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SENSEMAKING AND MEDICAL PROFESSIONAL IDENTITY WITHIN THE CONTEXT OF STRATEGIC CHANGE

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Abstract

Objective of the study: To identify how the physicians of a major Brazilian hospital perceive the proposed change in payment models for services provided and whether the proposed change affects elements of the professional identity of the physicians interviewed.
Methodology / approach: This study draws on the sensemaking theory, medical professional identity and implementation of strategies in complex organizations. It was carried out a qualitative research through semi-structured interviews with a group of physicians who works in a large Brazilian hospital that was facing changes in the reimbursement model.
Originality / Relevance: Research addressing the reasons why physicians tend to resist is important to help strategists to design an approach to obtain professional adherence.
Main results: The research participants perceive threats to their autonomy in two attributes, Clinical Autonomy and Financial Autonomy. Regarding the change in the payment model for services rendered, some interviewees perceive their need, but demonstrate a desire for more active participation in the discussion and elaboration of new models, thus configuring the need to maintain their Political Autonomy.
Theoretical / methodological contributions: This work contributes to the literature by advancing the process of understanding sensemaking triggers and demonstrating how and why threats to professional identity can hamper the process of implementing strategies in complex organizations.
Social / management contributions: The implementation of strategies in hospital organizations is a topic of great relevance for the managers of the healthcare industry, due to its multiplicity of actors and interests, in addition to exponential technological evolution.

Keywords: sensemaking, complex adaptive systems, professional identity, medical autonomy, strategic change

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SENSEMAKING E IDENTIDADE PROFISSIONAL MÉDICA NO CONTEXTO DA MUDANÇA ESTRATÉGICA

RESUMO

Objetivo do estudo: Identificar como os médicos de um grande hospital brasileiro percebem a mudança proposta nos modelos de pagamento pelos serviços prestados e se a mudança proposta afeta elementos da identidade profissional dos médicos entrevistados.
Metodologia/abordagem: Este estudo baseia-se na teoria que aborda sensemaking, identidade profissional médica e implementação de estratégias em organizações complexas. Foi realizada uma pesquisa qualitativa através de entrevistas semi- estruturadas com um grupo de médicos que trabalha em um grande hospital brasileiro que estava enfrentando mudanças no modelo de reembolso.
Originalidade/Relevância: Pesquisas abordando as razões pelas quais os médicos tendem a resistir é importante para ajudar os estrategistas a projetar uma abordagem para obter aderência profissional.
Principais resultados: Os participantes da pesquisa percebem ameaças a sua autonomia em dois atributos, Autonomia Clínica e Autonomia Financeira. Quanto à mudança no modelo de pagamento pelos serviços prestados, alguns entrevistados percebem sua necessidade, mas demonstram um desejo de participação mais ativa na discussão e elaboração de novos modelos, configurando assim a necessidade de manter sua Autonomia Política.
Contribuições teóricas/metodológicas: Este trabalho contribui para a literatura ao trazer avanços para a compreensão dos estímulos sensoriais e demonstrar como e por que as ameaças à identidade profissional podem dificultar o processo de implementação de estratégias em organizações complexas.
Contribuições sociais / para a gestão: a implementação de estratégias nas organizações hospitalares é um tema de grande relevância para os gestores da indústria da saúde, devido à sua multiplicidade de atores e interesses, além da evolução tecnológica exponencial.

Palavras-chave: sensemaking, sistemas adaptativos complexos, identidade profissional, autonomia médica, mudança estratégica

SENSEMAKING E IDENTIDAD PROFISIONAL MÉDICA EM EL CONTEXTO DEL CAMBIO ESTRATÉGICO

RESUMEN

Objetivo del estudio: Identificar cómo los médicos de un gran hospital brasileño perciben el cambio propuesto en los modelos de pago por los servicios prestados y si el cambio propuesto afecta elementos de la identidad profesional de los médicos entrevistados.
Metodología/abordage: este estudio se basa en la teoría del sensemaking, la identidad profesional médica y la implementación de estrategias en organizaciones complejas. Se llevó a cabo una investigación cualitativa a través de entrevistas semiestructuradas con un grupo de médicos que trabajaban en un gran hospital brasileño que enfrentaba cambios en el modelo de reembolso.
Originalidad/relevancia: la investigación que aborda las razones por las que los médicos tienden a resistirse es importante para ayudar a los estrategas a diseñar un enfoque para lograr la adherencia profesional.
Principales resultados: Los encuestados perciben amenazas a su autonomía en dos atributos, Autonomía Clínica y Autonomía Financiera. En cuanto al cambio en el modelo de pago por los servicios prestados, algunos entrevistados perciben su necesidad, pero manifiestan un deseo de participación más activa en la discusión y elaboración de nuevos modelos, configurando así la necesidad de mantener su Autonomía Política.
Contribuciones teóricas/metodológicas: Este trabajo contribuye a la literatura al avanzar en el proceso de comprensión de los estímulos sensoriales y demostrar cómo y por qué las amenazas a la identidad profesional pueden dificultar el proceso de implementación de estrategias en organizaciones complejas.
Contribuciones sociales/de gestión: la implementación de estrategias em las organizaciones hospitalarias es un tema de gran relevancia para los gestores de la industria de la salud, debido a su

multiplicidad de actores e intereses, además de la evolución tecnológica exponencial.

Palabras-clave: sensemaking, sistemas adaptativos complejos, identidad profesional, autonomía médica, cambio estratégico

1 Introduction

One of the characteristics of the healthcare industry is the complexity of the relationships and interactions between its agents (Glouberman & Mintzberg, 2001). Among those agents, physicians occupy a prominent position since their power is based on specific knowledge, which grants them legitimacy to oppose strategic decisions of the organizations where they are inserted (Glouberman & Mintzberg, 2001).

According to Meyer Junior, Pascucci, and Murphy (2012) and Takahashi (2011), hospital managers identify the resistance of the medical profession as an important focus of resistance to strategic changes. However, according to those same authors, when physicians are involved in the decision-making process, they show greater adherence to the new context (Meyer, Pascuci & Murphy, 2012.;Takahashi, 2011). This understanding is essential to all involved in the training of medical professionals and future hospital managers.

To understand the reasons that lead physicians to adopt antagonistic stances in the face of change processes, it is important to identify how the category interprets the meaning of change and whether they perceive threats in the process. Flitter, Riesenmy, and Van Stralen, 2012; Hoff and McCaffrey, 1996; Salvatore, Numerato, and Fattore, 2018; Kyratsis, Atun, Phillips, Tracey, and George, 2017; Fournier, Chênevert, and Jobin, 2020, report that, among the factors that can reinforce positions of resistance in the medical profession is the perception of threats to identity, especially with regard to professional autonomy.

In their recent literature review, Ackerhans, Huynh, Kaiser & Schultz (2024) found that the perception of change in professional identity of health professionals is influenced by status and professional experience and can evolve during the implementation of strategic change.

Karl Weick (1995) states that identity is one of the pillars of sensemaking in changing situations. Understanding if and how agents perceive threats to their identity during the planning and implementation of changes, as well as investigating their reaction – whether positive or negative -, becomes essential to the success of situations in which it is intended to change the current strategy and can inspire managers and educators to deal with similar situations.

In this work, we seek to identify how the physicians of a major Brazilian hospital

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perceive the proposed change in payment models for services provided and whether the proposed change affects elements of the professional identity of the physicians interviewed.

The results made it clear that the professionals interviewed realized the need for the proposed changes, but feared a loss of professional autonomy, which was tied to their own medical identity. They demand greater participation in the decision-making process as a way of maintaining a sense of autonomy.

This article tackles, firstly the key concepts that support the argument of the article, then we proceed to discuss the methodology and context of the research. Finally, we analyze the data and present our conclusions, as well as the limitations of the research.

2 Theoretical reference

Strategy constitutes a broad field of academic research (Fournier, Chênevert & Jobin, 2020; Whittington,1996). However, its implementation remains a challenge for organizations. Whittington (1996), supported by the sociological view of strategy, stated that action and interaction between practitioners can interfere with implementation (Cornelissen & Schildt 2015). By adopting this approach, we seek to understand how agents, or practitioners of the strategy, interfere in its implementation. Authors like Gioia and Chittipeddi (1991) propose that, in a context of change, it is up to the CEO to start the process, through actions that promote sensemaking in the team (Maitlis &Christianson, 2014). On their part, Smircich and Stubbart (1985), identified that despite legitimized power influences sensemaking, this action is not exclusive to leadership, and can be developed in several ways and places in organizations, thus influencing the way in which the strategy is implemented. Schuler, Orr, & Hughes (2023) in fact showed that professionals also construct meaning through their colleagues' attitudes towards the change. In a different perspective, Weiser (2021) found that implementing substantial measures, such as restructuring and granting leaders more "formal" authority, can enhance actors' comprehension of their implementation responsibilities. This, in turn, amplifies their ability to influence sensemaking and sensegiving throughout strategic changes.

All these efforts and considerations lead to an inevitable intersection with Weick's (1995) work on sensemaking. Sensemaking is defined quite differently in the literature. Maitlis and Christianson (2014, p 67), for instance, summarize the concepts of several scholars, defining sensemaking as "*a process, prompted by violated expectations, that involves attending to and bracketing cues in the environment, creating intersubjective meaning through cycles of interpretation and action, and thereby enacting a more ordered environment from which further*

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cues can be drawn." These authors also called attention to the fact that there are three triggers that activate the sensemaking processes, namely: turmoil in the environment and crisis in the company, threats to identity, and planned changes. For the authors, the instability caused by those triggers activates mechanisms of resignification of beliefs and values, initiating the process.

Flitter et al. (2012) argue that sensemaking can reinforce positions of resistance to change, by activating triggers that threaten group identity. This finding is similar to that reported by Azevedo, Sá, Cunha, Matta, Miranda, and Grabois (2017), studying the implementation of improvements in hospitals in Brazil. According to them, communication problems, combined with the bases of power construction and intersubjective aspects, in addition to an alleged interference in professional autonomy, would act as obstacles in the process of adjusting physicians to the changes.

Pascucci and Meyer Jr. (2013), on one hand, specifically mention the lack of support and cooperation from specialized professionals as a factor in strengthening the informal power system, hindering the formation of the strategy. According to Takahashi (2011), Pascucci and Meyer Jr. (2013), and Azevedo et al., (2017), physicians are known to be resistant to change, and may even develop negative sensemaking in relation to the intended strategy. On the other hand, for Edmondson, Bohmer, and Pisano (2001), even specialized professionals, when properly involved and actively participating in the change process, contribute to the success of its implementation. In the same vein, Lusiani and Langley (2019) conclude that the tools used to integrate professionals allow them to perceive that their proposals are considered, increasing the degree of engagement with the institution and the intended strategic direction. Indeed, Day, Balogun & Mayer (2023) studied how a change leader could create sensemaking opportunities influencing professionals through an orchestrated process of participatory meetings that lead to change consistent with the intended objectives.

Different set of studies have analyzed which factors, at the corporate or individual level, favor or hinder sensemaking practices during strategy implementation (Meyer, Pascuci & Murphy, 2012; Balogun et al.,2014; Jacobs, Jarzabkowski, Mantere & Vaara 2014;, Leonardi, 2015; Kraft, Sparr & Peus 2015). Among those factors, Bloor and Dawson (1994) and Denis, Langley, and Rouleau (2007) identify that power legitimized by knowledge has a great impact on complex organizations, also called pluralistic organizations or complex adaptive systems (CAS).

Plsek and Greenhalgh (2001, p. 625) conceptualize CAS as "a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions

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are interconnected so that one agent's actions change the context for other agents. Among the organizations identified as CASs, the healthcare system as a whole and hospitals in particular occupy a prominent position (Anderson & McDaniel 2000).

Based on Bloor and Dawson (1994), and Denis et al., (2007), in CASs the specialized knowledge of professionals, a specific code of ethics, and the degree of professional commitment constitute an ideological framework that gives legitimacy and power to request privileges, in addition to great autonomy of action. According to Denis et al. (2007), in those environments, the strategist is inserted in a stable and shared process, in which practices and routines are not changed instantly, requiring persistence and long-term commitment in order to make an impact.

3 Hospitals as complex adaptive systems

Plsek and Greenhalgh (2001), Plsek and Wilson (2001), and Sturmberg, O'Halloran, and Martin (2012) argue that there is a similarity between the characteristics inherent to CAS and healthcare systems, such as: continuous self-organization, poorly defined limits, multiplicity of non-linear relationships, and sensitivity to the system's initial condition. For those authors, adopting the CAS approach could help to understand the dynamics of the relationships between agents of the healthcare system. Glover, Nissiboin, and Naveh (2020) also endorse this argument, asserting that the causal relationship between interactions among team members and innovations can only be comprehended retroactively, which they identify as a fundamental characteristic of CAS. Those authors also argue that clinical practice, administration, and information management in hospitals are built on a web of interactions and agents, which are best described as complex adaptive systems. In fact, authors such as Anderson and McDaniel (2000), Plsek and Greenhalg (2001), Plsek and Wilson (2001), Sturmberg et al. (2012), and Meyer Jr. et al. (2012) have studied hospitals in the light of the CAS theory.

Anderson and McDaniel (2000), reviewing the literature on CAS, mention three characteristics of healthcare organizations that should be considered when thinking about their management. The first refers to the knowledge and values of the professionals involved, which can represent values socially rooted in the profession, constituting an important source of informal power. The second is the need to recognize that many professionals bring their skills and knowledge to the task, and said knowledge is a source of informal power.

Finally, there are significant differences between healthcare organizations themselves that make the situation even more complex (Anderson & McDaniel 2000). Understanding

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strategic practice in CASs requires observing how organization members make decisions, make sense of organizational phenomena, and operate strategies (Day, Balogun & Mayer, 2023).

However, with the progressive increase in hospital complexity and in the way care is produced, there was a replacement of physicians, as managers of institutions, by professional administrators, generating a dichotomy between the impact of clinical decisions and administrative decisions (Anderson & McDaniel 2000; Pascucci, Meyer & Crubellate 2017). This is partly because physicians and administrators have different standards of rationality (Anderson & McDaniel 2000).

Dealing specifically with interactions between agents, Glouberman and Mintzberg (2001) expressed the multiplicity and complexity of interrelationships between the different agents. The authors demonstrate that a hospital is not a single corporation, but a combination of interdependent organizations, with a high degree of autonomy legitimized by hierarchy or by the knowledge inherent to the profession. In line with this proposition, Meyer Jr. et al. (2012) argue that hospitals are organizations with multiple objectives, not necessarily compatible with a single strategic direction.

4 Medical identity, autonomy, and resistance to change processes in a hospital setting

An important factor associated with the difficulty in implementing a strategy in a hospital was identified by the research done by Meyer Jr. et al. (2012), was the lack of senior management engagement in sensemaking for middle management in two non profit brazilian hospitals. According to the authors' perspective, strategic management practices were diminished, particularly due to middle managers' lack of understanding regarding the implementation of strategies, as the holding company prioritized decision-making and the formulation of hospital goals and strategies (Meyer Jr. et al., 2012).

Studying the relationship between medical and non-medical leaders working in the National Health System (NHS), Mitra, Hoff, Brankin, and Dopson (2019) revealed three levels that generate tension between medical and non-medical leaders, namely: interpersonal, operational (especially deadlines and budgets), and cultural (medical culture). In order to mitigate tensions, leaders used proactive communication and silo breaking by establishing common goals among peers, recognizing that patients should be the focus of attention.

Specifically studying the implementation of new payment models in seven private hospitals, either for profit and nonprofit, in Sao Paulo, Brazil, Takahashi (2011) mentions that hospital managers claimed difficulty in involving physicians in the process of evaluating said

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models. However, some institutions achieve greater adherence by involving professionals in the process of developing those new models. This happens, in the words of the author, because "the protocols to be followed are formatted by the executing specialists themselves" (Takahashi, 2011 p. 80).

A study conducted by Hoff and McCafrey (1996), enrolling self-employed and salaried physicians, found that both groups share the same professional values, but make different sense of the changes in their autonomy and, thus, adopted different strategies to cope and negotiate the change. Self-employed physicians resist adaptations and work related games in order to maintain their economic autonomy while salaried physicians are more concerned with their technical autonomy, but they can only react to the HMO as it adapts itself to the change (Hoff and McCafrey, 1996).

Given the critical role played by the knowledge and values of the professionals involved, it is important to consider the independence of physicians in relation to the formal administrative hierarchy (Anderson & McDaneil, 2000). Physicians often establish their own hierarchy, which may influence their perception of organizational change. Additionally, hospital managers report difficulties in involving physicians in the change process, highlighting the need to understand how physicians perceive and interpret change. Such reinterpretation of change may affect deeply rooted professional values, potentially leading to the emergence of resistance mechanisms (Glouberman S, Mintzberg, 2001). In this context, one of the aspects under scrutiny is resistance, particularly as a response to perceived threats to the autonomy and professional identity of medical practitioners. Indeed, Hoff and McCafrey (1996), Kyratsis et al. (2017), Hendrikx (2018), Salvatore et al. (2018), and Fournier et al. (2020) identified medical autonomy as one of the main components of the medical professional identity (culture). Edmondson, Bohmer, and Pisano (2001), Pascucci and Meyer Jr. (2013) Azevedo et al. (2017), Luisiani and Langley (2019), and Salvatore, Numerato, and Fattore (2018) identified influence on organizational decisions as one of the attributes of medical autonomy.

Moreover, Salvatore et al. (2018) identify freedom to organize work and social and financial freedom as values of medical autonomy. Hence, according to Salvatore et al. (2018), the medical professional identity is shaped by various factors. These include the sense of professional autonomy, which encompasses the ability to influence organizational decisions, clinical autonomy in determining patient treatment, as well as financial and social autonomy, entailing control over one's financial resources and work schedule.

For Doolin (2002), medical autonomy is also based on three pillars named by the author as political autonomy, technical (clinical) autonomy, and economic autonomy. As stated by the

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author, political autonomy concerns the freedom to establish policies in their field of action. Clinical autonomy, on the other hand, refers to the claiming of the exclusive right to medical knowledge and to diagnose and treat patients. Economic autonomy consists of the freedom to establish their remuneration (Gioia et al.,1994). This author argues that understanding professional identity is essential for understanding physicians' reactions to attempts to control their practice and behavior. Table 1 below summarizes this construct.

Table 1

Main elements that constitute the medical professional identity

Analytical Category Constitutive Definition		Authors
Clinical Autonomy	Exclusive right to medical knowledge and to diagnose and treat patients as he or she deems most appropriate	Doolin 2002; Salvatore et al. 2018
Financial Autonomy	Freedom of the category to set their fees.	Doolin 2002; Salvatore et al. 2018
Political Autonomy	Possibility of influencing institutional decisions and establishing his or her own schedule, pace of work, and evaluation criteria	Doolin 2002; Slavatores et al. 2018; Azevedoet al. 2017; Lusiani and Langley 2019

Source: Prepared by the authors

Considering the aforementioned points, one would anticipate that a successful strategic change initiative would prioritize the management of meanings, particularly regarding the possibly resistant medical profession. This is essential for effectively engaging those impacted by the process, as emphasized by Edmondson, Bohmer, and Pisano (2001), thereby overcoming resistance and seamlessly integrating them into the collaborative development of the desired direction, as suggested by Day, Balogun, and Mayer (2023).

Therefore, in order to understand more specifically how the sensemaking process takes place for physicians and their resistance or adherence to the organizational strategy, it is important to understand which threats to elements of the professional identity are perceived by those agents, which would make it possible to identify potential ways to increase their adherence to change.

5 Methodology

Following the same trajectory as Maitlis (2005), Gioia and Chittipeddi (1991), Gioia, Thomas, Clark, and Chittipeddi (1994), and Balogun and Johnson (2005), this work used Qualitative Research, of a mixed deductive - inductive nature, through a cross-sectional Single Case Study in order to capture the diversity and complexity of the research context. The choice of method is further justified, as we propose to investigate complex social phenomena, highlighting the strategic organizational and identity processes of the practitioners, i.e.: how threats to professional identity influence the sensemaking process of physicians in the face of a new strategy that is being discussed within the organization (Yin, 2015). We went to the field with previously listed categories, but we accepted the inclusion of new categories during the analysis process.

In addition to access to doctors from the institution's clinical staff, we formally request access to the organization's documents. However, that access was denied due to the sensitivity of the topic and its relevance in the context of the market positioning of the studied hospital. Therefore, we chose to build this work using only interviews as a data collection method and a triangulation within the interviewees. A similar situation was reported by Jolemore (2018).

Data collection

The field research was carried out through semi-structured interviews by the first author, given his medical training, which allowed him to better dialog with and relate to the respondents. They were conducted between October 5 and 9, 2020, being recorded and transcribed verbatim. As we were unable to triangulate the sources, we followed Patton's recommendation (1990, p187), seeking greater triangulation of investigators.

Eleven professionals were interviewed, with varying lengths of service (from 1 year to 25 years at the hospital), whose selection was made by the Chief Medical Officer of the institution studied, based on the following criteria, established in common agreement with the researchers:

- Be a permanent member of the Clinical Staff (resident physicians and other categories whose connection with the institution is temporary were excluded)
- Heads and staff members.
- Professionals with varied experience at the Hospital.

- Physicians with clinical and surgical specialties.
- Physicians with and without administrative experience.

Table 2 summarizes the profile of the participants:

Table 2

Profile of the participants

Medical Speciality	Category	Years working in the hospital
Anesthetist	*Staff*	08
Skin surgery	*Head*	25
Abdominal surgeon	*Staff*	13
Head and neck surgeon	*Head*	15
Head and neck surgeon	*Staff*	18
Gynecologist surgeon	*Head*	13
Clinical oncologist	*Staff*	05
Clinical oncologist	*Staff*	01
Radiotherapy	*Head*	25
Urologist	*Head*	20
Urologist	*Staff*	15

Source: Prepared by the authors

In order to define the above categories, the following criteria were observed: proximity, by either time or type of work relationship established, access to strategic information, as well as dependence on said access for the execution of their work. Furthermore, we sought to avoid bias, which is why differences were observed in terms of length of time working at the hospital, differences in specialties, and experience with administrative roles.

To ensure confidentiality regarding the identity of respondents, we used the "True Random Generator®" application, available on the Google® Store, which generates random numbers. The researchers used the numerical range from 0 to 1000, without repetitions, to ensure complete confidentiality. Respondents were informed of their respective number (ex: Subject 568, or 677), and the interviews were identified only with the generated number. Only the first author has access to the name/number identification key in case any clarification is needed from a respondent.

The questionnaire was divided into two blocks of questions. The first, consisting of 4 questions, aimed to establish a relationship with the interviewee, learn about their academic

background and their professional context in the organization, in addition to their vision of the health sector and the context of the change in the remuneration model, identifying possible resistance to the model. The second block, with 6 questions, sought to explore the doctor's perception regarding the topic, such as internal awareness is being raised, what threats the interviewee perceives in relation to the subject and what are the suggestions to increase the professional category's adherence to the change.

For data categorization and analysis, we used the NVivo® software. The technique used was content analysis, defined by White and Marsh (2006) as a rigorous and systematic approach to analyzing documents obtained or generated during research. In line with Weick (1995), who reinforces that, although content is an essential resource for sensemaking, even more important is the meaning of the content. Moreover, this meaning depends on the way in which the various contents of the organization, embodied in signals, structures, and connections, are interconnected.

Gioia and Chittipeddi (1991) and Balogun and Johnson (2005) analyzed the content of interviews using first- and second-order findings. This methodology made it possible to identify events (first-order findings) and their consequences (second-order findings), from the viewpoint of the research subjects. Furthermore, Jolemore (2018), studying the process of training medical leaders, states that content analysis allows for the development of knowledge on the subjects that make up the content of the narratives. The authors used content categorization, considered a classic method in content analysis. Through this technique, the categories of each topic are identified, and their content is analyzed and compared. In her work focused on learning in leadership, the author found the issue of medical professional identity as one of the great subjects that emerged from the interviews. To complete the case study, the following analytical categories were defined in a deductive way, based on the literature already referenced (see Table 1), and expressed in Table 3.

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Table 3

Analysis categories and operational definitions

Analytical Category	Operational Definition			
	Constitutive Definition	**What was evaluated**	**Authors**	**Questions for the interview script**
Clinical Autonomy	Exclusive right to medical knowledge and to diagnose and treat patients as he or she deems most appropriate.	The respondent's perception regarding the imposition of internal or external controls on the prescribed treatment.	Doolin 2002); Salvatore et al. (2018)	9. Perception, by the respondent, of the potential impact on his or her medical practice resulting from those new models of payment for hospital services.
Financial Autonomy	Freedom of the category, or of the respondent him- or herself, to set their fees.	What is the meaning attributed by the respondent to this dimension and how, in his or her assessment, his or her financial autonomy will be impacted in the face of new payment models.	Doolin(2002); Salvatore et al. (2018)	3. The respondent's overview of the healthcare market and the relationship of hospital service providers with third party payers; 4. Knowledge and understanding, by the respondent, of existing hospital service payment models in the market;
Political Autonomy	Possibility of Influencing Institutional decisions and establishing his or her own schedule, pace of work, and Evaluation criteria	How the respondent perceives physicians' engagement in the change process, what is the level of participation of the categories studied (Coordinators and staff).	Edmondson et al. (2001); Doolin (2002); Pascucci & Meyer Jr. (2012); Salvatore et al. (2018); Azevedo et al. (2017); Luisiani & Langley (2019)	5. How are internal discussions on the topic conducted? Do you remember any event (general meetings, or those of the department to which you report) in which the subject was raised? 6. In addition to events, was there any kind of internal communication? What types of communications were used? 7. What caught your attention in this communication process? 8. Do you talk to other medical colleagues about this subject? 9. What is your perception of the engagement of physicians in general on this topic? In your opinion, what motivates this engagement? 10.Suggestions from the respondent to improve the process of internal discussion and communication in relation to the subject

Source: Prepared by the authors.

Research context

In Brazil, the healthcare system consists of a public component identified through the SUS (Unified Health System), with its own regulation, and a private sector, called Supplementary Health, whose regulatory framework occurred in 1998 through the enactment of law 9,656. The purpose of that law was to regulate the performance of Health Insurance Providers (OPS), by setting forth several requirements related to the solvency of companies, in addition to defining mandatory minimum coverage (later gathered in the List of Mandatory Minimum Coverage, or simply ROL), and to regulate the adjustment rates allowed for health insurance plans. In order to reach this goal, in 2000, law 9961 created the National Supplementary Health Agency (ANS), whose purpose is to regulate the performance of OPSs in relation to customers and service providers.

Those changes transformed a system that was deregulated into a heavily regulated system, in which OPSs coexist with considerable increases in costs, due to both the incorporation of new technologies and the increase in use due to the aging of the population (Reis 2018). In addition, the healthcare market is considered imperfect, as hospital cost perspectives are different for patients (consumers), healthcare providers (suppliers), insurance companies (third-party payers), and society (Scott, Solomon & McGowan 2001). This fact leads stakeholders to have different and sometimes conflicting perceptions of what is an essential expense and what would be a mere waste of resources.

Faced with this scenario, the ANS revealed, in 2019, that it intended to "[...]induce the sector to seek alternatives for how to remunerate service providers in replacement of the exclusive fee for service, provided that the new models ensure the quality of services provided and are not exclusively based on cost reduction."

Those discussions within the regulatory agency led the hospital sector to promote discussions, within the organizations or their representative entities, regarding the new remuneration models. An example of a discussion forum was the Congress of the National Association of Private Hospitals (CONAHP), in 2019, the subject of which was "Healthcare Based on Value Delivery: The Hospital's Role as a System Integrator," which shows the importance that some of the major Brazilian hospitals have been giving to this subject.

Next, we will briefly describe how the hospital has been internally addressing the issue and what is the empirical unit of analysis used in this work.

The hospital studied & strategic changes and the unit of empirical analysis

Founded in the 1950s, the Hospital is a tertiary-level philanthropic institution, specializing in high-complexity care, with a closed Medical Clinical Staff, composed of 570 physicians from various clinical and surgical specialties.

Schedule 1

Structure and care indicators of the hospital studied

- Operational Beds 372
- ICU beds 53
- Registered physicians 570
- Active employees 4,134
- ER consultations 26,424
- Outpatient consultations 345,049
- Hospitalizations 22,187
- Surgical procedures 22,107
- Tests conducted (Ancillary Diagnostic or Therapeutic Service) 2,155,849
- Insurance companies covered (including SUS) 88

Source: Adapted by the authors from the ANAHP Observatory (2020) and the Hospital's website.

Since 2017, the institution's Senior Management has been aware of the need to move forward with differentiated remuneration models and reporting greater proximity to paying sources in the development of said models, as verified in its Annual Sustainability Reports. Additionally, this hospital participated in a project for the treatment of a specific disease, by creating a bundle (or protocol) which provided for the payment of a previously determined amount and which encompassed all the care and procedures that the patient would need, for a period of 1 year. The preparation and pricing of that bundle involved several agents, both physicians and professionals from other areas of healthcare and the administrative staff. This signaled, in practice, the top management's willingness to advance in differentiated payment models and brought to the body of physicians involved the perspective of what those models represent.

In view of this, we sought elements that demonstrated the meaning attributed by physicians' knowledge about the strategy of developing alternative service payment models and their perception of this issue. In this way, the unit of empirical analysis was the physicians of the clinical team, mixing clinic heads and staff doctors.

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6 Presentation & discussion of results

The interviews were transcribed verbatim, and these transcripts were initially reviewed while listening to the corresponding recordings, aiming to identify any inconsistencies in the transcribed text. Subsequently, new readings were done until saturation was reached. After this step, the files were processed in the NVIVO® software.

Table 4 shows the analysis categories set out herein and the subcategories that emerged from the field and which we will explore next.

Clinical autonomy

Clinical Autonomy emerged in responses related to the perception of interference in prescription or restriction of freedom to appoint resources. According to the respondents, these elements negatively influence the construction of sense. For them, interference comes from the regulatory mechanisms established by the ANS.

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Table 4

Analysis categories and subcategories identified in the field

Analysis Categories & Subcategories Identified	Definition
A: Clinical Autonomy	**Exclusive right to medical knowledge and to diagnose and treat patients as he or she deems most appropriate.**
A1: Interference with medical prescription	Interference carried out after the prescription, internally in the institution or by health insurance plans, via denial of authorization, for instance.
A2: Freedom to appoint resources	Autonomy to prescribe the treatment he or she considers more effective for his or her patient.
B: Financial Autonomy	**Freedom of the category, or of the respondent him- or herself, to set their fees.**
C: Political Autonomy	**Possibility of influencing institutional decisions and establishing his or her own schedule, pace of work, and evaluation criteria.**
C1: Setting his or her own work schedule	Establishing his or her own pace of service and work schedules.
C2: Participation in the decision of performance evaluation criteria	Defining, together with his or her immediate supervisors, the criteria for evaluating care and academic performance.
C3: Participation or greater representativity in strategic decisions	Direct participation or via a greater number of representatives in committees and strategic discussions.
C3.1: Lack of clear information on proposed changes	Need to receive information in the most direct way possible, without intermediaries, and to receive status reports on initiatives in which he or she has already participated.

The respondents' perception in relation to the clinical autonomy category is that there is a need to measure the performance of professionals and evaluate the outcomes for patients. In addition, it is necessary to inform OPSs of the benefits in relation to items that are requested and are not authorized. In this way, they understand that there is an intertwining between the measurement of outcomes and performance and Clinical Autonomy. For Subject 115, the occasional refusal of authorization by OPSs is due to the lack of communication of the outcome for patients in relation to items used in the institution. Thus, this respondent understands that the change in the payment model would force his department to review prescriptions and measure the outcomes so that they could continue using what they think is best for the patient.

There is a clear perception, by the respondents, of the importance of measuring results and informing them to the paying sources and to society, but they believe that there is still a lack of adequate tools and processes to reach this goal. In the respondents' perception, this interference should increase with the implementation of new payment models. For Subject 568,

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change is a source of great insecurity, as it is made to "control what doctors are going to do as much as possible."

With regard to the autonomy to appoint resources, we found physicians who perceive that they still hold control over the means of diagnosis and treatment. They are supported by the assessment that their practice is based on scientific evidence (Subject 40) or by the belief that, when measuring outcomes (Subject 115) or directly participating in the construction of new models (Subject 588), their autonomy to appoint resources would be preserved.

Financial autonomy

From the Financial Autonomy point of view, there are those who believe that there will be a restriction of medical activity (Subjects 568, 677, and 924). The perception of Subject 568, based on informal conversations with other physicians, is that there is great insecurity, particularly in relation to financial and clinical aspects. This perception is corroborated in the discourse of other respondents, since medical fees are no longer agreed directly between professionals and patients and are now negotiated between the hospital and health insurance providers. Thus, for Subject 924, there is a fear that, if physicians do not take part in the discussions regarding the remuneration model, they will be "sold cheap." This sentiment is similar to the perception of Subjects 177, 568, and 677, for whom, in addition to the loss of autonomy in negotiation, there is also a depreciation of the fees negotiated between the institution and providers, despite their professional excellence being recognized. Conversely, there is a notion that the shift in the payment model and the emphasis on cost containment are essential to deter healthcare providers from directing their patients to alternative institutions, thereby potentially diminishing physicians' financial incentives.

Political autonomy

From the Political Autonomy point of view, we did not find, in our interviews, any references to the subcategory of setting one's own work schedule, but we did identify that there is a strong desire of the respondents for greater participation or representation in decisions, with this being the only attribute mentioned by all research participants. Some respondents were very emphatic, expressing that physicians should participate "for real... in a discussion that has decision-making power!" (Subject 924). Another respondent has the perception that "if the physician's gaze is missing, it will be hard!" (Subject 677). We can perceive in these statements

the physicians' intention to effectively participate in and maybe even resist decisions that have been made without their participation. One respondent justifies this position with a metaphor:

> *That is, the person makes a decision without talking at all to the person who is executing it, as if he were a general deciding that he is going to send the army to attack over there and he doesn't know that over there is a quagmire. So we, who are there, know that we can't enter that place, there is a quagmire there and we are going to die in this war. (Subject 383).*

This discourse shows that physicians consider that they have knowledge that can contribute for the institution to be able to reach the proposed goals with the change. A genuine interest in participating more in strategic decisions was identified.

In this work, several respondents expressed that, in the institution, there is a centralization of strategic information, which is only passed on to the Heads of medical departments at committee meetings. This creates communication gaps between senior management and the clinical staff, leading to a perception that the institution is indifferent to the views of its members. We identified a perception that the Clinical Staff does not receive clear information about the proposed changes, which motivated a more in-depth analysis of this issue, constituting a specific subcategory therefore. The communication of the hospital's strategy, according to the respondents, is transmitted to the Clinical Staff through the Heads of each department. This way, depending on the Head's position in relation to the strategy, the information may arrive filtered (Subjects 568 and 647) or even "skewed" (Subject 383). Direct communication is a desire of the Hospital's clinical staff. Another point of interest, raised by the professionals, is about clarifying the reasons for this change. The discourse of Subject 588 synthesizes the respondents' perception with regard to the need for change:

> *So this proposal for different remuneration models follows the evolution of what is happening in relation to the concern about the cost of sustainability. So, you, for example, say that you do procedure x and that you can cure the patient, that's great, it's perfect, it's excellent, but you need to understand at what cost you can do that, because the system needs to be supported. And then, I'm not saying that you don't have to treat them, but that, when you are going to propose a new treatment, you have to worry about whether said treatment needs to have a cost analysis. And it needs to have a rationality to be used and, in addition, there is something that all civil society today asks for, which is the result analysis. (Subject 588).*

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Table 5 synthesizes the analysis categories used herein and how the respondents perceive the questions related to each of them.

Table 5

Analysis categories and respondents' perception

Analytical Category	Constitutive Definition	Analysis Subcategories	Authors who address the subject	Respondents' Perception
Clinical Autonomy	Exclusive right to medical knowledge and to diagnose and treat patients as he or she deems most appropriate.	Interference with medical prescription; Freedom to appoint resources	Doolin (2002); Salvatore et al. (2018)	*"(...) and today I see that healthcare plans are increasingly restrictive in approving tests, procedures etc., especially due to the high costs that those procedures have. So I see that this ends up ultimately reflecting on the patient who sometimes has some procedure denied, some medication denied. So I see this as something that has been happening more and more, this kind of situation." (Subject 281)* *"Especially for the practice. You request a certain treatment and the insurance company denies it. I won't pay for it, you won't have it, you won't do it. "(Subject 281)* *"Huge insecurity! Huge insecurity!* *The feeling is that these changes are always made toward paying doctors as little as possible and controlling what doctors will do as much as possible." (Subject 569).*
Financial Autonomy	Freedom of the category, or of the respondent him- or herself, to set their fees.	What is the meaning attributed by the interviewee to this dimension and how, in their assessment, their financial autonomy will be impacted in the face of new payment models.	Doolin (2002); Salvatore et al. (2018)	*"It's a centuries-old, decades-old oral tradition, if you will, which is something that is coming to an end, so he would charge whatever he wanted, he would request whatever he wanted, he didn't have to care much about the paying source, how long the patient would be hospitalized, the material, medication. The feeling is that the number of administrators within the hospital is growing more and more, their power is growing, and, let's put it this way, the drive is to increasingly push doctors' salaries down, as much as possible." (Subject 568).* *"(...) this model that seems to come from abroad, with results obtained abroad, and we're asked to replicate it. Excellence like abroad, but with payment like here. And this is an issue, as doctors can see. So, I, so-and-so, used to do whatever I wanted, but now, ... I have to do it the way they want it and I have to earn what they want to pay me." (Subject 677).* *"(...) when you see your compensation, your compensation doesn't match what they advertise about you.." (Subject 177).*
C - Political Autonomy	Setting his or her own work schedule; Participation in the decision of performance evaluation criteria; Participation or greater representativity in strategic decisions; Lack of clear information on proposed changes.	How the interviewee perceives the physicians' engagement in the change process, what is the level of participation of the studied categories (Coordinators and staff).	Edmondson et al. (2001); Doolin (2002); Pascucci & Meyer Jr. (2012); Salvatore et al. (2018); Azevedo et al. (2017); Luisiani & Langley (2019)	*"I think that, actually, I think that the clinical staff should be involved, should be called, and this is a demand of ours, to really be involved in a discussion that has decision-making power." (Subject 924);* *"I think that there should be more direct communication. Direct communication with doctors. Without always going through communicating the head of the department and seeing what will get filtered later." (Subject 568).* *"I think that we need, I know that sometimes you can't engage everybody, open an auditorium with 1000 people and hold a meeting and sometimes it's not productive... so I'll have 50. So then you have more representativity and with more frequency, you do it, and another thing is that management needs to listen. Because it's part of the mechanism of the conception of wisdom, listening. You don't have to follow, but you have to listen! And it's not possible that, among 50 people talking, you won't take 10 or 15% who deserve to be brought to the front. This is why I think both parts need to be heard." (Subject 40).* *"I learned from my HR friends that, if you don't show why you're doing something, your chances of failing are gigantic. So, we need to go through that, to show why that thing is important and why you're doing it that way." (Subject 588).*

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Discussion of findings: Physicians' sensemaking in the face of strategic change: Threats to professional identity

Maitlis and Christianson (2014) identified that planned changes and threats to identity are powerful triggers for Sensemaking. Weick (1995) argues that, when one's identity is destabilized, the sensemaking process is threatened, and this threat can expand.

Also, Miettinen (2021), studying the impact of negative emotions on strategy implementation, found that these emotions can trigger a shift in response to change, which leads to implementation challenges.

The findings of this study reveal that physicians view many of the ongoing strategic changes as threats to their professional identity, particularly concerning the analysis of Clinical Autonomy, Financial Autonomy, and Political Autonomy. Numerous respondents recognize the necessity of a strategic change regarding the service payment model. In the previous fee-for-service model, there is a consensus that "one can't make ends meet" (Subject 924), as it encourages unnecessary utilization (Subjects 115 and 177), thus incentivizing inefficiency (Subjects 177, 40,647).

Thus, on one hand, we have, in the external environment, the institution, the regulatory agency (ANS), which, in addition to setting mandatory coverage for OPSs, encourages the adoption of alternative payment models. Additionally, the providers themselves, still in the external environment, pressure the Hospital's administration and physicians to contain costs and adopt new models. On the other hand, we have physicians, aware of the high cost of care, but driven by the desire to always offer the best to their patients, regardless of regulatory or contractual clauses. And, finally, hospital managers, pressured by both physicians and OPSs. The former wishes to continue enjoying clinical autonomy, and the latter eager to control care costs. These elements give the system the characteristics inherent to CASs, such as the non-linearity of interrelationships between the agents that give complexity to the strategic changes and the sensemaking management to implement them.

The case study revealed that physicians perceived a change, deemed necessary, as threatening. This perception stemmed from the change's impact on deeply ingrained professional values, which are integral to their professional identity. Despite understanding the need to change payment models, the respondents perceive and fear the loss of Clinical and Financial Autonomy, which activates triggers of resistance to change.

It is challenging for the physicians investigated to deal with this contradiction and to resignify change, in order to maintain a consistent and positive self-image (Kyratsis et al.,

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2017). For Doolin (2002), decisions to assume leadership positions in the institution may reflect physicians' desire to maintain Political Autonomy, influencing care services.

In the same vein, the works by Edmondson et al. (2001), Pascucci and Meyer Jr. (2013), Azevedo et al. (2017), Lusiani and Langley (2019), Salvatore et al. (2018), Day et al (2023) and Ackerhans et al (2024) show that the perception of greater participation in decision-making processes activates positive sensemaking triggers, promoting greater adherence to changes. In the case investigated, professionals do indeed feel the need for greater participation, to feel empowered as active agents in the defense of their professional prerogatives (Lusiani and Langley, 2019).

In this research, we identified the need and the value that respondents perceive in participating in strategic decisions that involve changes in healthcare service payment models.

In the next section, we will present the conclusions of this work, its limitations, and the suggestions and recommendations for the field and for the practice.

7 Conclusions

The aim of this study was to investigate how physicians at a prominent Brazilian hospital perceive the proposed change in payment models for services provided, and whether this proposed change affects elements of the professional identity of the physicians interviewed.

Based on the field findings, the study also aimed to determine, from the perspective of physicians, actions that could encourage greater adherence of the professional category to the intended strategy. In pursuit of this goal, insights were drawn from the concept of sensemaking and the theory of complex adaptive systems, given the unique characteristics of hospital organizations (Plsek and Greenhalgh 2001; Anderson and McDaniel 2000; Pascucci, Meyer Jr and Crubellate 2017).

According to the literature, medical professional identity is based on Medical Autonomy with its three pillars: Clinical Autonomy, Financial Autonomy, and Political Autonomy (Flitter and Riesenm 2012; Azevedo et al. 2017; Luziani and Langley 2019; Doolin 2002).

The interviews pointed to the relevance of Political Autonomy, through statements related to the "Participation or greater representation in strategic decisions" and "Lack of clear information on proposed changes" subcategories. The respondents suggested improvements in the internal communication process, such as more direct information to the Clinical Staff and greater clarity in the information passed on. They also suggested greater participation in discussions and greater participation in decision-making processes. These findings are in line

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with Edmondson et al. (2001) who state that the implementation of a change must observe, among others, communication and time so that those involved can collectively reflect on the appropriate process.

The interviews also revealed the need and value that the respondents perceive in participating in strategic decisions that involve changes in healthcare service payment models. This finding is corroborated by the works of Edmondson et al. (2001), Pascucci and Meyer Jr. (2013), Azevedo et al. (2017), Lusiani and Langley (2019), Salvatore et al. (2018), Takahashi (2011) and Ackerhans et al (2024). Salvatore et al. (2018) found a positive correlation between the participation of physicians in strategic decisions and their identification with the organization, showing the importance that those professionals ascribe to participation.[6] Still on this topic, Pascucci et al. (2017) report that the administrator of a hospital studied by the authors reported that she reduced physicians' resistance, showing them the benefits of the intended strategy, to them and to the institution. Ackerhans et al (2024), found that involving physicians in the decision making increases their willingness to change their long term practice patterns.

Doolin (2002) refers to the prerogative of making political decisions as a constitutive element of medical identity. For the author, physicians' desire for greater participation in decisions can be justified by their desire to maintain or expand control over care activities, and resistance tends to occur when there is a perception that a change challenges professional values.

In regard to clinical autonomy, some professionals perceive an interference in prescription or restriction of freedom to appoint resources, but others claim that they still maintain control over the means of diagnosis and treatment, since they use protocols and guidelines based on the best scientific evidence (Hoof T. J., & McCaffrey, 1996). Salvatore et al. (2018) warn of the potential misunderstanding of this perception, as it is necessary to look beyond managerial control and cost concerns. For the authors, performance measurement systems and institutional protocols are also elements that constitute barriers to professional autonomy (Flitter MA, Riesenmy, 2012).

The results of this research show that physicians are aware of and understand the need for changes in the service payment model. However, the lack of structured information generates feelings of threat to their professional identity, related to the Clinical Autonomy and Financial and Political Autonomy analysis categories. When confronted with a change deemed necessary yet posing a threat to deeply ingrained professional values that form integral components of their identity, physicians must navigate this contradiction. It becomes imperative for them to reinterpret the change, ensuring consistency and fostering a positive self-image

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(Kyratsis, 2017). Greater participation of physicians in the process of discussing changes, by promoting a sense of Political Autonomy, can activate positive sensemaking triggers, favoring the development and implementation of the proposed changes.

Contributions, limitations, and future advancements

This research was conducted in a single, specialized philanthropic hospital, with a closed Clinical Staff. Hospitals, despite being similar organizations, have distinct characteristics, which makes it difficult and complex to replicate results.

Another point of weakness lies in the sample size, consisting of 11 respondents in a universe of 570 registered physicians in the clinical staff. The fact that we were denied access to the organization's documents, as well as being a limitation to the study, shows how sensitive the topic still is in hospital management.

The limited sample, however, allowed for an in-depth analysis of the interviews, looking for elements of medical language and construction of sentences and meaning of words, enabling a greater understanding of the respondents' perception in relation to the proposed change. Despite these limitations, the study is supported by the literature presented, related to medical identity and the sensemaking process in organizations.

This work contributes to the literature by advancing the process of understanding sensemaking triggers and demonstrating how and why threats to professional identity can hamper the process of implementing strategies in complex organizations. We believe that other professional organizations, such as Universities, for example, would benefit from studies involving the elements that constitute the identity of the professional category of those institutions.

Furthermore, this study brought empirical contributions to previous findings recorded in the literature, as well as evidence on other analysis categories that make up medical identity and their contribution to the construction of sense.

In terms of advancement to the literature, qualitative research, when addressing issues from the participant's perspective, is subject to subjectivity (Maitlis, 2005). Thus, in order to establish the cause-and-effect correlation between analysis categories, their influence on professional identity, and change resistance triggers, a quantitative study could be conducted. Among the advantages of this method are reaching a greater number of participants and the possibility of establishing a correlation through statistical analysis between variables determined. Given that sensemaking is an ongoing process, influenced by cycles of

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interpretation and action, evaluating the perceptions of professionals at the Hospital studied after the action cycles have commenced would provide a valuable contribution to the literature. Such an assessment, conducted longitudinally, would shed light on the effectiveness of the practices implemented by senior management to garner adherence from the professional category towards the planned changes. As for the contributions to the practice, the implementation of strategies in hospital organizations is a topic of great relevance for the managers of those institutions, as the scenario of the healthcare industry is always chaotic, with a multiplicity of actors and interests, in addition to exponential technological evolution. Knowing how the proposed changes affect values ingrained in the medical professional identity is critical to understanding those professionals' objections and establishing strategies to gain their support. In the words of McDaniel and Driebe (2001):

> *When it is understood that healthcare organizations are complex adaptive systems and that they share the characteristics of those systems, the managerial focus changes. It is no longer on knowing the world, but understanding its meaning; predicting the future, in order to prepare the organization for an unpredictable future, and controlling the system, in order to unleash the system's dynamic potential.*

By recognizing the perceived threat to professional identity among the interviewed group and gathering suggestions from this group to enhance adherence to the planned changes, this study contributes to the advancement of strategy implementation. It serves as a crucial tool for the Hospital to gain competitive advantages in a fiercely contested segment such as the tertiary healthcare market. Another point that deserves to be highlighted is the importance of communication for constructing sense, involving the participants, and consequently implementing the desired strategy.

We suggest that future research analyze documents produced by hospitals on the subject. We also suggest a survey with a larger number of professionals.

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Ethics Disclaim: Since the Brazilian Board for National Health in its 49th extraordinary meeting, occurred on april/2016 published the Resolution nº 510 , witch states that research that aims at the theoretical deepening of situations that emerge spontaneously and contingently in professional practice, as long as they do not reveal data that can identify the subject will not be analyzed or registered in the national ethics research committee, we do not submitted this work to any ethics committee.

References

Ackerhans, S., Huynh, T., Kaiser, C., Schultz, C. (2024) Exploring the role of professional identity in the implementation of clinical decision support systems—a narrative review. Implementation Science (2024) 19:11. https://doi.org/10.1186/s13012-024-01339-x

Anderson RA. & McDaniel RR Managing health care organizations: Where professionalism meets complexity science. *Health Care Manag Rev*. 2000;25(1):83–92. doi: https://10.1097/00004010-200001000-00010

ANS, *Guia para Implementação de Modelos de Remuneração baseados em valor* (Guide to Implementing.

Azevedo CS, Sá MC, Cunha M, Matta GC, Miranda L, Grabois V. (2017). Racionalização e Construção de Sentido na Gestão do Cuidado: uma experiência de mudança em um hospital do SUS (Rationalization and Sensemaking in Care Management: na experience of strategic change in a SUS hospital). *Ciência & Saúde Coletiva* 22(6) (Jun.). 1991–2002. doi: https://10.1590/1413-81232017226.13312016

Balogun J., & Johnson, G. (2005). From Intended Strategies to Unintended Outcomes: The Impact of Change Recipient Sensemaking. Organization Studies 26(11) (nov.). 1573–1601. https://doi.org/10.1177/0170840605054624

Balogun, J, Jacobs, C, Jarzabkowski, P, Mantere, S & Vaara, E. (2014), Placing Strategy Discourse in Context: Sociomateriality, Sensemaking, and Power. *Journal of Management Studies*, 51(2), 175-201. doi: https://10.1111/joms.12059

Bloor G, Dawson P. Understanding professional culture in organizational context. *Org Stud*. 1994;15(2):275–295-h doi: https://10.1177/017084069401500205

Burgelman RA. A process model of internal corporate venturing in the diversified major firm. *Admin Sci Q*. 1983;28(2):223. doi: https://10.2307/2392619

Cornelissen J, Schildt H. (2015). Sensemaking in Strategy as Practice: A Phenomenon or a Perspective? In D. Golsorkhi, L. Rouleau, D. Seidl, & E. Vaara (Eds.), *Cambridge Handbook of strategy as practice* (second edition ed., pp. 345-364). Cambridge University Press.

Day, L, Balogun, J & Mayer, M. (2023). Strategic Change in a Pluralistic Context: Change leader sensegiving. *Organization Studies*, *44*(8), 1207–1230

Denis J, Langley A, Rouleau L (2007). Strategizing in pluralistic contexts: Rethinking theoretical frames. *Human Relations*. 60(1):179–215. https://10.1177/0018726707075288

Doolin D.(2002) Enterprise discourse, professional identity and the organizational control of hospital clinicians. *Org Stud.* 2:369-390.

Edmondson AC, Bohmer RM, Pisano GP. (2001). Disrupted Routines: Team Learning and New Technology Implementation in Hospitals., *Administrative Science Quarterly*, (46) 4.

Flitter MA, Riesenmy KR, van Stralen D. (2012)Current medical staff governance and physician sensemaking: A formula for resistance to high reliability. *Adv Health Care Manag*. 13.3–28. doi: https://10.1108/S1474-8231(2012)0000013006

Fournier P, Chênevert D, Jobin M (2020). The antecedents of physicians behavioral support for lean in healthcare: The mediating role of commitment to organizational change. Int *J Prod Econ.* 107961. doi: https://10.1016/j.ijpe

Gioia DA, Thomas JB, Clark SM, Chittipeddi K.(1994) Symbolism and strategic change in academia: The dynamics of sensemaking and influence. Org Sci. 5(3):367.

Glouberman S, Mintzberg H (2001). Managing the care of health and the cure of disease—Part I: Differentiation. *Health Care Manag Rev*. 26(1):56–69. doi: https://10.1097/00004010-200101000-00006

Glover WJ, Nissinboim N, Naveh (2020) Examining innovation in hospital units: A complex adaptive systems approach. BMC Health Serv Res., *20*(1). https://10.1186/s12913-020-05403-2

Hardy, C., & Thomas, R. (2014). Strategy, Discourse and Practice: The Intensification of Power: Strategy, Discourse and Practice. *Journal of Management Studies*, 51(2). (mar.) .320–48. https://doi.org/10.1111/joms.12005

Hendrikx W. Priced not praised: professional identity of GPs within market-oriented healthcare reform, *J Prof Org*. 2018;5(1):12–27. doi: https://10.1093/jpo/jox011

Hoff TJ & McCaffrey DH (1996). Adapting, resisting, and negotiating: How physicians cope with organizational and economic change, *Work Occup. 23*(2):165-189.

Hoof T. J., & McCaffrey, D. H. (1996). Adapting, resisting, and negotiating_How physicians cope with organizational and economic change, *Work and Occupations*, *23*(2) (May). 165- 189.

Jarzabkowski P.(2003) Strategic practices: An activity theory perspective on continuity and change: Strategic practices. *J Manag Stud*. 40(1):23–55. doi: https://10.1111/1467-6486.t01-1-00003

Jarzabkowski P (2004). Strategy as practice: Recursiveness, adaptation, and practices-in-use. *Org Stud. 25*(4):529–560.

Jolemore S. (2018). *A Narrative Inquiry of Physician Leadership*. [dissertation]. Retrieved from http://dc.msvu.ca:8080/xmlui/bitstream/handle/10587/1917/ShawnJolemorePhDT hesis2018.pdf?sequence=1&isAllowed=y

Kraft, A, Sparr, J L, & Peus, C. (2015). The Critical Role of Moderators in Leader Sensegiving: A Literature *Review. Journal of Change Management*, 15(4) (oct.). 308–31 https://doi.org/10.1080/14697017.2015.1091372

Kyratsis Y, Atun R, Phillips N, Tracey P, George G.(2017 Health systems in transition: Professional identity work in the context of shifting institutional logics. *Acad Manag J*. 60(2):610–641. doi: https://10.5465/amj.2013.0684

Leonardi, P. M. (2015). Materializing Strategy: The Blurry Line between Strategy Formulation and Strategy Implementation: Materializing Strategy. *British Journal of Management* 26 (jan.). S17–21. https://doi.org/10.1111/1467-8551.12077

Lusiani M &Langley A. (2019)The social construction of strategic coherence: Practices of enabling leadership. *Long Range Planning* 52(5):101840. doi: https://10.1016/j.lrp.2018.05.006

Maitlis S & Christianson M.(2014) Sensemaking in organizations: Taking stock and moving forward. *Acad Manag Ann*. 8(1):57–125. doi: https://10.1080/19416520.2014.873177

Maitlis S. (2005) The social processes of organizational sensemaking, *Acad Manag J*. 48(1):21–49. Mantere S.(2005) Strategic practices as enablers and disablers of championing activity. *Strat Org*. *3*(2):157–184. doi: https://10.1177/1476127005052208

McDaniel RR & Driebe DJ. (2001)Complexity science and health care management. *Adv Health Care Manag*. 2:11–36. doi: https://10.1016/S1474-8231(01)02021-3

Meyer Jr V, Pascuci L & Murphy PJ. (2012)Implementing strategies in complex systems: Lessons from Brazilian hospitals. *BAR - Brazilian Admin Rev*. 9:19–37. doi: https://10.1590/S1807-76922012000500003

Mintzberg H & Waters JA (1985). Of strategies, deliberate and emergent. *Strategic Management* J. *6*(3):257-272.

Mintzberg H (1979. *Patterns in strategy formation*. Int Stud Manag Org. 1979;9(3). Behavioral Models of Strategy Formulation - I (Fall), Taylor & Francis, Ltd.67-86.

Mitra M, Hoff T, Brankin P & Dopson S(2019). Making sense of effective partnerships among senior leaders in the national health service. *Health Care Manag Rev*. 2019;44(4):318–331. doi: https://10.1097/HMR.0000000000000166

Pascucci L & Meyer Jr V. (2013). Estratégia em contextos complexos e pluralísticos (Strategy in complex and pluralistic contexts). *Revista de Administração Contemporânea* 17(5) (Oct.): 536–55. doi: https://10.1590/S1415-65552013000500003

Pascucci LM, Meyer Júnior V, Crubellate JM (2017). Strategic management in hospitals: Tensions between the managerial and institutional lens. *BAR – Brazilian Admin Rev*. 14(2). doi: https://10.1590/1807-7692bar2017160092

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. SAGE Publications, inc.

Plsek PE, Wilson T (2001). *Complexity science*: Complexity, leadership, and management in healthcare *BMJ*. 323(7315):746–749. doi: https://10.1136/bmj.323.7315.746

Plsek P., Greenhalgh T. (2001)The challenge of complexity in healthcare. *BMJ*. 323 (7313):625-628.

Reis, A (2018) IESS. *Instituto de Estudos de saúde Suplementar.* Projeção das despesas assistenciais da Saúde Suplementar (Projection of Supplementary Health Care Expenses

Salvatore D, Numerato D, Fattore G (2018). Physicians professional autonomy and their organizational identification with their hospital. *BMC Health Serv Res. 18* (1). doi: https://10.1186/s12913-018-3582-z

Schuler, B. A., Orr, K. & Hughes, J. (2023). My colleagues (do not) think the same: Middle managers' shared and separate realities in strategy implementation. *Journal of Business Research*, 160, 113782

Scott, R. D., 2nd, Solomon, SL, & McGowan, Jr J. E. (2001). Applying Economic principles to health care. *Emerging Infectious Diseases*, 7(2), (March – April).

Smircich L & Stubbart C(1995). Strategic management in an enacted world. *Acad Manag Rev*. 1985;*10*(4):724-736.

Sturmberg JP, O'Halloran DM, Martin CM (2012). Understanding health system reform - a complex adaptive systems perspective: Understanding health system reform. *J Eval Clin Pract*. 2012;18(1):202–208. doi: https://10.1111/j.1365-2753.2011.01792.x

Takahashi ACD (2011), *Análise do Modelo de Remuneração Hospitalar no Mercado de Saúde Suplementar Paulistano* (Dissertation), São Paulo, SP, Brazil,. Escola de Administração de Empresas da Fundação Getulio Vargas.

Weick KE.(1995) *Sensemaking in Organizations*. Thousand Oaks, California, USA, SAGE Publications.

Weiser, A.-K. (2021). The Role of Substantive Actions in Sensemaking During Strategic Change.

Journal of Management Studies, 58(3 May). "White MD & Marsh EE (2006). Content analysis: A flexible methodology. Lib Trend. 55(1):22–45. doi: https://10.1353/lib.2006.0053

Whittington R. (2007). Strategy practice and strategy process: Family differences and the sociological eye. *Org Stud.* 2007;28(10):1575–1586. doi: https://10.1177/0170840607081557

Whittington, R. (1996). Strategy as Practice. Long Range Planning, 29(5), 731-735. Gioia DA, Chittipeddi K. (1991). Sensemaking and Sensegiving in Strategic Change Initiation, *Strategic Management Journal*, *12*(6), 433-448, 1991;

Yin RK. *Estudo de Caso*: Planejamento e Métodos (Case Study: Planning and Methods), Porto Alegre, RS, Brazil: Bookman; 2015, p. 2.