Professional identities and organizational performance in the operating theater: a comparative study in French hospitals

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Executive Summary

This article investigates how professional identity (PI) differences between surgeons and anesthesiologists influence perceived performance in hospital operating suites (OS) in France. The authors argue that while PI differences do exist and correlate with conflict, the root causes of poor OS performance are primarily organizational — specifically inadequate scheduling regulation, resource shortfalls, and managerial deficiencies — rather than deep-seated identity antagonism. A qualitative comparative case study was conducted across four French hospitals (two teaching, one public non-teaching, one private) between 2019 and 2022, involving semi-structured interviews and direct observations with 26 physicians (13 surgeons, 13 anesthesiologists). Findings indicate that surgeons prioritize patient access and operating slot availability, while anesthesiologists prioritize shift end-time adherence and quality of work life. The private (for-profit) facility demonstrated higher perceived performance, attributed to a shared productivity goal. The study concludes that improving management and leadership to enhance communication and scheduling regulation is more effective for OS performance than attempting to reshape or unify professional identities.

Key Insights

1. Conflicts between surgeons and anesthesiologists over operating suite scheduling are predominantly driven by organizational failures — such as dysfunctional regulatory councils and resource shortages — rather than by fundamental professional identity antagonism.

2. For-profit institutional identity (private hospital) was associated with higher perceived OS performance, largely because shared financial goals aligned surgeons and anesthesiologists around a common productivity objective.

3. Anesthesiologists' stronger union culture in French public hospitals shapes a distinct identity trait prioritizing shift end-time adherence, while surgeons' personalized patient relationships drive a competing identity trait favoring extended operating availability — a structural divergence that organizations can modulate but rarely eliminate.

Practical Takeaways

• Organizations experiencing OS performance conflicts may find greater impact from improving scheduling regulation and managerial communication structures than from identity-integration interventions such as team-building or shared identity programs.

• Performance measurement in operating suites involves multidimensional and profession-specific perceptions — objective time metrics alone fail to capture quality-of-work-life dimensions valued by

anesthesiologists, or patient-access dimensions valued by surgeons.

Frameworks Mentioned

Multi-Team Systems — A framework describing networks of two or more interdependent teams pursuing common objectives, applied here to characterize the operating suite as a complex system of surgical and anesthesiology teams.

Critical Analysis

Strengths: The study uses rigorous qualitative methodology including data triangulation, saturation monitoring, and comparative cross-facility analysis. Independent coding with consensus resolution strengthens analytical credibility. The inclusion of both interview and observational data across four structurally distinct facilities adds comparative depth. Limitations: The sample is small (26 physicians across four institutions), with only one private facility, limiting generalizability of the for-profit finding. Surgical nurses and other OR stakeholders were excluded, which may omit relevant identity dynamics. Reliance on perceived rather than objective performance is acknowledged but remains a constraint. The study is anchored in the French healthcare context — specifically the influence of French medical unions — which may limit transferability to other national systems. Potential bias: The article's framing leans toward organizational and managerial solutions; while this is supported by evidence, the counterargument that PI interventions could serve a complementary role is not deeply explored. The conclusion that organizations should not attempt to shift professional identities is stated somewhat prescriptively given the qualitative, context-specific evidence base.

Organizational Practice

Four French hospitals (two teaching, one general public, one private) were studied for their operating suite governance structures. Each facility operated a Regulatory Council (RC) for short-term scheduling and an Operating Suite Council (OSC) for strategic planning. Surgeons and anesthesiologists participated in both bodies. The private facility operated under a for-profit model where physicians worked until all scheduled patients were treated regardless of shift end times. Public facilities operated under salaried civil servant arrangements with pre-determined working hours, union-influenced shift norms, and reliance on financial incentives for overtime. Regulatory councils in teaching hospitals (Facilities 1 and 2) were observed to be informative but not effective at modifying OR schedules, leading to day-of cancellations and interprofessional conflict. In contrast, the general public hospital (Facility 3) had a functional regulatory council that actively cancelled overbooked surgeries to enforce shift compliance.

Strategic Implications

The findings point toward a pattern in which OS performance variability is more closely tied to the effectiveness of managerial and governance structures than to the professional composition of clinical teams. Institutions experiencing recurring scheduling conflicts may reflect a governance gap rather than a cultural or identity incompatibility. The for-profit finding raises questions about whether shared financial incentive structures can substitute for formal regulatory mechanisms in aligning multidisciplinary clinical teams. The study also surfaces a tension in performance framework design: metrics optimized for operative throughput may systematically underweight quality-of-work-life dimensions that influence clinician retention and engagement — particularly relevant given documented anesthesiologist shortages in France. The finding that specialty-level identification outperforms system-level identification in complex task environments has implications for how healthcare institutions design team structures and

accountability systems in high-complexity units.

Validation Status: passed
