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Inter-identity threats and opportunities shaping professional influence for the Allied Health Profession (AHP) healthcare workforce: a study of identity paradox

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ABSTRACT

This paper extends our understanding of complexities in professional identity within healthcare by exploring a diverse group, UK allied health professionals (AHPs) working in clinical settings in public healthcare. Through qualitative thematic enquiry, we harness identity theory to highlight the threats and opportunities facing this workforce who contend with a multiplicity of identities. AHPs face an identity paradox, insofar as they hold both singular and collective professional identities that shift and change as they interact with different identity expectations within their work environment. We explore the impact of inter-identity threats and opportunities upon AHPs' professional identity, examining their impact upon AHPs' capacity to address and resolve ever-increasing system healthcare challenges. Our contribution presents a process-oriented model that highlights the importance of inter-identity dynamics, showing the interconnectedness of AHP identity with a range of detrimental outcomes that hinder the contribution of these professions and perpetuate existing difficulties.

1. Introduction

Considerable research has explored identity within organizational life, aiming to disentangle a person's behaviour at work from how they are seen by themselves and others and, in turn, to understand how this contributes to a range of outcomes (Ashforth and Schinoff, 2016; Brown, 2022; Brown and Toyoki, 2013; Cascón-Pereira et al., 2016; Cain et al., 2019). In the context of healthcare, research has focused on strengthening our understanding of how identity plays out in various ways via role constraints and opportunities within systems that are complex and often under strain (Bertin and Pantalone, 2019; Waring et al., 2023; Zhao et al., 2024). Healthcare environments are characterized by hierarchies of professional status and influence, centred around the dominance of the medical profession, which not only shapes interaction amongst professional groups (Martin et al., 2021), but also has implications for each group's relative status and professional development (Croft et al., 2015; Bresnen et al., 2019; Zhao et al., 2024). We address a diverse, highly skilled, but lower status professional group — Allied Health Professionals'(AHPs) – who nevertheless have a critical role to play in enactment of healthcare agendas (NHS, 2022; Zhao et al., 2024). While we focus upon AHPs working in clinical settings, we are also mindful that many other AHPs work in organizational settings that may not involve the provision of, or proximity to, clinical care. Consequently, the level of diversity found within and between AHP professions, due to their distinct professional backgrounds and heterogeneity in their working environment, is even greater, when one considers that they may work in settings inside and outside of healthcare (both public and private), have differing experiences of autonomy and standing within, and experience differences in factors such as training and development. This study recognizes the breadth and variety of such circumstances but focuses upon AHPs employed in the UK's public National Health Service (NHS).

This paper is concerned with the underexplored notion of identity multiplicity. Current thinking about identity recognizes its complexity, with attention being drawn to the multiple identities that are not necessarily stable nor compatible, and which are shaped by people's

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working circumstances and the power relations in which they are embedded (Brown, 2022). At the same time, however, identities are also the result of agential 'identity work' (Ashcroft and Schinoff, 2016). Identity work may be proactive or a reaction to an individual's status, including extant threats to their self-identity (Alevesson and Wilmott, 2002). Moreover, where individuals possess multiple identities, a good deal of *inter-identity* work may be required to manage or reconcile internal tensions or conflicts that arise (Bataille and Vough, 2022). As such, individuals and groups may need to actively manage their identities to bring about changes to personal outcomes or organizational goals.

The prospect of identity multiplicity is well-understood in the healthcare context through work that, for example, has explored hybrid managers, those with both a distinct and established professional identity (namely doctors and nurses), as well as a separate identity as a manager (Bresnen et al., 2019; Croft et al., 2015). However, while this work addresses the relative influence and career prospects of dominant healthcare groups, it is limited in its exploration of how these and others internally reconcile the paradoxes and tensions that arise from multiple identities, and the factors that enable and inhibit this search for coherence and consistency. Wider work has similarly identified important gaps in theorizing about multi-identity challenges (Bataille and Vough, 2022).

In this paper, we use an identity lens to explore the threats and opportunities for professional recognition and influence facing the AHP public healthcare workforce. Specifically, through our data we highlight a double bind, dilemma or paradox that AHPs face: at one level, their professional status is tied into their generic role as 'AHP'; yet this source of identity erodes their distinct professional standing, e.g. as a singular profession such as a chiropodist or speech and language therapist. We identify and delineate a range of identity threats and opportunities for AHPs that reflect these professional dilemmas and relate them to changes and outcomes in the current healthcare context, linking this with strategic expectations of AHPs being "in the right place, at the right time, with the right skills" (NHS, 2022, p14).

Our research aim is to explore factors enabling and inhibiting the pursuit of professional recognition and influence of AHPs. Our research questions ask how identity threats and opportunities occur, are made sense of and affect professional identity. We also ask how multiplicity in identity can enable or inhibit AHPs' pursuit of professional status and influence.

The paper begins with the AHP context, before considering the professional identity literature, specifically managing multiplicity in identities, and threats and opportunities for identity and inter-identity work. We then discuss methodology and data, presenting rich narratives from both AHPs and their leaders to develop a theoretical contribution through our conceptual model of identity.

2. Allied Health Professions in UK healthcare

AHPs in England comprise a diverse group of clinicians, referred to collectively as AHPs, but also delineated according to their specific regulated and registered clinical profession, of which there are 14 (art therapists, dietitians, drama therapists, music therapists, occupational therapists, operating department practitioners, orthoptists, osteopaths, paramedics, physiotherapists, podiatrists, prosthetists and orthotists, diagnostic and therapeutic radiographers, and speech and language therapists). Together they constitute the third largest clinical workforce in the NHS, comprising 185,000 employees (NHS, 2022). Some AHP professions are larger and more well-known (for example, dietitians, speech and language therapists, physiotherapists); whereas others are smaller, more niche professions (e.g. prosthetists and orthoptists, art therapists).

In the most recent NHS AHP strategy (NHS, 2022), the importance of the AHP workforce in contributing to the aim of improving health outcomes is outlined. AHPs are described as providing *"system-wide care: … assessing, treating, diagnosing and discharging patients across health, social care, housing, education, early years, schools, the criminal justice system, independent and voluntary sectors"* (ibid: p.2). Adopting a holistic approach to care provision, they promote the wellbeing of individuals as they interact with social, educational and workplace settings. Importantly, AHPs' contribution is also seen as transformative, addressing major system challenges within healthcare that have arisen, *inter alia*, due to increased demands on GPs and hospitals, increased patient flow and longer treatment waiting times, an ageing population, lack of integration of health and social care, the increased costs of drugs and treatment, and financial pressures (NHS, 2022).

The NHS workforce development strategy is ambitious and predicated upon AHPs' highly valued skills in "support*[ing] integration, overcoming the barrier of historical service boundaries to reduce duplication and fragmentation*" (ibid: p. 14). They are therefore seen as having the ability to plug structural holes (cf. Burt, 2004) and contribute to boundary spanning and connectivity (Long et al., 2013), for example in improving integration between health and social care.

Despite their acknowledged significance, AHPs face challenges in achieving professional recognition and influence. McMurray (2011), for instance, has highlighted the 'struggles' for new professions in achieving professional status when occupying roles that are marginalized, stigmatized and considered 'subservient' to the dominant medical profession. In a study of Advanced Nurse Practitioners (ANPs), McMurray (2011) highlights how the socialization of medical professionals is bound by identity regulation with the medical profession acting as the baseline comparator and effectively consigning other occupational groups, including AHPs, to a lower status position: *"In the ongoing active struggle within and between occupations for institutional recognition it is medicine that has remained dominant … It stands at the apex of the organizational pyramid … in a position of social and material advantage over other occupations such as nursing, podiatry, dietetics, dentistry and occupational and physical therapy*" (ibid: p. 805).

Most recent studies of AHP workforces have focused upon their clinical contribution, examining interventions intended to improve public health outcomes within specific AHP domains (Fowler-Davis et al., 2021), for example, dietitians' role in reducing obesity. Importantly, AHPs comprise a group of professions, each with its own distinct body of knowledge, sources of accreditation, and required codes of practice (Saks, 2012). There is a history of exploring professions as a 'right to practice' (McMurray, 2011), governed by regulated principles that afford individuals the power and autonomy to conduct their workplace activities within a 'sanctioned sphere of exclusivity' (McMurray, 2011, p 803). Defining one's role as a 'profession' however, may not in itself be enough to offset AHPs' negative identity experiences, especially where many competing professions work together (Croft et al., 2015; Martin et al., 2021; Zhao et al., 2024).

3. Professional identity, identity work and health care

There is longstanding interest in professional identity and its consequences in healthcare environments, not least because of their challenging terrain for the organizing of people, resources and tasks (e.g. Bresnen et al., 2019; Cascón-Pereira et al., 2016; Martin et al., 2021; Waring et al., 2023). Healthcare is also typified by the many trappings of professional identity and status, from physical manifestations (uniforms, for example) to structurally embedded power relations, that privilege certain groups and forms of knowledge and action (notably doctors and medical expertise), while subordinating and potentially marginalizing others (cf. Brown and Toyoki, 2013). Identity is well-suited as a lens to explore such challenges, as it can offer understanding of the threats and opportunities facing AHPs in their drive for professional recognition and influence (Abbot, 1991). That is, achieving professional recognition and influence is not a one-off achievement but an ongoing accomplishment that is 'tenuous, fragile and elastic' (Brown, 2022), insofar as it is subject to various threats and opportunities (including from other professional

groups) that can help or hinder an individual or group's professional identity and development.

At one level, the consequences for professional identity within healthcare can be understood through identity regulation, that is, a set of definitions about a given identity that is situated within hierarchies and comparators (Alvesson and Willmott, 2002) where one's value is based upon one's position relative to others. Identity regulation is bound by power and legitimacy, notions that feature heavily in discourses about identity (Brown, 2022) and which perpetuate identity differentials between those who are considered experts and non-experts. Identities are also in part embodied within discourses of knowledge, who one 'is' may in part be a product of what knowledge one holds, how one chooses to share it, and how that affects one's credibility and standing. The consequences of such power relations and sources of legitimation can be far reaching in terms of their impact on personal and professional development, credibility, well-being and performance (Brown, 2022).

However, it is important to acknowledge the effort and agency involved in asserting professional standing through identity work (Ashforth and Schinoff, 2016; Waring et al., 2023) to build one's identity in a way perceived as favourable. This in turn suggests that the ways in which organizational conditions and identity work interact (Ashforth and Schinoff, 2016) can shape identity outcomes. This can be both positive and negative, through enabling or inhibiting factors and associated threats or opportunities for developing and exerting professional recognition and influence (Brown, 2022; Weaver, 2006). Consequently, the achievement of professional recognition and influence is a function of both identity regulation and identity work.

At the same time, their multiple identities complicate conditions for AHPs (Porter and Wilton, 2019). Aside from any personal identities (parent, sportsperson, etc), an occupational therapist, for example, is both an AHP *and* an occupational therapist. Such labels may be assigned by themselves or other actors (including co-workers, other professions, patients, the public) and different labels may exist within as well as across professions to account for distinct specialisms (e.g. paediatric occupational therapist). A colleague of the same profession may refer to such individuals by their particular professional title, whereas another actor may label them generically as an AHP. Perceptions can also be shaped and affected by localized organizational conditions (Bresnen et al., 2019; Zhao et al., 2024). It is then important to consider not just identity work per se, but also *inter*-identity work, that is, the space within and across different identities that individuals hold at one time, to explore how they converge or diverge, and how this is shaped by organizational conditions that, in turn, limit or expand possible outcomes (Cascón-Pereira et al., 2016).

Indeed, there is increasing recognition of the 'messiness' of identity and interest in the multitude of individual identities that may be fluid and contradictory (Brown, 2022: p. 1205). How individuals respond to this messiness may result in diverse outcomes. Cain et al. (2019) have highlighted identity conflict and synergy and argue that multiple identity issues are commonplace in healthcare within team-based activities where individuals contend with their singular professional identity alongside a team identity. Despite this, although conflict between professions with different identities is commonplace, *"higher level uniting identifications provide some stability to workers and even permit potentially conflicting professional and team identities to be reconciled"* (Cain et al., 2019: p. 388). This may suggest that the collective identity of 'AHP' offers a commonality of experience and a shared space for AHPs to unite and celebrate their collective contribution.

Existing studies of AHP identity and related constructs confirm the importance of this agenda. Jackson et al. (2019), for example, explore professional confidence as dynamic and fluctuating, influenced by experience, reflection, and workplace support for AHPs transitioning into expert roles. They find that confidence impacts wellbeing, retention, and quality of care, and is optimised through ongoing reflective practice and supportive environments. Moreover, Lewis et al. (2025) highlight professional identity formation in AHP students and new graduates, which is shaped by curriculum, placements, interpersonal relationships and personal traits and which underpins confidence, resilience, and retention, with mentorship and reflection identified as vital educational strategies. Porter and Wilton (2019) note that organizational (and wider) structural facets significantly impact AHP identity, noting stronger identity in bed-based and mental health settings where supervision and role clarity are important. Structural changes in healthcare systems may differentially affect staff identity and retention. With respect to such outcomes, Yeoh et al. (2024) review attrition rates and intentions to leave among AHPs worldwide, highlighting factors such as career progression, job satisfaction, workload, recognition, and burnout. They advocate holistic, evidence-informed retention strategies that address professional, systemic, and individual factors. This literature highlights the importance of identity for AHPs and underscores the intertwined effects of professional identity and confidence, organizational context, and systemic support in sustaining a resilient AHP workforce.

3.1. Research aim and questions

A research gap exists in understanding how individual AHPs make sense of the co-existence of both a generalized AHP professional status and that afforded by their particular specialism. Bataille and Vough (2022) note an emphasis in most literature on identity threats, with a need for research also to explore identity opportunities. Moreover, little is known about whether this multiplicity is challenging or empowering and the environmental cues that activate inter-identity work associated with reconciling or transgressing such dualistic tensions (cf. Bresnen et al., 2019). We recognize that AHPs and AHP leads responsible for the leadership of AHP teams may have different subjective constructions of threats and opportunities and that this warrants exploration, given that identity construction is a co-constructive space and is dependent upon structural conditions and power dynamics. Thus, our research aim is to explore the factors enabling and inhibiting the pursuit of professional recognition and influence of AHPs. Our specific research questions ask how identity threats and opportunities occur, are made sense of and affect professional identity. We also ask how multiplicity in identity can enable or inhibit AHPs' pursuit of professional status and influence.

4. Data and methods

We present a subset of qualitative data from a funded study that explored workforce planning and transformation for all AHP professions across a large NHS region in England. The funder used the findings to promote areas for development and work programmes at local level to address current and future workforce supply issues. Data were collected from AHPs and AHP leads across all fourteen professions. AHP leads had responsibility for leadership of their profession or group of professions. The full study used mixed methods, comprising a survey completed by 1586 AHPs, plus interviews and focus groups with 36 AHP leads. Data collection reflected the study's wider aims of highlighting the factors shaping AHP workforce supply and demand. Survey items were co-created by the academic researchers and the internal project team. The project aims were mapped against the academic literature and a guiding framework for the study constructed. This comprised the areas outlined in Table 1. Item generation was iterative, taking place through meetings where the researchers presented ideas drawn from the literature that were considered, amended and condensed. The final survey comprised sixty-eight questions related to areas of the guiding framework each measured on a 5-point Likert scale from strongly disagree to strongly agree. Survey design was underpinned by elements including: my working environment; working with others; well-being; career development; leadership and voice; image and value; and outcomes and impact. (see Table 1 for a summary and example items). After answering closed, numeric questions, participants were invited to make additional comments in written form. For each element, the number of free text

Table 1
Survey instrument structure, content and free text comment responses.

Model Segment	Content of survey questions (quantitative)	Free text comments (n)
My working environment	Job satisfaction; provision of resourcing and retention; intention to quit; relationships/ support from managers. Example items: "My manager is supportive and approachable"; "I am actively seeking work elsewhere"; "I am satisfied with the achievement I get from my work".	384
Working with others	Working across organizational boundaries, and with other professions Example items: "In my profession, we work well with other AHPs"; "We manage working across organizational boundaries well".	175
Well-being	Self- reported physical and psychological well-being Example items: "I've been feeling optimistic about the future"; "I've been feeling useful". Warwick–Edinburgh Mental Well-being Scale (WEMWBS)	160
Career Development	Experiences of training and learning experiences and perception as to adequacy of career development and training provision Example items: "I feel that the career pathway for my profession is clearly defined"; "I have opportunities to learn from others in my role"	341
Leadership and voice	Satisfaction with leadership provision and opportunity for progression to AHP lead. Perceptions of change/growth for each AHP Example items: "We have a good leadership team who support the work that we do"; "I am satisfied with the amount of involvement I have in decision making".	409
Image and value	Experiences of how AHP provision is promoted internally and externally and how values that may exist internally and externally to work for or against a positive AHP image Example items: "My profession has a positive image"; "My profession gets adequate support and funding"; "I think that people outside of my organization have a good understanding of my role".	194
Outcomes and impact	These outcome measures assessed the extent to which AHPS perceived they provide good quality care Example items: "I am satisfied that in my direct working environment we are able to provide good quality care"; "More resources are needed to help us meet the demands in our working environment".	140
	Total number of qualitative survey responses	1803

comments received is indicated. In total, across all areas of the survey there were 1803 qualitative responses giving a total of 81,675 words. These responses encompassed all AHP professions, and the breakdown of responses by profession is included in the supplementary data file (link). Participants across all AHP professions responded to the free text comments with an average response rate of 21.4 % across the full sample, with the lowest proportion at 7 % for chiropodists and the highest 42 % for art therapists.

In interviews and focus groups, data collection focused on identity as a co-constructive process. This was complex for AHP leads who held multiple hybrid identities, not only as AHPs (in singular and collective identity spaces), but also as leaders and managerial hybrids (Croft et al., 2015; Bresnen et al., 2019) Three focus groups took place, one in each of the three project sub-regions, and selection was stratified by AHP type and locality. Not all individual professions were represented as AHP leadership roles tended to encompass several professions (for example: a lead registered as an occupational therapist might have leadership for both occupational therapy and physiotherapy). Sampling of leads was broadly opportunistic and reliant upon the NHS project contact in each sub-region, but efforts were made to ensure that focus groups were as professionally diverse as possible. Table 2 shows the split of lead representation for each profession across each focus group. Where participants could not attend focus groups, individual interviews were conducted. Thirty-one of the thirty-six participants partook in a focus group with the remainder engaged in one-to-one interviews. Focus groups lasted 1.5–2 h and asked about: challenges in attracting and retaining employees; how AHPs solve healthcare challenges; how AHPs work collaboratively with others; career progression opportunities; the availability of leadership initiatives; the extent to which AHPs are valued and promoted; and examples of best practice.

Focus group and interview data were transcribed and analysed thematically using a template matrix (King, 2004). Each interview question was positioned in its segment to correspond to the broad research theme, established *a-priori,* and alongside each we populated a column with quotations that were sub-divided to indicate themes. These were refined and added to as analysis progressed. Experiences of identity are well-suited to rich, discursive qualitative enquiry as meaning is rooted in and ascribed to the interplay between self-identified elements of identity and interactions with the environment. Thematic analysis captures subjective, self-constructed discourses surrounding identity experiences, which is appropriate and akin to the often-fleeting nature of identities as 'ongoing accomplishments' (Brown, 2022) that are not generalizable (nor should aspire to be) and require ongoing sense-making in encoding and decoding. We acknowledge the active role of the researchers in the interpretation of data, where themes are constructed through analytic decision making. Moreover, the analytical process involved the overlaying of data with the identity lens, where the conceptualization of our data against identity theory was an active process that occurred during analysis. To ensure consistency, data analysis involved three research team members who each analysed different data segments. The lead researcher integrated analyses and presented the final thematic template, which was discussed and further refined by the full research team. The AHP survey data was extracted from the survey software to an excel spreadsheet. Each segment was analysed separately and a template matrix drawn up as above for each. Thus, two final templates – one for AHPs and one for AHP leads – emerged which were then integrated in developing the theoretical framework and the tabulated results (see supplementary data file). Note that AHP leads are not delineated by their AHP profession because they often had responsibility for more than one.

5. Results

The overarching analytical framework consists of identity threats

Table 2
Mapping of AHP leads representation across each focus group region.

AHP Lead representation	Sub region label		
	1 (n = 10)	2 (n = 12)	3 (n = 9)
Art Therapist	X		
Chiropodist		X	
Diagnostic Radiographer		X	X
Dietitian		X	
Drama Therapist	X		
Music Therapist	X		
Occupational Therapist	X		
Operating Department Practitioner	X	X	
Orthoptist			X
Osteopath			X
Paramedic		X	X
Prosthetist/Orthotist		X	
Podiatrist	X		
Physiotherapist	X		X
Speech and Language Therapist		X	X
Therapeutic Radiographer	X	X	

and opportunities, with themes presented within each. Rich quotations illustrate and contextualize each theme. In addition, we provide a supplementary thematic template analysis (link to supplementary file) which charts the analytical pathway between narrative descriptors and verbatim content in generating our coding and theorization, as well as providing additional quotations.

5.1. Identity threats

We begin by exploring identity threats. AHPs' lower hierarchical position relative to dominant medical professions presented barriers to exercising their skillset in certain instances of care provision, which in turn perpetuated their lack of visibility and marginalization. This highlights the structural challenges and situational variables that erode professional status (McMurray et al., 2011; Brown, 2022). The four themes that were identified through analysis were: *'Visibility, marginalization and misunderstanding', 'Barriers to career progression', 'Career conversion', and 'Individual and collective identity'*.

5.1.1. Visibility, marginalization and misunderstanding

Symbolic expression portrayed largely negative identity definitions and many accounts included descriptions of negative psychological impacts (cf. Brown, 2022). For example, for one Operating Department Practitioner (ODP):

> "In my department we are expected to take care of everything 'with a plug' leading to an increased workload. I feel that in my department we are viewed as 'dogs bodies' to make the scrub staff life easier ….in general, it is very rare to meet anyone who has heard of this profession …".

Differences between AHP professions were evident. For example, for small and less visible professions, certain identity definitions perpetuated further damage. An orthoptist, for example, described their marginalizing 'handmaiden' identity as making their profession more precarious, not least due to its impact on attracting students. Although no gendered patterns emerged, it is noteworthy that the symbolism of 'handmaiden' used to express marginalization did have, in this instance, gendered connotations. Poor visibility was also cited as embedded within NHS systems. Examples were given of omitted designations on IT systems with ODPs not being listed, and such invisibility was seen to lead to incorrect assumptions about job title, role and profession, which further heightened AHPs' invisibility.

Agency for transforming identity labels was sometimes asserted. For example, in more niche professions, AHPs took responsibility for identity work to overcome lack of visibility:

> "… it would be really positive if art therapy could find a language to promote itself and the amazing work it undertakes so that its value and benefit could be known, appreciated and understood more widely by other professions …". (Art therapist)

Misunderstanding was also a feature of identity definition that shaped expectations of others' behaviours during inter-professional interactions. For example, assumptions about physiotherapists as passive providers of resources, such as wheelchairs, were problematic and detracted from opportunities to provide active rehabilitation. As such, others' perceptions perpetuated an inaccurate ascribed skillset that in turn reduced the opportunities afforded for physiotherapists to engage with different care elements. Identity definitions and misrepresentation also centred around misguided public perceptions, and this was the case for both larger, more established professions (e.g. dietitian) as well as smaller, niche professions (therapeutic radiographers), as shown in examples in our template.

Identity misrepresentation was more pronounced for AHPs than for AHP leads, though our data included examples where they also observed visibility and changes in societal stigma:

> "… some of the professions are still relatively hidden. So, we all know that only doctors and nurses work in healthcare (laughter). And some of the other professions -people have never heard of them. So, it's like the profile isn't out there, people don't know about that professional group. How do we get children to talk about playing at AHPs?" (AHP lead)

Similarly, the notion of AHPs as marginalized related to senior leadership representation, and was a concern across a number of professions, although for some the presence of leadership at higher (if not the highest) levels was reassuring. Leadership, or lack thereof, within the organizational hierarchy created challenging outcomes, especially where it was perceived that leaders had little understanding about clinical specialisms, and where participants regarded themselves as minority professions:

> "We have [a] physio manager now in the OT dept who makes it clear that she does not value our profession and so, although in the [named] team we work well together, we feel we have a limited voice". (Occupational therapist)

Moreover, sometimes opportunities for growth were evident but thwarted by a reluctance or inability of leadership to champion them:

> "Unfortunately, there is a distinct lack of leadership from AHPs across all areas. Leadership tends to be nursing focused. Many people are unaware that AHPs are (in general) responsible clinicians - this gives us more autonomy than nursing colleagues.". (AHP lead)

Many comparisons were made to nursing in signposting the inequity in professional representation. Other reflections centred on exclusionary experiences of professions resulting from lack of leadership, particularly in terms of strategic direction and the ability of AHPs to engage in interprofessional working. Presence on NHS executive boards for AHP leads was also noted to be less prevalent than in nursing.

5.1.2. Barriers to career progression

Occupational position was further captured in career development, where nurses had greater opportunities than AHPs. AHPs and AHP leads both highlighted the negative effect and how this shaped behaviours that detracted from attraction:

> "Why would you join a profession where you can go no higher than [certain pay scales]?] … We've often said, 'would you recommend your son or daughter as a dietitian or a nurse?' - because a nurse has endless opportunities". (AHP lead)

Challenges were commonplace and participants across many professions saw limited scope for development. Holistic working and learning across disciplines were essential to create new career pathways, but there were barriers. Comparisons to dominant professions were again signposted. For example, the nursing associate role was seen as detracting from investment in AHPs' formal career development. It was strongly felt that nursing received more investment and that such inequity required a culture change regarding how AHPs were positioned relative to other dominant professions:

> "We need to gently challenge and say: 'it's not just nurses who can do that'". (AHP lead)

Career development opportunities were compromised by resource constraints and demands, and a lack of leadership championing. Some participants reported improvements in development opportunities, but questioned their value in securing promotion and improving retention:

> "I am at the top of [my] pay scale and there is little opportunity to progress further due to a lack of [promotional] posts …. I therefore moved sideways into a different specialty as I had become bored … I find my new role a lot more challenging and there is a lot of scope for development and learning within it, but this is only for my own job satisfaction, there is no monetary reward …". (Dietitian)

This comment points to individual motivations as being important and participants cited individual agency and the need for proactivity in engaging with career development as, to some extent, a mitigating influence. However, for the most part, marginalization was evident in career development experiences and inhibited new skillsets through the erosion of confidence and credibility.

5.1.3. Career conversion

Career conversion signified moving away from one's specialism to progress. However, this came at an 'opportunity cost' in terms of professional status for those shifting to more senior roles in different organizational functions. Moreover, while there were different pathways to becoming an ACP (Advanced Clinical Practitioner), initial barriers to AHPs applying for ACP roles again highlighted relatively low status comparative to nursing:

> "… our organization had the ACP, they went to nurses to start with and they're also working in acute and emergency care. And then they went, 'oh, no, AHPs can apply for this as well, but what you have to do is stop being a radiographer or a dietitian and you've got to go and be a junior doctor'". (AHP lead)

Progression opportunities were thus framed as a dilution of clinical specialism, and as identity threats, with participants' reflections often centred on the anxieties of moving away from one's specific professional identity. Such 'conversion' was indicative of a paradox where an opportunity cost existed for individuals shifting career paths to progress via ACP roles (and similar managerial transitions). Moreover, it was clearly felt that conversion often amounted to replacement of doctors, through the filling of gaps in core clinical capacity:

> "A lot of the … advanced clinical practice that's being developed is to meet in part doctor replacement roles and that type of thing. And I think there's almost been a devaluing of the clinical specialist within the profession". (AHP lead)

Thus, despite the usefulness of multidisciplinary approaches for improving visibility and career progression, this could be at the detriment of retaining specialist AHP knowledge and identity.

5.1.4. Individual and collective identity

Participants reflected upon how others labelled their profession and the impacts of a singular or collective AHP identity. The umbrella term 'AHP' was unhelpful in promotion of clinical specialism, diluting or misrepresenting the specific contribution that each profession could make:

> "I worked … on a secondment … as a leadership fellow … consequently being referred to as an AHP colleague or 'non-medic'. Not one person referred to me as a therapy radiographer. When they did, they called me a radiologist despite me educating them. They also thought I did a similar degree to nursing and didn't understand my training". (Therapeutic radiographer)

Though visibility in a general sense appeared heightened by the term 'AHP', and its value as a collective for promoting a clinical career was helpful in some instances, participants noted the co-existing challenges and opportunities this created. In short, collective labelling had rather messy (Brown, 2022) consequences for professional identity:

> "It is important that we work together as AHPs but that there is a strong individual professional identity; most professions are quite different … AHP management is often by individuals who have come from a physiotherapist background and there are difficulties in understanding … This impacts on good working when working practices/ structures are implemented that do not consider different professional needs". (Dietitian)

Marginalization stemming from comparisons *within* the AHP professions was also common. Our template contains examples of the inter-profession hierarchy, with some professions seen as more influential than others. Moreover, there was some discord amongst AHP professions despite their collective grouping and this was highlighted by both AHPs and AHP leads:

> "… even the other AHPs have no idea of what our role is". (AHP lead)

> "Professional identity is important: there are far too many new services employing AHPs doing excellent jobs but being given weird and wonderful job titles that make no sense to the AHPs. The patient has got no chance of understanding, so we all get called nurses". (Occupational therapist)

5.2. Identity opportunities

Our data also yielded evidence of identity opportunities. These were associated with the strengthening of hierarchical position relative to other professions through four identified themes: *'Promotion of AHP professions', 'Substitution and augmentation', 'Heightening visibility' and 'Working collaboratively with others'*. These highlighted AHPs' contribution to improving healthcare delivery that could in turn shape positive identity transformations. Significantly, though, these were articulated mainly by AHP leads, rather than AHPs themselves.

5.2.1. Promotion of AHP professions

Participants noted the power and value in positive promotion of AHPs' skill set and value. This could be resource-intensive, was conducted both internally and externally, and was judged by its contribution to transforming the worth and image of AHPs:

> "Ever since the TV programmes with loads of paramedics, paramedic courses are full to busting, everyone wants to do it. It's like, why don't we have radiography on EastEnders or something?" (AHP lead)

Other mechanisms included promoting services provided, attending conferences to communicate more widely, entering national awards and providing realistic job previews to prepare entrants to the profession.

NHS executive board-level representation was seen as critical to achievement of a high-profile, highly valued role for AHPs and was a concern regarding leadership and AHP voice. The work of leads in promoting AHPs' contribution was paramount and had brought positive changes:

> "It can only work with good relationship building with the nursing exec … We've changed the nature of the conversation and we are working hard to see how we can help each other. We'll go in and say 'this is what we can do for you'. It has taken years of hard work – it is about having voice and confidence and being politically astute". (AHP lead)

5.2.2. Substitution and augmentation

Substitution and augmentation signposted evidence of AHPs taking on wider responsibilities and working in both generic and specific roles typically covered by doctors (or other dominant groups). This provided opportunities to strengthen professional identity through showcasing their skillsets:

> "… we do have an advanced clinical practice, certainly at the front end in our acute assessment unit - we've now got a radiographer, a physio, a paramedic, all in the advanced practice workforce. I think the NHS has picked up really heavily on this, you know, substituting junior doctors". (AHP lead)

Examples of AHPs working in an adaptive way to meet difficulties in other service provision were evidenced where opportunities arose from resourcing constraints in more dominant healthcare professions. Identity marginalization could be transformed into more positive identity definitions when opportunities were actively where AHPs were

ordinarily excluded:

> "They didn't have enough nursing staff, so they had to go to the AHPs. It has been a massive success, and I think it's a region wide success, and it's something that you can actually put up high and say, we were given the opportunity and we made it work. But what I've noticed is the change in the nurses' thought process, where actually before it was like, well no, you wouldn't do that, that's not what AHPs do". (AHP Lead)

Such widened opportunities for extended professional influence were numerous. However, there were paradoxes in the diluting effect role extensions had on professional expertise and their dependence upon systemic resource pressures.

5.2.3. *Heightening visibility*

Drivers of professional identity sometimes resulted from system imperatives rather than professional agency. Their enactment offered a platform for increasing visibility of AHP contributions, in an often external-facing capacity such as being the first point of contact in GP surgeries. Likewise, participants cited AHPs as effective in employing innovative approaches and having the ability to contribute to changing care models that helped bridge primary care and community work. AHPs were also seen to have the skill set needed to boundary span and support structural connectivity (Long et al., 2013) to optimize continuity of care:

> "With voluntary sector organizations, we're thinking about pathways when someone's discharged, what will support and maintain their recovery. It's not going to be NHS contact, it's not even going to be social care contact, it's going to be what's in their local communities, education, employment. It's developing the skills to work in those other settings and have those partnerships …". (AHP lead)

Recognition of AHP contribution was regarded as a challenge, especially for smaller less visible professions. Here, appreciation could be lacking as to the value of specialist contributions due to their small scale, which further assigned that profession a niche label:

> "The system challenges for [music therapists] is the recognition of their contribution and value … From the people who've received those services they are hugely valued, and there's always more people wanting that input … We had a very, very tiny resource. We lost fifty percent of it a few years ago … [and] were in danger of losing it all (laughs) … and we had to fight very hard to keep it". (AHP lead)

5.2.4. *Working collaboratively with others*

Many examples of the momentum for creating a positive identity were related to AHPs' presence within interdisciplinary teams, working alongside other AHP and non-AHP professions:

> "I think it's also because of the success of AHPs in all areas, they're now recognised … When I first started you worked very much on your own …. Whereas now you're an integrated part of that [multidisciplinary team] … so the teams don't function without the relevant AHPs". (AHP lead)

This moved beyond AHPs' singular contribution to solving system challenges and explained how their contribution could be enhanced by working with other professions, a concern in health policy and practice (Cain et al., 2019). It was widely acknowledged that joint working was beneficial in heightening connectivity. Yet, in practice, problems with commissioning, funding and implementation could work against its enactment:

> "… these programmes often work across organizational barriers, and that's actually where they start to work really, really well. But again, therefore a barrier to developing those is typically it won't be one organization that develops them. So, the examples where OTs are going out with the ambulance service. How does the funding work for that?" (AHP lead)

Good practice examples of working within multidisciplinary teams as well as the emergence of new roles to bridge interdisciplinary challenges were numerous. Our data included examples of occupational therapy and physiotherapy working well together to aid care in the community, and dietetics and physiotherapy working alongside each other in hospital settings. Some participants explicitly noted the benefits of learning and skill acquisition associated with working alongside other professional groups. Instances of professional identity shaped in this way were, however, sometimes cited as problematic. For example, the medical model was perceived as a barrier for some AHPs, where AHP expertise was considered secondary to the 'medic' influence.

6. Discussion

Our research questions first asked how identity threats and opportunities occur and are made sense of as experiences of AHP professional identity. Second, we asked how the multiplicity in identity can enable or inhibit AHPs' pursuit of professional status and influence. We find mutually occurring and competing threats and opportunities can be problematic for AHPs, creating a paradox in the quest for greater professional recognition and influence, with identity threats being more commonplace than opportunities and more salient for AHPs than their leads.

Our theoretical and empirical approach examined different professional roles and considered how each could present threats or opportunities for recognition and influence. This establishes the parameters for understanding identity work and inter-identity work. AHPs' positions as often marginalized group(s) within healthcare limit their ability to demonstrate their contribution, yet at the same time highlight a need, and sets an agenda, for change. Similarly, identity opportunities may exist independently of, in conjunction with, and/or in response to identity threats. Exploration of both threats and opportunities is warranted and is helpful in unpacking the complexities of AHP inter-identity experiences. Threats and opportunities can be mutually occurring within each identity or indeed occupy the space between them. Similarly, some individuals benefit from more power in the optimization of identity opportunities or in response to identity threats from their position in the hierarchy, either because they are more senior (and visible) in the case of AHP leads; or because they occupy a profession that is less marginalized (McMurray, 2011).

To illustrate these complexities, we present a conceptual model of AHP identity paradox (Fig. 1) where we return to the notion of identity as fluid and assert the importance of the interplay between identity definition, threats and opportunities, and outcomes (Yeoh et al., 2024). Our model depicts themes from our empirical analysis across both 'threats to influence' and 'opportunities for influence'. These are denoted by the darker shaded segments. Our model shows how such threats and opportunities are inter-dependent and exist in ways that can be supportive or destructive. For example, visibility, marginalization and misunderstanding as an identity threat may, in some instances, constrain the identity opportunity of collaborative working.

In addition, our model contains elements of identity definition that we term 'Identity regulation: Occupational position'. The competing and sometimes mutually occurring opportunities and threats that bring about these paradoxical circumstances are influenced by factors that collectively shape AHP identity definition (Alvesson and Willmott, 2002). This segment, on the top left and denoted by the hatched lines, delineates important identity characteristics that act to shape threats and opportunities depending upon their prevalence. For example, leadership was seen as a vehicle through which many other opportunities or enabling factors could be heightened and/or eroding threats be diminished, and participants punctuated their experiences of leadership

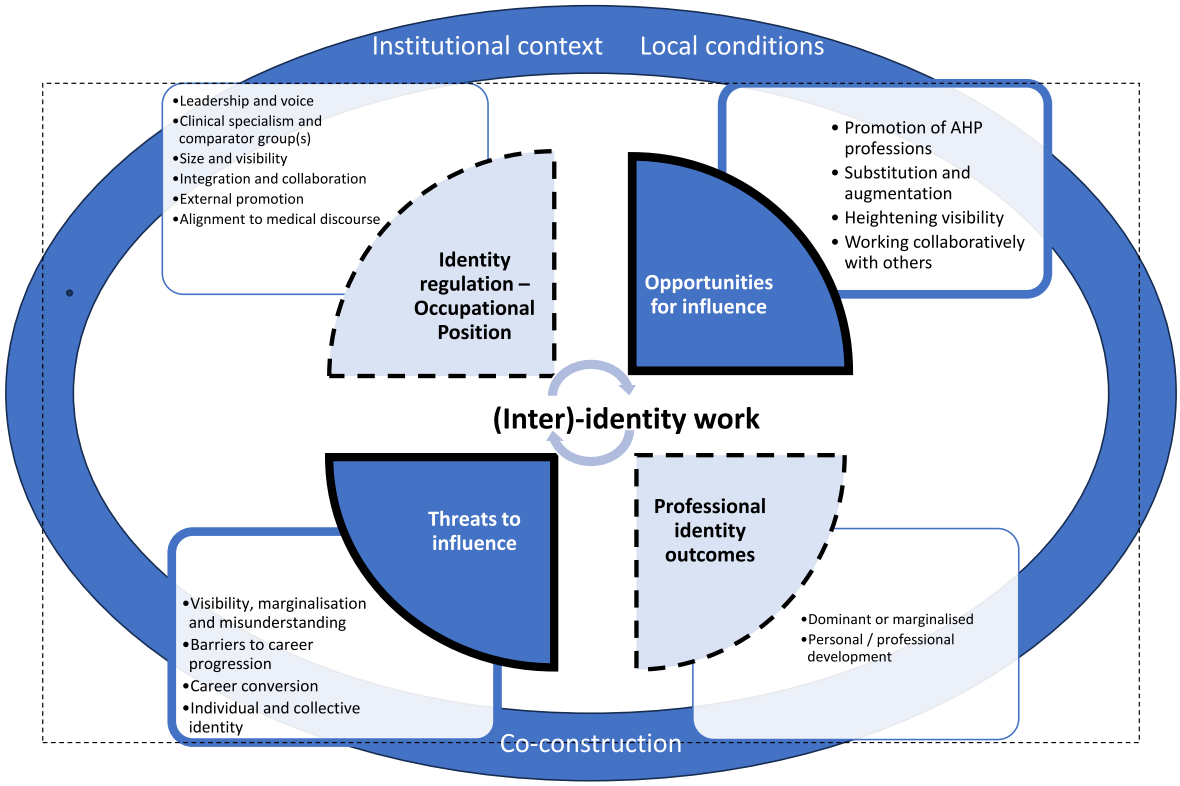

Fig. 1. A theoretical model of identity paradox for AHPs in clinical healthcare settings.

always with reference to outcomes, and to comparisons with other professions. Leadership could therefore act as a gateway for the optimization of identity opportunities.

We use the term 'Occupational position' in the identity regulation segment to correspond to hierarchical influences within marginalized professions (McMurray, 2011; Yeoh et al., 2024; Jackson et al., 2019). Numerous factors worked across different threats and challenges acting as identity markers. Alongside leadership, these include profession size, affiliation or alignment to dominant medical discourse, high or low external image/promotion, and hidden, niche professions. It is noteworthy that across the emergent themes, participants cited nurses as comparators, where their ability to align more closely with clinical discourse places them in a more influential position.

We suggest these markers of occupational position are axes through which to appraise the propensity for threats or opportunities for a given profession. This could be used in a practical sense to appraise the risks and opportunities for mobilization of AHP skills in meeting important care agendas (NHS, 2022). Note our intention here is not to perpetuate further identity regulation, as is the risk when distinct sub-populations are grouped together and set aside from one another (Alvesson and Willmott, 2002). Rather, it is to illustrate the myriad factors that impact on the positivity or negativity of AHP identity, despite (and, arguably, in some cases, because of) their composite label. Indeed, there is a need to uncover both individual and collective experiences as they are impacted by identity conflict, notwithstanding the assumption that such identity challenges differ by locales and are shaped by micro cultures and exposure or voice (Brown, 2022; Porter and Wilton, 2019; Lewis et al., 2025). We see the power of identity transformation from promotion of AHP careers in media sources, for example, and how a previously disregarded and invisible identity definition can gain rapid traction if exposure is forthcoming (see, for example, the quote about paramedic media exposure). Likewise, the power of AHP leads (where their position affords it) provides instances of agency or activation of opportunities to enhance professional identity (Bataille and Vough, 2022; Yeoh et al., 2024).

Our fourth quadrant, bottom right with hatched lines, refers to identity outcomes. The combination of threats, opportunities and identity definition for a particular AHP at a particular point, impacted by additional local conditions and institutional context (denoted in the outer circle), works to shape such outcomes (Yeoh et al., 2024; Jackson et al., 2019). This modelling comprises our contribution and our framework could be a useful way to explore emergent identity 'clusters' to acknowledge the diversity of AHP identity experiences. We are especially interested in the paradox of the double bind faced by AHPs: at one level, their professional status is tied into their generic role as 'AHP'; yet this source of identity can dilute their distinct professional status (as a singular profession). At the same time, system challenges both enable professional development through creating opportunities for collaboration and visibility while eroding professional status through reinforcing marginalization due to challenges such as poor leadership pathways that diminish professional power.

Our work is important for policy and practice, illuminating how opportunities for AHPs to support organizational agendas are impacted by identity challenges which may act as a barrier to their role in transformational change (cf. NHS, 2022; Porter and Wilton, 2019). It also signposts how identity opportunities and identity work can build traction in supporting AHPs to plug structural holes, span boundaries and contribute to many healthcare agendas (Long et al., 2013; Burt, 2004; Yeoh et al., 2024).

It is evident that AHPs are well-placed to support patient care in the context of system challenges (NHS, 2022). While the data illuminate ways in which AHPs can contribute, the themes largely paint a weak picture of their professional status. This is mainly due to the tenuousness of specific occupational identity and accommodation to other professionals' needs given their low hierarchical position (Bataille and Vough, 2022), combined with the high prevalence of identity threats. AHPs remain a malleable group and it seems their identities are only marginally strengthened as they adapt to system requirements. Though these skills for adaptation to environmental need are evident, associated benefits for professional identity appear lacking because of longstanding

identity threats which position enduring challenges that create marginalization. Our model suggests that where less marginalized experiences prevail, professional agency and associated positive impacts on identity are increased and that instances of occupational position across numerous parameters are key.

Our model has a dynamic quality in capturing the fluctuating fortunes of AHPs, as reflected in spirals of building and sustaining progress towards professional empowerment and spirals of degradation of professional status and influence. These are also moderated not only by motivations (such as individual agency and leadership), but the ability to promote change depending on characteristics such as size and prominence. With some baseline appreciation of AHPs' contributions, together with noted barriers to their upward professional mobility, there may be upper and lower limits, shaped locally, within which their shifting influence to effect change lies.

AHPs with their diverse skillset appear well equipped to fill a number of structural holes (Burt, 2004): for example, in boundary spanning and fulfilling specialist tasks across different clinical specialisms (Porter and Wilton, 2019; Lewis et al., 2025). Their ability to do so is embedded within their skill set, but the mobilization of this is compromised by identity threats. Yet, identity opportunities are evident and often exist concurrently. Our data suggest that the brokers (Long et al., 2013) of such boundary spanning activities and identity work are AHPs themselves, should they experience supportive environmental elements, and more prominently AHP leads with their (sometimes) increased power and leverage.

Returning to the notion of paradox, many identity opportunities appear to have associated opportunity costs. Indeed, where opportunities present themselves for interprofessional working, they often involve a dilution of clinical specialism (Croft et al., 2015) or a transformation of job role away from their core profession (Cascón-Pereira et al., 2016). AHPs appear to have a wider, more adaptable skillset that could be a distinctive competence of AHPs (compared to doctors and nurses, say), providing an identity opportunity. At the same time, this may detract from the foundations of professional status sought in terms of singular professional identity. Thus, opportunities may be apparent but have paradoxical effects regarding professional recognition and influence.

7. Conclusion

In this paper, we have developed a model to depict the intersection of identity threats and opportunities in the co-construction of AHPs and AHP lead identity. This supports understanding of identity as it applies to managing the multiplicity of singular and collective professional identities experienced by AHPs. This in turn helps characterize AHP professional groups as being dominant or marginalized and, in turn, more challenged or empowered professionally, with the implications that has for their wider impact on service delivery and transformative care agendas.

Our findings echo other work on marginalized professions within healthcare (McMurray, 2011; Cain et al., 2019; Zhao et al., 2024; Yeoh et al., 2024) and we evidence the impact of identity regulation and identity work on outcomes (Waring et al., 2023). Moreover, we highlight the fluctuating fortunes of AHPs as their influence is shaped by individual/group agency and local context intertwined with multiplicity. Opportunities often also bring costs to professional identity that, in turn, further heighten threats to professional identity. Being seen as AHPs has some value in that it shapes certain opportunities for inclusion, yet it can equally underplay distinct occupational specialisms. This is an important concern in unravelling the complexities of multiplicity in how identity threats and opportunities exist mutually and are difficult to disentangle, especially within inter-identity spaces (Bataille and Vough, 2022) where they are fluid and messy (Brown, 2022). Our findings offer better understanding of the blockages to AHPs contribution to system challenges despite overarching (NHS) strategies that promote this. Though not dominant in our themes, we evidenced transformative identity experiences where others' perceptions about AHP identity changed due to the strength of their contribution. Heightening these opportunities is an important policy and practice priority to promote transformation of identity and movement away from AHPs' marginalized experiences.

This paradox illuminates the fluidity of identity and its power to shape outcomes and demonstrates the usefulness of leadership and voice as important vehicles for identity work to overcome marginalization. Returning to the strategic goals articulated for AHPs (NHS, 2022), our study suggests that identity threats and opportunities as a function of multiplicity impact this ambition in both positive and negative ways.

As we noted earlier, our focus is AHPs who work primarily within clinical settings and our model and findings apply to these settings. We suggest further research may examine and adapt our model for AHP roles in research and/or outside of clinical settings. It could also analyse conditions facing specific AHP professions and explore the longitudinal impacts of identity threats and opportunities. Similarly, we encourage work to explore the paradoxical tensions for identity in professions in other institutional fields that encounter multiplicity. Likewise, studies could explore identity work strategies that overcome challenges and create positive outcomes in order to share practice in how marginalized identities can be transformed.

CRediT authorship contribution statement

Sarah Crozier: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Carol Atkinson:** Writing – review & editing, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Mike Bresnen:** Writing – review & editing, Writing – original draft, Methodology, Conceptualization. **Peter Goodwin:** Writing – review & editing, Investigation, Formal analysis, Data curation, Conceptualization.

Funder

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Ethical approval

Ethical approval was sought and granted from the Manchester Metropolitan University research ethics committee (application 0528)

Declaration of competing interest

There is no conflict of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2025.118638.

Data availability

The data that has been used is confidential.

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