On becoming a GP: professional identity formation in GP residents

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You gotta make your own kind of music,

sing your own special song.

Cass Elliot

Chapter 5

“What kind of doctor do you want to become?”: Clinical supervisors’ perceptions of their roles in the professional identity formation of General Practice residents

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Abstract

Purpose: Supporting the development of a professional identity is a primary objective in postgraduate education. Few empirical studies have explored professional identity formation (PIF) in residency, and little is known about supervisors' perceptions of their roles in residents' PIF. In this study, we sought to understand how supervisors perceive their roles in the PIF of General Practice (GP) residents.

Materials and methods: Guided by principles of qualitative description, we conducted eight focus groups with 55 supervisors at four General Practice training institutes across the Netherlands. Informed by a conceptual framework of PIF, we performed a thematic analysis of focus group transcripts.

Results: Three themes related to how GP supervisors described their roles in supporting residents' PIF: supervising with the desired goal of GP training in mind; role modeling and mentoring as key strategies to achieve that goal; and the value of developing bonds of trust to support the process.

Conclusions: To our knowledge, this study is the first to explore PIF in GP training from the perspective of clinical supervisors. The identified themes mirror the components of the therapeutic alliance between doctors and patients from a supervisor's perspective and highlight the pivotal roles of the supervisor in a resident's PIF.

Practice points

- GP supervisors see a pivotal role for themselves in guiding the PIF of residents.
- GP supervisors guide residents with an image in mind about what a GP should look like.
- Role modeling and mentoring are key strategies used by supervisors in supporting PIF among residents.
- Supervisors value a bond of trust with the resident, often described by them as the 'need for a click,' in order to guide residents' PIF.

Introduction

Supporting the development of a strong professional identity (PI) is a primary objective in specialist training programs(1-5). Professional Identity - who we are as professionals - guides our behavior as professionals and is the cornerstone of professionalism(1, 6). A weak PI is associated with poor resilience and burnout in junior doctors(7). In contrast, a strong PI is associated with wellbeing, life satisfaction and professionalism(7). Supporting the development of a PI, aligned with the values and norms of the profession, is increasingly highlighted in medical education (2, 8, 9). More recently, identity and its formation have become of even greater importance because of the dramatic change in both health care and medical education with the emergence of COVID-19(10). Professional identity formation (PIF) - the development of professional values, actions and aspirations(11) - is a process at two levels. At the individual level it involves a person's psychological development; at the collective level it involves a socialisation process(12). The renewed emphasis on PIF redirects medical educators to focus on the socialisation process, in which learners come to "think, act, and feel like physicians"(2, 4, 13).

Since residency is a key stage in the formation of the physician-to-be(11, 14, 15), insights into the process of PIF during residency are needed. While many studies have explored PIF in undergraduate medical education(16-25), few have explored PIF in postgraduate medical education (PGME)(9, 14, 15, 26-28). The latter studies in PGME have highlighted the pivotal relationship between resident and supervisor, and focused specifically on PIF from the resident's perspective(14, 15, 26, 28). Only one study focused on supervisors' perceptions of their roles in residents' PIF (9) and the authors identified caring for patients, role modeling, and providing graded autonomy as important ways for clinical teachers to support PIF. However, the primary care, or general practice (GP), setting has been left relatively unexplored. The GP setting is interesting because the relationship between residents and supervisors is generally more one-on-one; it is also more long-term than in many other healthcare settings, and the supervisor can consequently witness the unfolding of a resident's PIF over time.

In this exploratory study, we focus on an important factor in PIF - the supervisor - and aim to complement the sparse data on PIF in PGME by answering the following research question: How do supervisors perceive their roles in the PIF of residents?

Method

Study design

We conducted a qualitative study, based on qualitative description(29, 30).

Qualitative description is particularly useful in applied settings to answer questions of relevance to practice and policy. Qualitative description also aligns with a constructivist perspective, which we adopted in this study, and is considered to be effective in testing theoretical constructs, as we set out to do. As PIF is a social process which also takes place at the collective level(12), we chose focus groups for data collection to facilitate interaction among participants as they reflected on their experiences and normative beliefs regarding PIF. We applied the consolidated criteria for reporting qualitative research (COREQ)(31).

Conceptual framework

We used a conceptual framework of PIF developed by Cruess et al.(4) to inform the interview guide and initial deductive data analysis. This framework, which describes the gradual shift of learners from peripheral to full participation in a community of practice, highlights multiple factors that interact with learners' pre-existing identities, including clinical and non-clinical experiences and role models. From this perspective, learners have to negotiate the influence of these factors as their new identities are being formed, which may or may not align with their pre-existing identities.

Context and setting

Eight university medical centers offer GP training in the Netherlands. This training consists of providing patient care under the supervision of a single designated supervisor during the first and third (final) year of training. Year two consists of rotations in Accident & Emergency, nursing homes, and psychiatric outpatient clinics with different supervisors. Throughout, the training, four days of practice alternate with a day-release program at the university, staffed by GPs and behavioral science teachers, designed to deepen learning from experiences in practice. The days in GP practice expose residents to increasingly complex clinical experiences over time and allow them to consult their supervisors as needed(28). Residents' progress in their development as a GP is monitored and assessed in joint collaboration between clinical supervisors and GP staff and behavioral science teachers.

Clinical supervisors are also offered group-based faculty development training programmes in supervising and assessing residents at the university to which they are affiliated.

The research team

PB is a GP and chairman of both the local professionalism committee at Leiden University Medical Center (LUMC) and the national professionalism committee of the Netherlands Association of Medical Education. VN is a health scientist. YS is a clinical psychologist and professor of family medicine and health sciences education. MN is a GP and professor of general practice and head of department. WvM is an intensivist, chairman of Maastricht University Medical Centre+ (MaastrichtUMC+) professionalism committee and professor of professional development. All authors are experienced researchers and medical teachers and have published extensively about PIF and professionalism.

Participants and procedure

We asked the contact persons responsible for supervisor faculty development training at four institutes across the Netherlands: (Leiden (LUMC), Rotterdam (ErasmusMC), Maastricht (MaastrichtUMC+), and Groningen (UMCG)), to select one or more of their existing faculty development training groups of supervisors of final-year residents to participate in this study. We purposefully selected these institutes, aiming for a balance between rural and urban sites, as variations in work content and processes in different practice environments can impact the socialisation process(14). Focus groups were voluntary and planned during the faculty development training programmes. The main researcher (PB) moderated all in-person focus groups, each lasting approximately 90 minutes. In each group, an educational researcher, either a member of the team (VN) or an educational researcher from the research department, was present to observe interactions, take field notes and, when necessary, ask clarifying and deepening questions.

We used a semi-structured interview guide (see appendix 1) derived from pilot interviews and the prevailing literature, with an emphasis on the aforementioned conceptual framework(4). All interviews were audiotaped and transcribed verbatim.

Analysis

We chose an abductive approach to analysis in which we integrated inductive data-driven coding with deductive theory-driven interpretation(32). We conducted a thematic analysis in which first PB and VN performed open, inductive coding independently from one other. Together they developed an initial codebook, which was informed by the factors highlighted in the conceptual framework developed by Cruess et al.(4), and discussed codes within the team consisting of all authors. Thereafter, the team iteratively discussed relationships between codes to construct themes. During analysis, PB and VN kept memos to document coding and analysis.

Results

All selected supervisor groups participated willingly. Eight focus groups, with 4 to 8 participants in each, were conducted with 55 supervisors at four training institutes. Twenty-seven supervisors (49%) were female. Supervisors spoke openly about their pivotal roles in residents' PIF, but at times had difficulty articulating exactly how they could support PIF. The three themes we identified are discussed below, illustrated with quotes (identified by gender (F/M), and interview number (n)).

Supervising with the end in mind

Supervisors seemed to have an image in mind about *what* a GP should look like. Based on this image, which they saw as the goal of residency training, supervisors supported residents' PIF, using observable "signposts" to direct them toward that goal. For example, supervisors believed that third-year residents should switch from merely solving medical problems - treating symptoms or diseases - to delivering whole-person care, taking into account psychological and social factors.

"Often you see that development in how the consultations are done. In the beginning, consultations are very much focused on the medical problem and at a certain point they become much more patient-centered. So, it becomes much more of a social conversation, no longer a forced solving of a medical problem. And then you think ... there's a GP sitting here instead of a doctor solving a problem ... A GP emerges from this doctor."(M1)

Supervisors also observed that being a GP involves much more than taking care of individual patients, and that residents had to "feel responsible for GP-care in its entire scope"(M4); take responsibility for "managing tasks"(M7), provide "out-of-hours care"(F4), and ensure "continuity of care"(M1).

Supervisors described using three types of "signposts" to evaluate progress in residents' attainment of a PIF: patient safety; residents becoming a patient's primary physician; and a changing resident-supervisor relationship.

Supervisors stated that the first priority in PIF concerned patient safety, “it has to be safe”(M5). Only after supervisors felt that their patients were safe in the hands of the residents would they “dare to let [them] loose on patients”(F1). A second signpost was the emergence of “a small practice within the practice”(M1), with patients “reconsulting the resident”(F1) without needing a second opinion from the clinical supervisor. As residents became the patients’ main physician, supervisors often noticed that the resident “feels more at ease”(F1) and “behaves in a more relaxed manner”(M1), which was evidenced by “making jokes, but taking the job seriously”(F1) and “accepting you don’t know everything right away”(M1). This development toward “taking responsibility [and] independence”(M2) often yielded a change in the supervisor-resident relationship as well. Supervisors saw their changing relationship with residents, toward more “equality”(M8), as a third signpost of progress.

“When you interact as equals, [in] the last three months, I think that's always the most beautiful thing.”(F8)

Role modeling and mentoring

Supervisors also described *how* they supported residents in their PIF: through role modeling and mentoring. When role modeling, supervisors relied on rather informal, often unplanned ‘performance driven’(33) transfer of knowledge and skills based on the resident observing the supervisor. When mentoring, supervisors were more ‘development driven’(33) and offered their support beyond the biomedical context of knowledge and skills, helping residents find their place within the profession.

Supervisors voiced that one way to support residents’ PIF, was through “role modeling”(M2), especially because residents are trained in a “master-apprentice type setting”(M3). They said that they often preferred to “just show”(M8) residents what to do, and only sometimes tell, hoping residents would copy them. Many supervisors expressed this element of spontaneously copying the supervisor as an “implicit transfer of know-how”(M2).

"[Much is] implicit. You've got them on your tail all the time. … You're together for a year: you have lunch together, you sit in the car together. They observe you. Even without you consciously telling them things."(M4)

In contrast to this implicit role modeling, supervisors wanted to be explicit about their own mistakes and uncertainties, as they thought residents' PIF was best supported by "sharing what you don't know and how you figured that out."(M1).

"I have a number of people in my personal graveyard, and those stories … What I have learned from these cases, I share … So I share my biggest mistakes."(M2)

In the final year, supervisors felt that they had to address questions like "what kind of a doctor do you want to become?"(F4). To meet this objective, they felt that they had to adopt a mentoring role.

"In the third year ... The basics, they're all there. But what kind of GP do you want to become? What do you stand for? Much broader. Not just the responsibility of seeing the patient."(F4)

Many supervisors stressed that residents "already had a pre-existing [personal] identity"(F5) and that in their final year they had already mastered most professional aspects. Therefore, they saw that the supervisors' role was mainly to "fine-tune"(F7). In addition, supervisors saw "giving space"(F3) to the resident, combined with "giving confidence"(M3), as important ingredients for mentoring residents in their PIF.

"[Residents] are already formed. Those people coming into GP training are around thirty. And of course, they already have their own identity, so you can't shape them completely. At best, you can give them a certain direction."(F5)

Developing bonds of trust

To support residents' PIF as described above, many supervisors felt that they needed a bond of trust with the resident, often described as the "need for a click". Supervisors observed that in supporting residents' PIF, they had to be "transparent"(F2) and "vulnerable as a supervisor

and a human being"(M7), and that this transparency and vulnerability necessitated a bond of trust between supervisor and resident.

"You have to trust your resident. If that's not quite the case, then you can't give that openness needed, because then you don't feel safe yourself … I've been in situations where I thought: there is some kind of a barrier to discussing certain things with my resident. And then you can't really be a good supervisor."(F1)

Having "life experience"(F5) and "work experience"(M5) appeared to be important ingredients for the "click". Supervisors emphasised that "a connection or match"(M1), or "a certain communality"(M3) form the basis for the "click". When a connection or communality was felt, supervisors were able to "[give] space"(F3) and "[give] confidence"(M3) to the resident.

"But I think it becomes very difficult to pass on the profession in the way I want it to if I don't have that feeling [of trust] with the resident."(M1)

When a bond of trust was felt, supervisors didn't feel obligated to "stick to learning plans"(F7); rather, they felt they could support residents' PIF in a more spontaneous way, trusting that the most important learning goals would be achieved while the resident was doing his/her work as a GP.

"Often it's very serendipitous, and at very unexpected moments when you have intimate conversations. … it could be on the way to a patient or when you come back from a visit that you talk about it again. Or during a shift, which I always enjoy. Especially, when it's not busy for once. Those are often the moments that you have different conversations."(F5)

However, in case of a poor or absent bond of trust, supervisors felt they could not navigate "on serendipity" but instead had to "adopt a more active stance"(M7) and "do [the training] by the book" (M7). In those cases, supervisors changed their focus from supporting PIF to acquisition of competencies and assessed residents' performance in a manner that was as "concrete as possible"(M8). They then - often reluctantly – felt they had to make the implicit

explicit, and had to instruct the residents “as they had learned it at the training institute”(M7) by “direct observation”(M8), “video observation”(M7) or “doing consultation hours together”(M7). This way of working often caused “loss of energy”(M1) and made supervisors “doubt [their] commitment to resident training”(M1).

Discussion

In this study on supervisors' perceptions regarding their roles in the PIF of residents, we identified three themes: the desired goal of GP training (supervising with the end in mind), supervisors' ways of working toward that goal (role modeling and mentoring), and prerequisites for achieving that goal (developing bonds of trust). Below we will discuss these themes in the context of the literature and provide future avenues for research and practice.

Supervising with the end in mind

From the supervisors' perspective, residents had to transition from *doing* the work of a GP to *becoming* a GP. This resonates with the proposed amended version of Miller's pyramid(3) used to provide a structured approach to the assessment of medical competence. While the original version of Miller's pyramid consists of four layers - "Knows," "Knows How," "Shows How," and "Does," in the amended version a fifth level of "Is" is added at the apex, reflecting the presence of a professional identity. Although this study did not focus on assessment per se, the amended version of Miller's pyramid resonates with our findings. That is, we found that residents merely becoming medical problem-solvers was not enough for supervisors. Rather, they had an "Is" level in mind – reflecting the presence of a holistic PI – as the end goal. The move from doing to becoming also echoes theory on how learners move from the periphery toward full participation in a community of practice(4). Ultimately, this journey of becoming a GP ends in being seen as a trustworthy physician by both supervisors and patients. A progression toward equality in the resident-supervisor relationship was another signpost in evaluating progress in PIF, required for development and patient safety when supporting residents' PIF(34, 35).

Role modeling and mentoring

The way in which supervisors reported supporting residents' PIF came closest to the notions of role modeling and mentoring, processes conceptualised as important factors in PIF by Cruess et al. and others(4, 36). In the one study specifically focusing on supervisors' perceptions of their roles in residents' PIF(9), supervisors described role modeling as one of the most important ways in which they believed they could support PIF. In spite of different definitions of role modeling and mentoring, and how these processes effect PIF, there is

consensus about some central characteristics(4, 33, 36). Role modeling is mostly focused on performance, whereas mentoring is more developmentally driven(4, 33, 36). This distinction between 'performance' and 'development-driven' was also reflected in our findings. On the one hand, supervisors spoke about mostly unplanned, implicit transmission of knowledge and skills, which we categorised as role modeling. On the other hand, they also reported more explicitly supporting residents in conversations about what kind of a doctor they wanted to become, which we categorised as mentoring. Jackson et al. recently reviewed the multiple roles of GP supervisors(35). This review – although not focused on PIF – identified being both a role model and a mentor as important in supporting residents toward becoming GPs(35).

Developing bonds of trust

Becoming a GP takes place in supervised practice. Earlier studies have shown the importance of the supervisory relationship in residency(27, 35, 37, 38). Many of them focused on stepwise entrustment, defined as entrustment of professional activities(37, 38). In our study we found another type of trust; a bond of trust or 'click' appeared to facilitate both residents' PIF as well as entrustment of professional activities. When a bond of trust was felt, supervisors felt they could support residents' PIF in a spontaneous fashion, *trusting* that residents would achieve the most important learning goals independently, in the workplace. However, when the bond of trust was lacking, supervisors reported that they could not leave learning 'to chance'; rather they had to organise training 'by the book'. Earlier research on the development of mutual trust relationships endorses these finding(37, 39).

This bond of trust also mirrors the bond needed between doctors and patients, as an important ingredient of the therapeutic alliance(40), which includes three components: (1) a mutual understanding of the purpose or goal of therapy; (2) an agreement about how to work toward that goal or the tasks of therapy; and (3) the patient's liking, trusting, and valuing of the doctor. Telio et al. translated this therapeutic alliance for the educational setting into an educational alliance, and included the same three components(41). It should also be noted that the therapeutic alliance is defined as experienced by the patient, and the educational alliance, by the trainee. In our study, however, it was the supervisor who expressed the need for a bond of trust as a prerequisite for supporting PIF. This has potential risks. Just as clinicians are known to overestimate the quality of the therapeutic alliance and may therefore

not be able to assess when it breaks down, supervisors might also overestimate the quality of the educational alliance and be unaware of its failings(41). Although the specific GP setting, with a limited number of supervisors - often only one - may foster a relationship that facilitates PIF(42), it may, also put unwanted pressure on this interpersonal interaction.

Strengths and limitations

This study is the first to have been carried out among a large and diverse group of GP supervisors to explore how supervisors perceive their roles in the process of PIF of residents. Using the conceptual framework of PIF developed by Cruess et al. as a sensitising framework to design the interview guide as well as the initial data analysis added rigor to the study, as did analysis of these data using the different perspectives of an interdisciplinary team(4). However, this study has limitations. Because it was a single-country study limited to GP residency, the transferability to other countries and other residency contexts may be limited. Further, being interviewed by a colleague (PB) could have led participants to give 'socially desirable' answers. However, our findings provide insights into the process of PIF during residency, especially into the roles of supervisors in resident's PIF.

Implications for further research and practice

To further understand residents' PIF, future studies should focus on other stakeholder perspectives, including supervisors in other specialties, residents, educators outside the clinical workplace, and patients. Future research is also needed to explore the role of bonds of trust in PIF, the relationship of these bonds with entrustment, and the risks and benefits of these bonds for residents.

We also see two implications for practice based on these findings, both of which can be incorporated into faculty development programmes. First, supervisors need to be trained in when and how to apply different role modelling and mentoring skills across the different stages of PIF(33, 43, 44). Second, the development of a bond of trust between supervisor and resident needs specific attention during faculty development courses; that is, supervisors need to become aware of their own responsibility in establishing bonds of trust and how they can use these bonds to support residents' PIF.

Conclusions

This study is the first to explore PIF in GP training from the perspective of clinical supervisors. We identified three themes; the desired goal of GP training; supervisors' ways of working toward that goal; and prerequisites for achieving that goal. These themes mirror the three components of both the therapeutic alliance between doctors and patients, and of the educational alliance between teachers and learners in education. In contrast to the therapeutic alliance, which is experienced by the patient, and the educational alliance, which is experienced by the learners, in our study it was the *supervisor* who stated that a bond of trust was a prerequisite for supporting PIF. Since PIF is essential for the future career development of GP trainees, this implies a great responsibility for supervisors as well as those involved in coaching their educational skills.

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