could have been a nursing manager, and I kept thinking about that missed opportunity. [Mediteam Nurse 6]
Psychiatrist	Being a reference for patients and families for psychological support. Taking care of patients' psychological needs. Accompanying patients in the recovery process.	The longer I stayed with patients, the more I realized that I could be more than a technician catering to blood circulation or to catheter changing. Their frailties, their emotional coping did resonate with me, I knew that I could take charge of their needs in a better way. [...] I would watch the TV series on doctors and nurses, I would remember Florence Nightingale's

		example studied at the nursing school, and kept wondering how I could also become some sort of a psychological help to my patients. [Care Nurse 1]
Hospital nurse	Interacting with and becoming the contact person for doctors. Developing autonomy and specialized competencies. Applying standardized protocols to cure complex patients.	When I was in the operating theater, I felt involved, I mean, during surgeries you often don't even talk 'cause, just by looking at surgeons, you know what they are expecting of you. I couldn't give up on gaining more autonomy, learning more, as happens in hospitals. I had started home care nursing, but that image of me [as a hospital nurse] still lingered in my mind and I knew that I would somehow get back on track. [Arcmed Nurse 8]
Lawyer	Being the champion of patients and families' rights. Providing guidance and assistance with clinical procedures. Orienting patients towards suitable solutions.	I wanted to be a lawyer, so I attended the International Law School first year in Romania. But then communism took over, and it became difficult for me to attend university, so I had to drop Law school. I thought: 'What is my second choice?' and nursing was my only answer. I'd have loved to be a lawyer, but when you don't have anyone who financially supports you, you can't fulfill your dreams. But it's always been a guidepost in my life for the help that it can bring to people, especially when you work pro bono. [Hospmed Nurse 15]
Medical journalist	Disseminating knowledge about diseases and therapies to a non-specialistic audience	I had in my mind the social and political side of being a doctor, in a good sense, how to serve best the community through communication […] That's why [before opening CH] I tried also journalism, I tried to cooperate with healthcare trade unions. [Care Doctor 1]
Sports doctor	Providing medical assistance in sports settings, such as at sports centers and competitions. Elaborating physical development plan	When I was young, I had icons in my mind. I would have liked to work in sports medicine, for example preparing climbers to reach the Himalaya summit. You have to know the body and the mind pretty well to identify personal training plans. […] Life has taken a different path and I had to give up on my dream in my occupation. Icons lingered in my mind, however. [Hospmed Doctor 14]
Counsellor/mediator	Coaching professionals, patients, and relatives in healthcare settings. Acting as a mediator when conflicts arise	I have always wanted to take charge of the relational aspect in disease occurrences. Being able to accompany people towards future accomplishment has always been important to me. […] While a psychologist delves into the past of people's lives, I wished to make them look ahead and work for their future. I mean, empowering people, acting as a coach to help them exploit their talents and chances. [Hospmed Social Worker 1]

Figure 1: Data Structure



Note: The different colors (white, light grey, dark grey) reflect the way we structured the description of events and the various phases in which the processes of identity work inside an identity worspace unfolded. In particular, the white, light grey and dark grey colors represent, respectively, events occurring during the convergence phase, the impasse phase, and the mutual exploration phase.

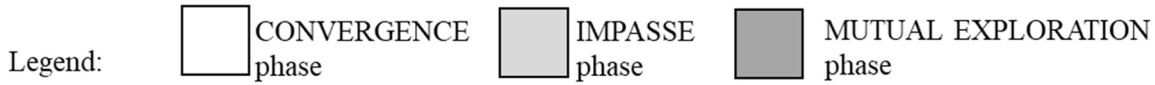
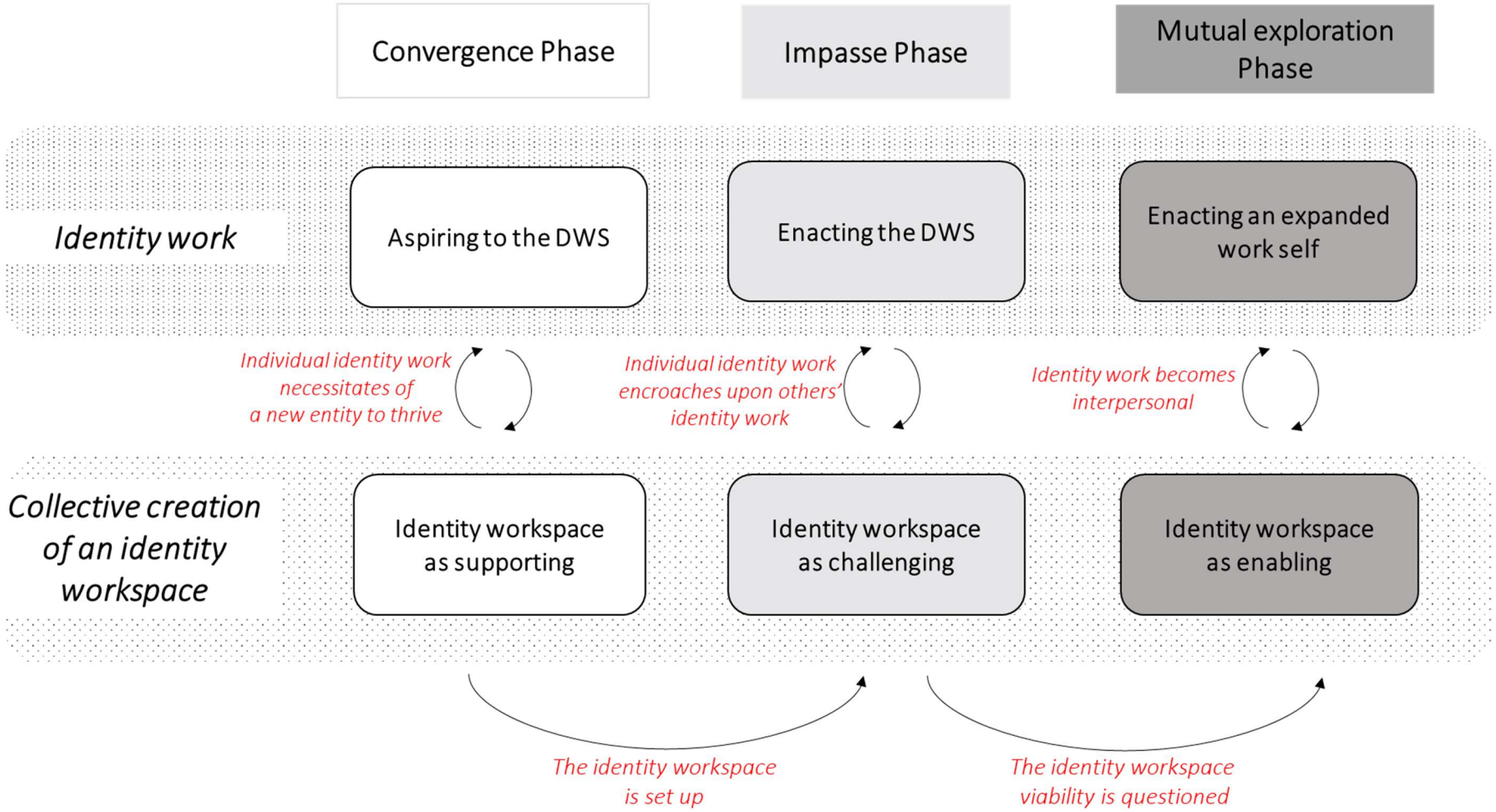


Figure 2: A process model of identity work to enact desired work selves inside identity workspaces



Appendix 1

Interview Protocol. First Version

Individual level

- Can you tell us about your career up to now? What education and work experiences have you had?
- Can you tell us what the core attributes of your job are? Have they changed over time and, if so, how and why?
- What were your motivations for founding/joining CH? What expectations did you have when you founded/joined CH?
- Can you tell us what a regular work day in CH is like for you?
- Is CH your only job or do you keep any other job appointments outside CH? How did/do you handle the transition from your regular job to job in CH?

Organizational level

- What are, in your opinion, the core and distinctive features of your CH?
- Can you describe how a CH operates every day? What core practices/routines take place in a CH?
- Can you tell us what a regular work day in CH is like for you? Can you explain what activities do you perform in CH?
- Think about the CH experience as a story to tell in chapter. Can you help us go through the different chapters? Can you tell us, for each chapter, one or two episodes particularly relevant for you?
- What do you like about CH and what you don't like?

Institutional level

- Can you tell us how your CH was born?
- What institutions/organizations/groups supported its birth and growth? What instead hampered them?
- Can you tell us what regulation applies to CH, and if and how it has changed over time?
- What relationships does your CH have with other institutions/organizations/groups? Can you tell us whether and how they have changed over time?
- Are you aware of any differences among CHs in Italy? If so, what factors affect these variations, in your opinion?
- What do people outside CH think of it, in your opinion? Do you believe that opinions have changed over time and, if so, how and why?
- Is there anything that we have not asked you but that you think is relevant, especially concerning your experience in CH?

Interview Protocol. Revised Version

Individual level

- Can you tell us about your career trajectory? What education and work experiences have you had?
- Can you tell us what the core attributes of your job are? Have they changed over time and, if so, how and why?
- What people helped you make your career choices and professional aspirations? Who sustained you and who didn't?
- Please think about salient events in your life. Can you tell us if and what turning points you faced in your life, and if and how they affected your career trajectory?
- Before founding/joining CH, did you have images of what your professional life should be? Please detail these images as carefully as you can.
- If you had to describe yourself to someone you meet, would you tell them about these images and/or salient events, and how?
- If you had to compare these images and/or salient events with your life before founding/joining CH, how would you compare?
- How often did you think about these images and/or salient events before founding/joining CH? With whom did you talk about them?
- What were your motivations for founding/joining CH? What expectations did you have when you founded/joined CH?
- Is CH your only job or do you keep any other job appointments outside CH? How did/do you handle the transition from your regular job to job in CH?

Organizational level

- What are, in your opinion, the core and distinctive features of your CH?
- Can you describe how a CH operates every day? What core practices/routines take place in a CH?
- Can you tell us what a regular work day in CH is like for you? Can you explain what activities do you perform in CH?
- Think about the CH experience as a story to tell in chapters. Can you help us go through the different chapters? Can you tell us, for each chapter, one or two episodes particularly relevant for you?
- What do you like about CH and what you don't like?
- Do you think that the experience in CH has changed you, and, if so, how?
- Is there anything that we have not asked you but that you think is relevant, especially concerning your images and/or salient events and your experience in CH?