

Thoroughgood, Christian N., Art Padilla, Samuel T. Hunter, and Brian W. Tate. 2012. "The Susceptible Circle: A Taxonomy of Followers Associated with Destructive Leadership." *Leadership Quarterly* 23 (5): 897–917.

White, Ralph K., and Ronald Lippitt. 1960. *Autocracy and Democracy: An Experimental Inquiry*. New York: Harper & Brothers.

8 Health Care Communication Technology and Its Promise of Patient Empowerment

Unpacking Patient Empowerment through Patients' Identity Constructions

*Laura Visser, Inge Bleijenbergh,
Yvonne Benschop and Allard van Riel*

A major development affecting the organization of health care today is the implementation of technologies in daily care provision, especially those that focus on improving communication between patients and health care professionals (Schwamm 2014; Bishop et al. 2013; Krist and Woolf 2011; Dedding et al. 2011). Implementing communication technology is often seen as a promising avenue for dealing with the current wicked challenges faced by health care systems in many countries in the Global North (i.e., combining aging populations, increase of patients with long-term illnesses, cost reductions and increased quality of care). These expectations are based on the assumption that technology can give patients a more central role, by empowering them to become better informed and involved patients, striving for what is often called 'integrated care' (Kodner and Spreeuwenberg 2002). Although there is much speculation about the empowering benefits of technology, we know little of how the technology is actually used and what the implications for patients are (Berwick 2009; Davies 2012). From a Critical Management Studies perspective, however, we know that 'empowerment' is often a more complex issue than generally assumed (Alvesson and Willmott 1996; Hardy and Leiba-O'Sullivan 1998; Henwood et al. 2003), one not easily or necessarily achieved through implementing technology. Therefore, we argue that it is important to critically analyze claims of increased empowerment and see what actually happens when communication technologies are introduced in health care to question if they actually provide a better alternative for long-term illness management. This chapter will provide this critical analysis and ask, based on an empirical study, how patients' role in health care is affected by using health care communication technology.

To understand the use of technology and its effect on roles of patients, we are especially interested in examining how the use of communication technology affects patients' identity constructions. We use patients' identities as

a way to unpack the supposed empowering effects of the technology, taking a critical approach to the idea of patient empowerment through technology. As a result, we show the complexity of using communication technology and its effect on health care management. To understand patients' identities, we make a distinction between identity work and regulation (Alvesson and Willmott 2002) as we see patients' identities both in the light of the day-to-day work they do to construct their identity (i.e., identity work) and how these identities are regulated by the larger social and organizational context of the health care technology and health care management in general (i.e., identity regulation). While our empirical question is related to understanding patients' empowerment through technology, the related theoretical question asks how identities are constructed in environments that are explicitly meant to be empowering. In other words, the context of this technology might create a 'wicked' environment in which identity work of patients is messier than the empowered identity constructions assumed by the advocates of health care technology. As we will discuss in the coming sections, our case provides an interesting environment in which to link to a recent debate around the instability and incoherence of identity work (Daskalaki and Simosi 2018; Beech et al. 2016; Brown and Coupland 2015; Carollo and Guerri 2017) and to further question the division between (controlling) regulation and (empowering) identity work.

The communication technology we examine is that of Personal Online Health Communities (POHCs). The online communities allow an individual patient to communicate with her or his own health care professionals in a secured online space. As such, the POHCs are designed to give patients easier access to their health care professionals, no longer bound by restrictions in time and space or by a gatekeeper (e.g. secretary), which existed before.¹ We collected data from a pilot project set up by ParkinsonNet, an organization aiming to improve the lives of patients with Parkinson's disease. We followed 18 patients, who we interviewed and who allowed us to follow the communication on the POHC.

In the next sections, we will discuss our position in the literature, our methods for data collection and analysis and the findings based on that analysis. In the final section of this chapter, we discuss the theoretical and practical relevance of our findings.

Identity Work and Regulation

Critical literature has a long tradition in showing how people's organizational identities are constructed through an interplay between regulatory control and identity work (Alvesson and Willmott 2002). In many studies on organizational identities, Alvesson and Willmott's (2002) model, which relates identity regulation, identity work and self-identity to each other, is drawn upon (e.g. Brown and Coupland 2015; Gotsi et al. 2010; Watson

a distinction between identity regulation at the organizational (and societal) level and identity work at the individual level (Ybema et al. 2009). Identity regulation is seen as a way through which organizations exert control, as identity regulation sets standards for appropriate behavior (e.g. how to 'professionally' communicate a diagnosis to a patient) that organizational members are influenced by. Importantly, organizational members do not just undergo this regulation, their constructed identities are also an effect of the identity work done in a relational process to identity regulation. Individuals engage in conforming and/or resisting identity work, meaning they comply with the regulation and/or find ways to subvert or circumvent the regulation on their identity construction (Alvesson and Willmott 2002; Zanoni and Janssens 2007). Identity work is defined by the active participation of individuals in "forming, repairing, maintaining, strengthening or revising [identities]" (Alvesson, Lee Ashcraft and Thomas 2008, 626). As such, identity work is a constant activity that individuals engage in to ensure that their constructed identities align with norms. Both the organizational-level identity regulation and the individual-level identity work are, therefore, important for identity construction.

Identity Work in Changing Environments

When we relate this theoretical framework to our empirical case, there is an important difference to note, especially when it comes to the notion of empowerment. In the framework constructed by Alvesson and Willmott (2002), identity regulation through organizational practices are positioned as maintaining the status quo whereas identity work sits on the opposite side as the individual's attempt to disrupt this. Although a potentially useful distinction, it also creates a separation between identity regulation as controlling and identity work as potentially empowering. In our empirical context such a separation seems less useful as we have a case where the POHCs form a regulatory environment that itself is geared to change and the disruption of norms: identities are expected to change through regulation in POHCs. As empowerment is no longer solely up to the individual patient, but part of the organizational agenda (and therefore, identity regulation) as well, we suggest that the concept of empowerment becomes more ambiguous, potentially leading to the exacerbation of conflicts and tensions in individuals' (ambiguous) identity work.

To further understand the ambiguity of this identity work, we link up with and contribute to a recent debate that attempts to complicate the concept of identity work, by challenging the assumed coherence and stability of identity work (Carollo and Guerri 2017; Beech 2011; Beech et al. 2016; Daskalaki and Simosi 2017). As the concept is commonly used, identity work explains ways to repair and adjust one's self-identity in a changing context, aiming to restore a sense of coherence (e.g. when a manager goes through a

that identity work is mostly geared toward constructing a coherent sense of self and instead argues that some might feel comfortable sitting in a space of ambiguity and constant questioning and restructuring of their sense of self (Beech et al. 2016; Clarke, Brown and Hailey 2009; Carollo and Guerci 2017). For example, Beech et al. (2016) show that individuals (in their case, indie musicians) constantly engaged in identity work that was self-criticizing and at times, self-deprecating, and this questioning was part of their self-identity. This literature is useful to help understand patients' identity constructions when using communication technology, because POHCs also present a context of change, where patients' identity work is affected by the environment (but also strongly affects the environment). Moreover, patients with chronic degenerative diseases (such as Parkinson's disease) are constantly changing themselves as their disease progresses, increasing the 'wickedness' of their identity work. As such, it might be more useful to see patients' identity construction on the POHCs as a process of "self-questioning [that is] ongoing and unresolved; it [is] not a means to an end; it [is] an end in itself" (Beech et al. 2016, 519). We will use this lens of ambiguity and tensions to explore the complexity of patients' identity constructions when using the assumed empowering context of POHCs.

Methods

To answer our research question (how the patient's role is affected by using health care communication technology), we draw on data from 18 patients with Parkinson's disease using a POHC. These patients represent a sample from one hundred patients who joined a pilot project on POHCs in the Netherlands from 2011 to 2013. The criterion for selecting patients was the frequency with which they used their community. By focusing on frequent users (which applied to only a third of the participants in the pilot project), we ensured to have enough data to analyze patients' identity construction using communication technology. The data collection consisted of in-depth interviews with patients and long-term observations of their POHCs. The combination of two types of data collection allows us a multisided understanding of patients' use of their communities. The local hospital's medical ethics committee approved the research project before starting.

Parkinson's Disease and the POHC System

The POHCs used by our sample of patients were set up by the ParkinsonNet foundation. ParkinsonNet aims to improve care for patients with Parkinson's disease by finding innovative ways to organize the current complex and multidisciplinary care provision process (ParkinsonNet 2012). The technological system of the communities provides patients and health care professionals with a menu of options (ParkinsonNet 2012).

These options consist of sections called 'files,' 'diary,' 'meeting,' 'apps,' 'problem list' and 'team.' Patients use the diary and meeting sections most frequently. The 'diary' section allows patients to provide updates on their well-being. In the 'meeting' section, patients or health care professionals can start a virtual meeting and invite specific health care professionals to participate.

Collecting the Data

We combined interviews with 18 patients with observations of their POHCs. For the interviews, we used a topic list, which focused on how patients experience the use of their POHC, how they experience their relationship with their health care professionals, and how they experience their role in the care provision process. Since all patients were Dutch native speakers, interviews were performed in Dutch and lasted between 45 and 90 minutes, with an average duration of 60 minutes. After the interview, we asked all interviewees permission to observe their POHC. All interviewees, except for four, gave the interviewer permission to access their POHCs. Some patients stipulated that they would only give access to the POHC for a limited amount of time. These patients stated that they preferred not to be observed constantly, but allowed the interviewer temporary access to save the necessary data. The patients who gave permission for observations only granted access to the first author and added her to their virtual team on the POHC. This allowed her to receive notifications and read new postings. Patients' data were anonymized before the first author shared them with the other authors. The names used in Table 8.1 are aliases to protect the privacy of the interviewees.

Table 8.1 Overview of Characteristics of the Patients

Name	User since	Number of health care professionals	Number of diary entries	Number of virtual meeting entries	Number of documents
Adam	Oct 2011	6	6	12	2
Kristina	Apr 2012	4	22	13	4
Camille	Feb 2013	4	11	1	1
Sarah	Jan 2012	5	108	11	4
Julia	Dec 2011	6	33	8	26 ⁱ
Victor	May 2012	5	4	7	8
Nora	Nov 2011	5	8	26	3

ⁱ This patient has posted a large number of documents in her capacity as a patient advocate. These documents are not related to her own health, but are meant for distribution among the patient population.

Analyzing the Data

We analyzed the verbatim transcripts of the interviews and patients' writings on their POHCs using a critical discourse analysis approach. Going beyond the superficial content of quotes, we analyzed how patients phrase their sentences in the interviews and on the POHCs. Critical discourse analysis allows for the examination of power processes embedded in use of language by paying close attention to not only what was said (or not said), but also to how it is said and how it is embedded in a specific place and time (Alvesson 2010). It enables us to reflect on how language constitutes patients' identities and relations with others (Fairclough 1993). Therefore, we treat the text produced by our interviewees not as a reflection of a stable reality, but as language created in that specific context in relation to the interviewer (Alvesson 2010).

When analyzing how patients talked about their use of the online communities three themes emerged, namely reflections on the frequency of their postings, the content of their postings, and intersections of online and offline space. Using these themes as guiding principles, we analyzed how patients displayed hesitations, assertiveness and/or contradictions in discussing those themes. In this chapter, we analyze quotes from seven different patients that best expressed the main findings, but represented patterns in the entire sample. We translated the Dutch quotes to English only in the last stage of writing, trying to preserve the subtle character of the used language (including grammatical errors and punctuation) and to identify (in the analysis) when Dutch expressions have a slightly different meaning than English ones.

Results

As mentioned above, our analysis revealed three themes linked to the patients' identity work. We successively discuss the number of postings, the content of postings and online-offline intersection.

Number of Postings

Patients show variations in the number of postings in the different sections of their POHCs. Some use their diary to present updates multiple times a week; others only use the virtual meeting space to ask questions. To illustrate how the number of postings is a topic that patients explicitly reflect on, we first introduce Adam, who started using his POHC two years ago, and posted 12 times in the virtual meeting. He uses his diary much less often, only having posted six diary entries. When asked about the frequency of his postings, he states:

To me it's also about not too much . . . Because if you ask too many questions to . . . but then they [health care professionals] will also think 'here's that nuisance again.'

Adam talks about what the result would be if he makes 'too much' use of his POHC: his health care professionals thinking "here's that nuisance again." Even though the POHCs are supposed to allow patients to ask questions when and where they want to ask them, Adam clearly identifies a norm here: there are limits to posting. If we delve into this, we note that patients discuss limits to the number of postings mostly in relation to the activity of asking questions. The POHC system is set up in such a way that when patients ask questions (in the virtual meeting section), their health care professionals receive a notification, setting the expectation for receiving a response. In contrast, when patients write in the diary section, health care professionals do not receive a notification and generally a response to these messages is not required nor provided. Therefore, patients who talk about limiting the number of postings refer to the activity of asking questions in the 'virtual meeting' section. Interestingly, while writing in their diary, patients are regulated by a different norm from what we have seen so far: informing your health care professionals as frequently as possible. We illustrate this with the excerpts below:

It's been a while since I last wrote something in my diary
Camille, diary

From today on, going back again to writing a short diary entry regularly
Had no energy to write for a couple of days. Wasn't feeling well at all
Sarah, diary

Already 16 days since I last wrote
Kristina, diary

Already been a while since I last wrote in my diary, but was in Portugal for 4 weeks, next time I'll write there as well, if there's ever going to be a next time
Julia, diary

In these excerpts, we notice the role of the design of the POHC in shaping norms. The label 'diary,' literally translated from Dutch, actually means 'day journal,' implying one should write in it on a daily basis. Indeed, as we see above, patients start some of their diary entries referring to the regularity with which they write in this section of their POHCs. These postings often contain justifications and apologies. Julia even apologizes for not posting while she was on vacation, promising that next time she will also update her diary from over there. These excerpts expose an interesting development:

patients usually do or share with their health care professionals. Progression of symptoms are generally discussed in a more limited way, for example, during the biannual consultation with the neurologist. The availability of the diary section in the POHC, and the implicit suggestion that it should be used on a daily basis, seems to impose extra duties on patients.

The patients, therefore, relate to strict norms around the number of postings. Even though the POHCs are meant to facilitate increased frequency of contact and empower patients to choose when and about what to contact their health care professionals, their identity work suggests the coexistence of other regulatory norms, which, in a sense, limits the possibilities offered by the technology.

Content of Postings

Patients do not only carefully reflect on the number of postings, but also on the content of their postings. The design of the POHC does not allow for nonverbal communication, meaning that what patients say cannot be nuanced by other methods of communication. Therefore, patients consciously reflect on how the content of their postings comes across to their health care professionals. What is considered appropriate content is conceived of differently by different patients, as we illustrate below.

One concept that came up frequently during the interviews and the observations of the POHCs, is that of 'complaining.' Victor brings this issue up during an interview. He started using his POHC a year and a half ago, and makes the following statement:

You are . . . very consciously thinking . . . should I bother him [the neurologist] with this, yes or no? [I: Do you hesitate when posting?] Yes. [silence] Yes . . . I am not someone who complains quickly.

(Victor, interview)

The excerpt shows the conscious thought process going into posting on the POHC. When asked if he ever hesitates, Victor links his hesitation to coming across as a complainer. As such he, and other interviewees, identify a norm of not complaining about issues related to their illness. Even though Parkinson's disease has had an enormous impact on these patients' lives, they suggested on multiple occasions their desire to avoid expressing negative emotions around this impact, for fear of coming across as a complainer.

We compare his identity work with another patient named Nora. She has been using her POHC for over a year. Nora also hesitates about complaining, saying earlier in the interview that she would rather be a bit 'tough' than complain. Below she relates the lack of face-to-face contact to making it more difficult to nuance her postings:

[In face-to-face interaction] I am there as my whole person interacting

electronic [system], you have to put that into words, if you want to include that aspect. [. . .] With that surgery on my foot, I make a little bit of a dramatic . . . how should I put it . . . story out of it. [laughing:] because it needs to be a taken a bit serious of course. So I use my negative mood to really emphasize my worries, like gosh, I am really worried about that.

(Nora, interview)

Nora states that she finds it easier to avoid coming across as a complainer by interacting face-to-face with her health care professionals. This allows her to display 'self-mockery' and her 'whole person' through which she can both express emotions and nuance them simultaneously. She states that she "should be taken a bit serious of course" while she starts laughing. She frames her storytelling as a way to express fears ("emphasize my worries") and convince her health care professionals of the severity of her symptoms. Such emphasizing ensures that her health care professionals take her seriously. In fact, with her use of the word 'should,' Nora voices an expectation that she has of her health care professionals; they *should* take her seriously.

As such, as patients consciously consider the content of their posts, the idea of complaining frequently comes to the surface. In this online space, patients reflectively navigate the thin line between reaching out to their health care professionals and disturbing them with too much irrelevant or inappropriate information.

Intersection of Online and Offline Spaces

As we have seen in Nora's case, the online space does not exist separately from the offline space where health care provision takes place (i.e., the doctor's office). To understand how the offline and online spaces intersect, we need to provide more background information about the common pattern of interaction between Parkinson patients and their health care professionals. Almost all patients have biannual appointments with their neurologist for which they tend to save up questions. Most patients also see other health care professionals, but the intensity of contact with them varies and fluctuates.

In this section, we move on to Kristina. She has been using the online community for about a year and a half and mainly uses the diary section to keep track of how she is doing. She wrote one of her diary entries in preparation for the first meeting with her new neurologist. The title of this diary entry is "Is everything actually fine?" and in it she writes:

Tomorrow first time to Dr. [name neurologist]. Knowing myself, I will say that everything's going fine. It is going fine, but I haven't been sleeping well lately because the tremor is becoming more and more

The excerpt indicates that Kristina is aware that she will probably find it difficult to articulate that she has not been sleeping well lately, during the face-to-face meeting with the neurologist. Although she does not articulate it specifically, her reasoning behind this behavior might be similar to the patients we discussed before: she wants to avoid coming across as a complainer. She recognizes she is inclined not to discuss her well-being openly, and counteracts this tendency by making this comment in her diary. Through this statement, she (deliberately) loses the opportunity to pretend she is fine in the offline consultation room. In a rather complex way, Kristina uses the online space to change her offline behavior. She avoids transgressing the norm of coming across as a complainer, but is still able to transfer that she is not doing 'fine.' During the interview, Kristina shows another example of impacting her activities in the consultation room through using her online community:

Before I go there, I write down some things [on the POHC], that I want to discuss for a bit. So he has . . . he prints it out and has it there with him. And that's what I also think is very convenient. Because, I think, if I come in myself with a piece of paper, then I always think 'that's so [self-important].' But then he has that piece of paper with him [. . .] and just the other day as well, I had forgotten something and then he said as well 'we haven't talked about that yet.'

(Kristina, interview)

Kristina describes how she uses her POHC to post an overview of issues she would otherwise bring in print. She signals that her questions are not that worthy of attention when she states that she feels "so self-important" when she comes to the consultation and brings out a piece of paper. However, through Kristina's words, it becomes clear that the neurologist *is* deserving of this importance because he can bring a printout of her issues. By appreciating that he uses a printout, she ascribes him the importance necessary to possess such physical evidence of her problems. In these excerpts, we witness Kristina engage in identity work that is specifically geared to impacting her offline identity. The POHCs create a complex environment in which patients' identities are regulated by both online and offline spaces. As a result, patients' identity work now interacts with both worlds at the same time. The POHC disrupts the common, face-to-face communication with the neurologist and offers space to reflect on oneself as a patient, engaging in identity work that downplays certain issues, but also makes sure that some issues are discussed, as we see Kristina doing. Although she partly leaves it to the neurologist to bring up her issues, Kristina navigates the identity regulation embedded in the POHC in a way that is comfortable to her. Where she, in the past, left it completely up to the neurologist to initiate the conversation, she now gives stronger suggestions online for what she

Discussion

Based on the excerpts analyzed above, we can conclude that patients' identity work is based on reflecting on what they post, how frequently and to whom. Their identity work is done in interaction with the identity regulation embedded in the care provision through POHCs. However, we find that the disrupting ways of working introduced by the POHC have blurred the regulation of their identities. Although the POHCs are supposed to lead to empowerment, patients' identity work does not automatically follow this identity regulation. Our analysis shows that the communication technology comes with ambiguous norms dictating that patients should provide more information, without asking more questions. Therefore, the material structure of the POHC also restricts patients' identity work because the website sends email alerts for certain postings (virtual meetings) and not for others (diary entries), patients make decisions about what and when to post based on the level of intrusiveness for health care professionals. Equally ambiguous is the norm that emotional elements (in patients' words 'complaining') should not appear in postings unless one explicitly includes humor into accounts of daily life. Lastly, the offline integration of online communication shows that by posting about certain topics online, patients create space for discussing these topics during the offline consultations. Although the online space seems to take away some barriers to address certain issues, there is a layer of ambiguity as the initiative to discuss those issues still remains with the health care professional.

The POHCs, being the vehicles through which this empowerment is supposed to be organized, present a new regulatory context. Regulation on POHCs is not done by an external actor (such as a secretary), as was the case before, but by the presence and design of the technology. This makes POHCs highly empowering at first sight (individuals are free to act as they wish) but it simultaneously creates a responsibility for the patient to become empowered. Phrased in theoretical terms, although some argue that such 'blurred lines' provide space for actively resisting restricting norms (Fleming 2007), we argue that in empowering contexts—where individuals are encouraged, but left to their own devices to become empowered—the idea of empowerment moves away from a 'right' that individuals possess to a 'duty' that they themselves are made partly responsible for. Therefore, we can theorize that identity regulation through POHCs in combination with patients' identity work produces a complex web where especially the responsibility for this empowerment becomes a site for contestation.

The contestation over responsibility for empowerment becomes clear through examining the increased ambiguity of patients' identity work. When using the POHCs, patients displayed identity work that often showed tensions, further substantiating the idea that identity work is not always aimed at developing a coherent self (Beech et al. 2016). The ambiguity is central

more active, and use some of the options that the POHCs present to contact their health care professionals, patients also remain wary of bothering their health care professionals 'too much.' As the regulation of what 'good patients' do and are is disrupted by the introduction of the POHCs, incoherence, ambiguity and self-questioning became an integral part of patients' identity work. Part of their identity work involved creative ways of embracing this ambiguity, for example by writing on the online communities about experiences that the neurologist could later bring up for discussion in the offline consultation room.

We want to emphasize that the introduction of POHCs is not merely driven by 'humanistic' ideals of liberating patients from organizational power processes. The other side of introducing the POHCs is one of increased efficiency and cutting costs. Empowering patients through encouraging them to play an active, self-managing role in their care, is expected to come with financial benefits. The limited research on empowerment at the organizational level has argued that organizations saying they promote 'empowerment' need to be examined in light of neoliberalist ideals (Fleming and Sturdy 2009). Empowering discourses may merely mask new forms of organizational control, ultimately aimed at further tying individuals to organizations to increase profit (Fleming and Sturdy 2009; Fotaki 2006; Ezzamel and Willmott 1998). From a neoliberalist standpoint, patients taking on some of the care may save professionals some time (and thus, money) and may increase the quality of the care itself because it is explicitly adjusted to the patients' individual needs and desires. Although we were specifically interested in the micro-level of patients' identity work, this economic discourse, and its ties to neo-liberal celebrations of the individual and the market (Gleadle, Cornelius and Pezet 2008), could provide an interesting avenue for future research.

Lastly, we want to reflect on ways on moving forward with technology in health care, as it seem inevitable that technology such as this will be part of the future of health care provision, especially for management of chronic illnesses. Chronic illness, and the frequent doctor and hospital visits that might accompany it, do lend itself for some kind of technology implementation based on convenience. We noted that patients appreciated being able to contact their health care professionals from their own space at times that were convenient to them. This might create a sense of some empowerment for patients, but we also feel we need to think beyond this 'convenience' to address the other issues that we have raised in this chapter. We feel that it is important to bring in the perspective of the health care professionals in as well, because their practices help to (re)produce patients' roles. Although we have no simple recipe for patients' empowerment, we recommend that users of this technology (both health care professionals and patients) engage in an open dialogue, to voice their expectations and wishes with regard to using the system. As opposed to setting up user guidelines (which could be seen

create a space where both parties can express their ideal use of the communication technology. Although we have no illusions that such conversations are devoid of power, they might make each party more aware of the assumptions they hold about the abilities the other parties have in terms of using the technology. This dialogue might create innovative ways of managing care and supporting patients in the navigation of their chronic illness to ultimately have a more meaningful impact on patient empowerment.

Note

1. Previously, a patient would have to go through the process of contacting a secretary, setting up an appointment and ultimately talking to a health care professional over the phone or face-to-face at a time that was convenient for both.

References

- Alvesson, Mats. 2010. *Interpreting Interviews*. London: Sage Publications.
- Alvesson, Mats, Karen Lee Ashcraft, and Robyn Thomas. 2008. "Identity Matters: Reflections on the Construction of Identity Scholarship in Organization Studies." *Organization* 15 (1): 5–28.
- Alvesson, Mats, and Hugh Willmott. 1996. *Making Sense of Management: A Critical Introduction*. London: Sage Publications.
- Alvesson, Mats, and Hugh Willmott. 2002. "Identity Regulation as Organizational Control: Producing the Appropriate Individual." *Journal of Management Studies* 39 (5): 619–644.
- Beech, Nic. 2011. "Liminality and the Practices of Identity Reconstruction." *Human Relations* 64 (2): 285–302.
- Beech, Nic, Charlotte Gilmore, Paul Hibbert, and Sierk Ybema. 2016. "Identity-in-the-Work and Musicians' Struggles: The Production of Self-Questioning Identity Work." *Work, Employment & Society* 30 (3): 506–522.
- Berwick, Donald M. 2009. "What 'Patient-Centered' Should Mean: Confessions of an Extremist." *Health Affairs* 28 (4): w555–w565.
- Bishop, Tara F., Matthew J. Press, Jayme L. Mendelsohn, and Lawrence P. Casalino. 2013. "Electronic Communication Improves Access, But Barriers to Its Widespread Adoption Remain." *Health Affairs* 32 (8): 1361–1367.
- Brown, Andrew D., and Christine Coupland. 2015. "Identity Threats, Identity Work and Elite Professionals." *Organization Studies* 36 (10): 1315–1336.
- Carollo, Luca, and Marco Guerici. 2017. "'Activists in a Suit': Paradoxes and Metaphors in Sustainability Managers' Identity Work." *Journal of Business Ethics* 148 (2): 249–268.
- Clarke, Caroline A., Andrew D. Brown, and Veronica Hope Hailey. 2009. "Working Identities? Antagonistic Discursive Resources and Managerial Identity." *Human Relations* 62 (3): 323–352.
- Daskalaki, Maria, and Maria Simosi. 2018. "Unemployment as a liminoid Phenomenon: Identity Trajectories in Times of Crisis." *Human Relations* 71 (9): 1153–1178.
- Davies, Peter. 2012. "Should Patients Be Able to Control Their Own Records?" *British Medical Journal* 345: e4905.
- Dedding, Christine, Roesja van Doorn, Lex Winkler, and Ria Reis. 2011. "How Will

- and the Current Evidence for Changes in the Relationship Between Medical Professionals and Patients." *Social Science & Medicine* 72 (1): 49–53.
- Essers, Caroline, Hans Doorewaard, and Yvonne Benschop. 2013. "Family Ties: Migrant Female Business Owners Doing Identity Work on the Public—Private Divide." *Human Relations* 66 (12): 1645–1665.
- Ezzamel, Mahmoud, and Hugh Willmott. 1998. "Accounting for Teamwork: A Critical Study of Group-Based Systems of Organizational Control." *Administrative Science Quarterly* 43 (2): 358–396.
- Fairclough, Norman. 1993. "Critical Discourse Analysis and the Marketization of Public Discourse: The Universities." *Discourse & Society* 4 (2): 133–168.
- Fleming, Peter. 2007. "Sexuality, Power and Resistance in the Workplace." *Organization Studies* 28 (2): 239–256.
- Fleming, Peter, and Andrew Sturdy. 2009. "‘Just Be Yourself!’: Towards Neo-Normative Control in Organisations?" *Employee Relations* 31 (6): 569–583.
- Fotaki, Marianna. 2006. "Choice Is Yours: A Psychodynamic Exploration of Health Policymaking and Its Consequences for the English National Health Service." *Human Relations* 59 (12): 1711–1744.
- Gleadle, Pauline, Nelarine Cornelius, and Eric Pezet. 2008. "Enterprising Selves: How Governmentality Meets Agency." *Organization* 15 (3): 307–313.
- Gotsi, Manto, Constantine Andriopoulos, Marianne W. Lewis, and Amy E. Ingram. 2010. "Managing Creatives: Paradoxical Approaches to Identity Regulation." *Human Relations* 63 (6): 781–805.
- Hardy, Cynthia, and Sharon Leiba-O’Sullivan. 1998. "The Power Behind Empowerment: Implications for Research and Practice." *Human Relations* 51 (4): 451–483.
- Henwood, Flis, Sally Wyatt, Angie Hart, and Julie Smith. 2003. "‘Ignorance Is Bliss Sometimes’: Constraints on the Emergence of the ‘informed patient’ in the Changing Landscapes of Health Information." *Sociology of Health & Illness* 25 (6): 589–607.
- Kodner, Dennis L., and Cor Spreeuwenberg. 2002. "Integrated Care: Meaning, Logic, Applications, and Implications—A Discussion Paper." *International Journal of Integrated Care* 2: e12.
- Krist, Alex H., and Steven H. Woolf. 2011. "A Vision for Patient-Centered Health Information Systems." *JAMA* 305 (3): 300–301.
- ParkinsonNet. 2012. "MijnP@rkinsonZorg." Accessed December 13, 2012. www.parkinsonnet.nl/video's/parkinsonnet-video's/mijnp@rkinsonzorg.
- Schwamm, Lee H. 2014. "Telehealth: Seven Strategies to Successfully Implement Disruptive Technology and Transform Health Care." *Health Affairs* 33 (2): 200–206.
- Watson, Tony J. 2008. "Managing Identity: Identity Work, Personal Predicaments and Structural Circumstances." *Organization* 15 (1): 121–143.
- Ybema, Sierk, Tom Keenoy, Cliff Oswick, Armin Beverungen, Nick Ellis, and Ida Sabelis. 2009. "Articulating Identities." *Human Relations* 62 (3): 299–322.
- Zanoni, Patrizia, and Maddy Janssens. 2007. "Minority Employees Engaging with (Diversity) Management: An Analysis of Control, Agency, and Micro-Emancipation." *Journal of Management Studies* 44 (8): 1371–1397.

Section 3

Silent Voices

Making the Invisible Visible

One aim of diverse critical approaches and raising wicked problems for discussion is giving a hearing to silent voices and making visible unnoticed, and even marginalized, and stigmatized, groups and their experiences. The third section of the book is devoted to listening to these voices and comprehending how the approach to wicked problems can support taking these special groups and particular experiences into account at the political level and in everyday encounters. It is also questioned here if the approach to wicked problems is just another way to marginalize.

Ruth Strudwick makes visible one of the marginalized cultures in health care, the culture of blame among specialist radiographers within the NHS. She illustrates how the blame culture is constructed and maintained at a personal and cultural level. The blame culture turns out to be an unnoticed wicked problem that has an impact on the safety and quality of services. Kristina Brown’s chapter continues the theme of uncovering hidden dynamics in a study of the darker side of interorganizational teams that draws on social psychology to offer valuable insights into mandated groups. In the third chapter Elizabeth Pyle, Deanna Grant-Smith and Robyn Mayes give a voice to indigenous people by portraying the wickedness of the deficit discourse in Australia and Australian Indigenous Affairs policy. They also raise the critical point of the risk of re-marginalizing when relying on the discourse of wickedness. Will Thomas makes a stimulating contribution to the discussion on making the invisible visible by critically exploring the complexity of dependency, claiming that there is both necessary and unnecessary dependency. Scrutinizing the experiences of individuals with chronic disease enriches the understanding of wicked problems.