On becoming a GP: professional identity formation in GP residents

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Existentie gaat vooraf aan essentie.

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Chapter 6

General discussion

6

Background

This thesis presents a series of studies aimed at unravelling Professional Identity Formation (PIF) in the context of General Practice (GP) residency.

The first objective of this dissertation was to identify unprofessional behaviour in both GP practice and GP training. Therefore, we started with research into patient complaints in general practice with a special focus on professionalism, followed by research on unprofessional behaviour of GP residents as perceived by their supervisors and faculty.

The second objective of this dissertation was to gain insight into Professional Identity Formation of GP residents. Therefore, we first explored PIF during GP training from the viewpoint of GP residents and thereafter from the viewpoint of GP supervisors.

With this dissertation we hope to; contribute to a more in-depth understanding of the nature of unprofessional behaviour in both GP practice and GP training; and narrow the gap in our understanding of the process of becoming a professional GP.

In this chapter we present the main findings - with an overview in Table 6.1 - of our studies and discuss them in the context of the literature. Subsequently, we reflect on the methodology used. We conclude with recommendations for both research and practice.

Aims	Main findings	Chap.
Identify unprofessional behaviour in both GP practice and GP training.	Although most unsolicited patient complaints relate to clinical problems, a substantial proportion (35%) concern professionalism issues. Unprofessional behaviour is described in a variety of ways. 'Not being taken seriously' is a common denominator.	2
	Supervisors and faculty share a conceptualisation in pinpointing and assessing unprofessional behaviour, which matches the descriptors and categories of the 4 I's model,	3

	to which two new groups: 'nervous exhaustion complaints' and 'nine-to-five mentality' need to be added. The processes of identification and remediation of unprofessional behaviour in residents are intertwined. Identification of behaviours related to lack of introspection or integrity are the most important to remediate.	
Gain insight into Professional Identity Formation of GP residents.	According to residents, identity formation occurs primarily in the workplace as they move from doing the work of to becoming a GP and negotiate perceived norms. Residents feel that a tapestry of interrelated influencing factors – most prominently clinical experiences, clinical supervisors, and self-assessments – which changes over time, is felt to exert its influence predominantly in the workplace.	4
	Supervisors have an image of the professional identity they are supporting and work toward that goal through role-modeling and mentoring. Supervisors believe that a bond of trust between supervisor and resident is a prerequisite to properly support residents' PIF.	5

Table 6.1 Aims and main findings of this dissertation

Main findings

Unprofessional behaviour in practice (**Study 1**)

With our first study, presented in **Chapter 2**, we aimed to gain insight into patients' expectations regarding the professionalism of GPs, by studying unsolicited complaints. More specifically, our aim was to investigate the exact nature of patient complaints in out-of-hours general practice (OOH GP) care, with a special focus on perceived lapses of professionalism among physicians. This resulted in two research questions: 'How can patient complaints in the GP setting be characterised?' and 'What elements of physicians' professionalism do are addressed in these complaints?'

Professionalism is often mentioned in patient complaints

Our retrospective observational study showed that most unsolicited patient complaints were related to medical expertise (45%), such as diagnoses being missed or unsuccessful clinical treatment. Nineteen percent were related to management problems, especially waiting times and access to care. Communication issues, such as not being called back, were only explicitly mentioned in 1% of the complaints. A substantial proportion (35%) of the complaints however, concerned issues around professionalism. Among the complaints concerning professionalism, the description of perceived unprofessional behaviour was worded in a variety of ways, including; not being taken seriously; being patronised; being unpleasantly spoken to; getting inappropriate comments; perceiving a lack of empathy; perceiving the physician as being rushed; physicians not introducing themselves; physicians not shaking hands; physicians appearing arrogant or disinterested; or displaying physical harshness or unwanted intimacy. The theme most frequently found within the professionalism category was 'not being taken seriously', mostly in regard to the health issue at hand, the urgency of the complaint, or the perception that one was seen as being overprotective.

Unprofessional behaviour in training (**Study 2**)

With our second study, reported in **Chapter 3**, we aimed to investigate which GP resident behaviours are considered unprofessional according to supervisors and faculty, and how these unprofessional behaviours were remediated. Our research questions for Study 2 were: 'Which behaviours of GP residents are considered unprofessional according to their supervisors and faculty and how is remediation applied?'

Conceptualisation matching the undergraduate 4 I's model

The results of this focus group study among GP supervisors and designated professionalism faculty members showed that supervisors and faculty shared a conceptualisation in pinpointing and assessing unprofessional behaviour, which matched the descriptors and categories of the recently developed 4 I's model(1, 2). This model was developed based on research in undergraduate medical education (UGME) aiming to overcome the 'failure to fail' problem. It does so by guiding educators in how to document unprofessional behaviour and

provides directions for effective remediation. The 4 I's model consists of descriptors for unprofessional behaviour, classified into four distinct categories; lack of Involvement (failure to engage); lack of Integrity (dishonest behaviour); lack of Interaction (disrespectful behaviour); and lack of Introspection (poor self-awareness)(1, 2).

New groups of unprofessional behaviour in the PGME setting

Two new groups of behaviours; 'nervous exhaustion complaints' and 'nine-to-five mentality', needed to be added to the 4 I's model, both in the Introspection category. Behaviours in the categories 'Involvement' and 'Interaction' were assessed as mild and received informal, pedagogical feedback. Behaviours in the categories 'Introspection' and 'Integrity', were seen as very alarming and received strict remediation.

Tools and phases in detecting and remediation

The tools used by both GP clinical supervisors and designated professionalism faculty members to identify unprofessional behaviours seem very similar to those used by GPs in their diagnostic reasoning: that is, a combination of non-analytic and analytic reasoning(3). The diagnostic phase usually started with the supervisor getting a sense of alarm about residents' PIF, described as either a 'gut feeling', 'a loss of enthusiasm for teaching' or 'fuss surrounding the resident'. This sense of alarm often triggered the remediation phase. The diagnostic phase, however, appeared to be intertwined with the remediation phase: exploring the unprofessional behaviour in a conversation with the resident often already had a remediating effect, and vice versa: the way in which residents coped with the remediation phase gave new input for the diagnostic phase. Remediation varied from informal or 'pedagogical' feedback to formally planned meetings. In the latter the Compass(4) was more explicitly used, to exactly pinpoint and assess in which competency domain the resident was underperforming. When formally planned meetings were needed, often faculty members were also consulted to collaborate on a remediation plan.

PIF according to residents (**Study 3**)

With our third study, reported in **Chapter 4**, we aimed to explore the process of PIF during GP residency according to GP residents. Our research question for this study was: 'How do

residents perceive their PIF process during GP residency and what factors are perceived to be influential?'

Three themes

Using focus groups among GP residents and the conceptual framework of PIF developed by Cruess et al.(5) as a sensitising framework for both the interview guide and for conducting the deductive part of the analysis, revealed three major themes. These three themes together provided insight into the process of PIF among GP residents: 1. it all happens in the workplace, 2. from doing to becoming and 3. negotiating perceived norms.

It all happens in the workplace

First, we found that identity formation of GP residents occurs primarily in the workplace. In the GP training practices, multiple interrelated factors, especially clinical experiences, clinical supervisors, and residents' self-assessment were found to be at play in forming the professional identity.

From doing to becoming

Second, we found that during the years of training, residents' identity formation reflected their move from doing the work of a GP to becoming a GP. During this process, residents found themselves changing their focus from the biomedical and technical aspects of clinical experience to being able to view patients holistically, rather than as people with diseases. During this process of becoming, residents also changed from observing and imitating their supervisor and reflecting with the supervisor, to gradually finding their own way to practice GP medicine.

Negotiating perceived norms

Third, we found that the multiplicity of personal and professional roles residents have, and how they expected to balance personal roles with their role as a GP, appeared to be important aspects of their identity development. And although residents agreed on GP core values, they differed with their supervisors on how to operationalise those values. The perceived norms caused internal negotiations about how to balance professional roles with personal roles. However, residents perceived no room to discuss these challenges with their supervisors.

PIF according to supervisors (**Study 4**)

In the fourth study, presented in **Chapter 5**, we addressed the research question: 'How do supervisors perceive their role in the PIF of residents?'

Three themes

Using focus groups among GP supervisors and again using the conceptual framework of PIF developed by Cruess et al.(5) as a sensitizing framework for the interview guide, we revealed three major themes. These three themes provided insight into the role of the supervisor in the process of PIF among GP residents: 1. supervising with the end in mind, 2. role modelling and mentoring, and 3. developing bonds of trust.

Supervising with the end in mind

First, supervisors seemed to have an image in mind about what a GP should look like. Based on this image, which they saw as the desired goal of residency training, they supported residents' PIF and used observable 'signposts' to direct them toward that goal. The signposts supervisors used to evaluate residents' PIF were; patient safety; residents becoming a patient's primary physician; and a changing resident-supervisor relationship.

Role modelling and mentoring

Second, supervisors described how they worked toward that goal by supporting residents' PIF through role modelling and mentoring. When role modelling, supervisors relied on rather informal, often unplanned 'performance driven' transfer of knowledge and skills based on the resident observing the supervisor. When mentoring, supervisors were more 'development driven' and offered their support beyond the biomedical context of knowledge and skills, instead helping residents find their place within the profession.

Developing bonds of trust

Third, supervisors described the prerequisites for achieving that goal. To support residents' PIF, supervisors needed to be transparent and vulnerable, necessitating a bond of trust with the resident, often described as the need for a 'click'. When a bond of trust was felt,

supervisors felt they could support residents' PIF in a spontaneous fashion, trusting that they would achieve the most important learning goals by themselves while doing the work of a GP. However, in case of a poor or absent bond of trust, supervisors felt they could not navigate on serendipity but instead had to organise training 'by the book'.

Synthesis of the findings in the context of the literature

In this paragraph we display the relationship of this thesis to the literature and how the separate studies interconnect to form a clarifying line of research.

Unprofessional behaviour of GPs is a serious problem

Unfortuantely, unprofessional behaviour among GPs is a reality for some patients(6). We found that 35% of unsolicited patient complaints concerned professionalism lapses: this is in line with the existing literature(6). However, there are reasons to believe that the actual number of professionalism lapses may even be higher than our and other research shows. First, the scientific literature shows that not all adverse outcomes or all instances of patient dissatisfaction lead to complaints(7, 8).

Second, professionalism is a meta-competence or second-order competence and thus can also be expressed via the performance of other competences(9, 10). In expressing itself in the performance of other competences the CanMEDS role 'Professional' is fundamentally different from the other six roles(11). Thus, even when other competences are complained about, professionalism lapses can be the root cause. This could explain the relatively high percentage of combinations of competencies that were complained about in each complaint letter. We therefore conclude that unprofessional behaviour among GPs is a serious problem, potentially even bigger than this study reveals.

Supervisors describe more abstract unprofessional behaviour than patients

Our second study, in which we investigated unprofessional behaviour in GP training, yielded different descriptions of unprofessional behaviour from those found in Study 1. Where we found specific and concrete descriptions of unprofessional behaviours in Study 1, we found more abstract descriptions of unprofessional behaviours in Study 2. This resonates with

literature which found a difference between elements of professionalism emerging from patients complaints and those considered relevant by residents intensive care(12).

One reason for this difference in abstraction level might be that patients described unprofessional behaviour with which they were actually confronted themselves. Supervisors and faculty, however, were asked to reflect more generally on which behaviours of GP residents they considered unprofessional. This led to descriptions of behaviours that were displayed in a broader context, more at a distance, and not limited to a patient-physician situation.

A second reason might be that supervisors and faculty view the unprofessional behaviour of residents from a more formational point of view, which is supported by the findings of Studies 2 and 4. These studies show that supervisors first and foremost focus on supporting the identity formation of residents and only in secondary instance - and often reluctantly - change to a concrete focus on behaviour using direct observation, video observation and consultation hours together.

By discussing professionalism in too abstract a manner, it may be of limited practical operational significance for patients. This resonates with the danger of treating professionalism as a 'god term'(11, 13). God terms are terms that keep recurring in the rhetoric of a particular culture or subculture in a particular time, as the core values of that place and time: thus, terms expressed in a powerful, positive, but extremely vague way. A god term can often be recognised by the fact that you can't really be 'against' it. And precisely because god terms sound so positive and you can hardly protest against them, they carry the potential danger of drowning out conversation(11, 13). This is something that, certainly in the light of Study 1 – in which we sought to understand the exact nature of patient complaints - should be avoided at all costs.

Competing views on professionalism between supervisors and residents

Study 2 revealed two unprofessional behaviours which we think should be added to the 4 I's model, if used in a GP resident setting: 'nervous exhaustion complaints' and 'nine-to-five mentality'. For both clinical supervisors and faculty these behaviours illustrated a poor fit with the GP community. For them, these behaviours disclose long-held professional values being threatened in the new generation of GPs. It is tempting to endorse faculty and supervisors' simple explanation of 'poor fit' and 'values under threat'. However, especially in the light of

Study 3 and 4, these behaviours might also reflect competing views on professionalism between clinical supervisors and residents. In Studies 2 and 4, clinical supervisors voiced the opinion that apparently the GP community has implicit expectations of what it takes to be a GP and conclude that residents do not always notice these implicit expectations. This is contradicted in Study 3, where residents stated they do perceive these unspoken norms but didn't feel room to discuss them. So, other explanations than 'poor fit' and 'values under threat' are possible.

Unprofessional behaviour or self-protection?

The novel descriptor 'nervous exhaustion complaints' might also reflect residents' risk for burnout and stress(14, 15), just as the novel descriptor 'nine-to-five mentality' might reflect residents' self-protection reaction to that risk(16, 17). Residency is a phase in a physician's career where work-life interference can be experienced as especially demanding, which might induce a shift from other to self(18). This self-focus is interpreted as foreshadowing unprofessional behaviour(18). However, residents across all our focus groups agreed on the typical GP values about best possible care, like continuity of care, commitment and being available for patients, but differed with their supervisors about how to operationalise these values. The same picture of difference in operationalisation of values between generations of healthcare workers emerges in both the non-scientific (19-21) and scientific literature(16, 17, 22, 23). This is in line with the notion that the concept of professionalism is in constant evolution because it is time- and context-dependent(24, 25).

It might be, as Castellani et al. argue, that 'poor fit' and 'values under threat' are typical statements of the ruling class of medicine - individuals, groups and organisations that hold an elite status within organised medicine - which for ages made its imprint on the professionalism discourse(17). Younger physicians on the other hand believe that nostalgic professionalism over-emphasises work to the exclusion of other important values(17) and seem to ask for other interpretations of professionalism, e.g. lifestyle professionalism.

Generational gap

Our studies also show a picture of a clash between generations. At the one end stand supervisors, leaning toward interpreting professionalism as nostalgic professionalism, i.e. training residents with the goal to become practice owners taking responsibility for their

enlisted population of patients, which is seen as the only way to take responsibility for the future of general practice. At the other end stand residents, leaning toward interpreting professionalism as lifestyle professionalism, i.e. working in a shared practice, part-time, as a locum, with fewer patients, enabling them to live up to other values than hard work. Our studies also indicate that clinical supervisors – by imposing their nostalgic professionalism norms - behave as the ruling class of medicine. However, what residents wished for were supervisors who did not impose their norms but rather take a coaching role in this regard. Residents perceived supervisors' norms but had a desire to discuss them. They especially wanted to discuss the challenges generated by these norms, challenges about how to balance their professional roles with their personal roles. However, residents perceived little room to discuss these norms and challenges with their supervisors. Problems in safeguarding practice succession, young GPs leaving the profession and the difficulty in fulfilling OOH GP shifts might be a consequence of this lack of discussion between the generations of GPs(19-21). The failure to discuss competing views on professionalism means residents are denied subjectivity and will not help the profession move forward.

Are there limits to socialisation?

Imposing professional norms as described in the section above, however, is not without risk. It is at odds with what is seen as a very important goal of training; subjectification. The educational philosopher Biesta introduced subjectification as one of the three domains of education(26, 27). The other two are; qualification- acquiring knowledge, skills and expertise; and socialization - identity formation, becoming part of the professional community. Qualification and socialisation both already receive a lot of attention in Health Profession Education in general and in this dissertation in particular. Qualification, for example, is explicitly addressed in article 3 where residents come to speak about that 'it all happens in the workplace' and how they move from 'doing to becoming'. In Health Profession Education, PIF is seen as a dynamic process achieved through socialisation. And socialisation is the main lens through which PIF is seen in this dissertation. However, with too much focus on qualification and socialisation, the third domain of education – subjectification – might fall into disarray(28).

Subjectification

In subjectification the word subject resounds. First, subject is to be understood as opposed to object. Within GP training, this means that relationships between clinical supervisors & faculty and residents are prone to instrumental interactions, predefined and oriented toward a certain aim, with the resident as object instead of subject. The experience residents voice in Study 3 that the norms imposed on them can be interpreted as instrumental interactions. Although this way of encountering residents is not always something that has to be avoided, good education goes beyond instrumentalised relationships.

Subjectivity, on the other hand, is about one's freedom to define oneself through action(29). Although, GP training has a pre-defined goal, namely delivering GPs to society, imposing norms can easily be seen as denying the resident's subjectivity. Moreover, because responsibility comes with the freedom to define oneself, by denying a resident's subjectivity the responsibility for his choices and actions is also denied(29, 30).

Socialisation can bring about reproductions of the past

Socialisation is without a doubt valuable in education. However, education is not only about socialising into the profession. It is also (and, probably, fundamentally) about how unique individuals can be free to develop their own ways of being within the profession, whilst questioning the professional standards along the way(27). Too much focus on qualification and socialisation can easily lead to seeing education as a box-ticking exercise that produces professionals that fit the established orders of the profession. However, if the space for unique individuals to 'appear' does not exist, education will produce a reproduction of the past instead of providing room for the future. Diversity and inclusivity are not only relevant for the way they acknowledge differences: they also have great potential in progressing the profession by adapting the professional standards in flux with society. Debate is needed to understand to what extent the notion of negotiating one's identity(5, 31) overlaps with the notion of subjectification.

Other factors involved in the process of PIF

In Study 3 we found three factors in particular to be at play in residents' PIF. And although the other factors of the theoretical PIF framework developed by Cruess et al(5). were touched upon during the focus group discussions these three - clinical experiences, clinical supervisors,

and residents' self-assessment - appeared to be most important in the PIF of residents in our studies(5).

Since the publication of Cruess' perspective, other studies on PIF and influencing factors have appeared(32-34). To our knowledge however, none of these systematically explored the factors Cruess et al. proposed. Cruess et al. stated that not all these factors exert equal influence. They particularly emphasised the importance of clinical experiences and role models/mentors. These factors also emerge as very important in the PIF of residents in our studies. As discussed in our studies, this is in line with recent literature(35-40). Interestingly, our study 3 also indicated that in addition to supervisors and clinical experiences, residents' self-assessment is an important influence in PIF. We found that residents especially self-asses their clinical experiences; whether they ran out of time in the workplace; whether their patients were satisfied; whether their diagnoses and therapy decisions were right; whether they were managing to cope with uncertainty; and whether their experiences in the workplace were in line with those of their peers; can all be seen as self-assessments of their clinical experiences. In this study it appears that self-assessment is the intermediate factor between clinical experiences and socialisation. Self-assessment thus seems to take a place where Cruess et al. placed 'conscious reflection' and 'unconscious acquisition' in their model(5). Where Cruess et al. propose self-assessment as a separate factor, separate from conscious reflection and unconscious acquisition, our data suggest that self-assessment, conscious reflection, and unconscious acquisition might be entangled when they are related to the factor clinical experiences.

Thoughts on methodology

The research methods used in the studies of this dissertation were all qualitative in nature. Because in qualitative research, the researcher is the main instrument in both data collection and data analysis, the researcher is also a possible source of bias. Therefore, qualitative research requires even more reflexivity than is required in quantitative research. Reflexivity is about how the researchers relate to the fact that most findings in qualitative research are not 'found' but rather are 'produced'. Describing it this way, reflects our vision that reality is constructed by and between people. This aligns with a constructivist paradigm(41, 42).

Because the role of the researchers themselves undoubtedly influences the research process, we provided information about the researchers in the different studies. The following additional information about the main researcher and his motives to start this PhD trajectory, however, may be valuable in the light of further reflexivity. The main researcher is a GP, sexologist, and medical teacher in both undergraduate and postgraduate medical education. This diverse work experience led him to belief that much can be improved in healthcare. Especially in relation to the professionalism of (future) healthcare workers, he believes there is much to be gained. To this end, he accepted the position of chairman of both the LUMC and the national professionalism committee. In 2021 the book 'Professionalism in healthcare' was published under his editorship. Regularly he shares his vision on how healthcare can be improved in various media. Every fortnight from 2016 to 2020 he shared his view on current affairs in healthcare as 'friend of the show' on radio 1, Netherlands's largest national news radio station. Summarised, the main researcher has a mission. However, he is fully aware that his inclination to activism can compromise a scientific approach and influence the research process. To overcome prematurely drawn conclusions, limited views and potential sources of bias, the main researcher therefore closely collaborated with a diverse and interdisciplinary group of experienced (educational) researchers and medical teachers with more distance to either general practice and/or medical education. Furthermore, the main researcher kept and discussed audit trails in order to consider his own influences and contributions to the research process. These were discussed during both the weekly meetings between the main researcher and the co-promotor as well as the monthly meetings with the entire research team.

A further strength of this dissertation is its relevance for practice via medical education. Physicians' professionalism is a core factor in providing high-quality patient care(6, 43). Unprofessional behaviour by physicians on the other hand, compromises patient-physician relationships, patient safety and quality of care, and can harm patients' trust in the medical profession(44-49). Research has revealed a clear association between the unprofessional behaviour of physicians and unprofessional behaviour during undergraduate and postgraduate training(50-54). And therefore, supporting the development of a strong professional identity is a primary objective in specialist training programs(5, 55-58). This dissertation can contribute to that important objective.

Another strength of the studies in this dissertation is that they provide empirical evidence for what earlier has been theorised on unprofessional behaviour and PIF. Study 2 confirmed the continued value and validity of the Four I's model in PGME(1, 2). Studies 3 and 4 confirmed the continued value and validity of the conceptual framework of PIF developed by Cruess et al(5).

A last strength of this dissertation is the rigour with which the different studies were performed. The studies in this dissertation build on each other as they move from unprofessional behaviour to PIF and from practice to medical education. Further, in each successive studies we used a wide variety of research methods: content analysis, in-depth interviews and focus group interviews. Moreover, we drew input from all stakeholders relevant to professionalism in general practice: patients, residents, clinical supervisors, and faculty. These choices generated successive layers of data reflecting the perspectives of people who actually experience unprofessional behaviour and PIF. We also used different theoretical lenses in this dissertation: the CanMEDS model(59), the 4 I's model for describing unprofessional behaviours(1, 2), the multi-level professionalism framework for remediation(58) and the conceptual framework of PIF developed by Cruess et al.(5) as a sensitising framework for designing the interview guide as well as for conducting the deductive part of the analysis. Looking at the problem at hand through these different theoretical lenses added further rigour to our studies, whilst the exploratory approach left open the possibility of finding complementary themes.

The four empirical studies we present in this dissertation, however, also have limitations. A first limitation is that although many stakeholders are directly interviewed about unprofessional behaviour and PIF, the most important stakeholder in health care - the patient - is only questioned indirectly via unsolicited patient complaints. As a consequence, the patient's view on (un)professional behaviour and PIF is not addressed in depth in this dissertation. We will touch upon this point in the recommendations for both research and practice.

A second limitation – already discussed above – is the various roles of the main researcher. Being interviewed by a (well-known) colleague could have negatively affected data collection:

the participants might have provided 'socially desirable' answers. However, the PhD-candidate kept a research journal and audit trails in which he reflected on his role in each interview and discussed in the research group, which added to the rigour of the study. Being interviewed by an intrinsically interested and trustworthy colleague could equally have a positive influence. The participants seemed to experience a confidential atmosphere with an interviewer who recognised their daily challenges and seemed to provide rich 'inside information'.

A third limitation is that - due to the qualitative nature of our studies - caution should be exercised to generalise our findings. Exploration - rather than generalisation of the findings - is the goal of qualitative studies. And having explored patients' views (indirectly) and interviewed a large and diverse group of residents, supervisors, and faculty from eight different GP training institutes made it possible to discern a wide range of perceptions on (un)professional behaviour and PIF. Hence, this dissertation provides a rich - although contextualised - understanding of unprofessional behaviours, remediation and PIF in a PGME GP setting. Therefore, we think our study has implications for practice and further research in PGME, which we will discuss next.

Recommendations for research

We strongly encourage further research on the findings of the different studies in this dissertation.

Unprofessional behaviour in both practice and training

To gain a better insight into patients' experiences regarding professionalism, future research should focus on a deeper analysis of complaints concerning the container concept professionalism. For this, in-depth interviews with patients are needed to further investigate the subtleties of how lapses in professionalism are perceived(60).

Further studies might also delve into what categories of professionalism GPs and GP residents perceive as important and compare these categories with the descriptions of unprofessional

behaviours patients describe. Research done by van Mook et al.(12) can serve as an example for such research.

Following our second study, further research is also needed on the two novel descriptors: 'nervous exhaustion complaints' and 'nine-to-five mentality'. We especially welcome the viewpoint of the residents herein. Some of this work has already been carried out in Studies 3 and 4, where we investigated what it takes to become a GP and what it takes to 'make' a GP, respectively. However, the way in which the current generation of physicians makes different behavioural choices compared to their older colleagues when certain values are at stake still needs to be explored further: in particular, the challenges experienced in the area of work-life interference and how these challenges affect the vision on professionalism need further exploration. The growing discontent between generations of GPs, the problems in safeguarding practice succession, young GPs leaving the profession and the difficulty in fulfilling OOH GP shifts are three of the most significant challenges which make this research all the more urgent(19-21).

Further research also is needed to identify the best way to remediate unprofessional behaviours of residents. This research is especially needed for those cases in which introspection seems to be hampered or even absent.

PIF of GP residents

The results of the third and fourth study begin to make explicit what PIF in GP residency comprises. However, to allow for a more purposeful approach to PIF in GP residency, further exploratory studies are needed to capture the subtleties of PIF in GP residency. Themes which warrant further exploration are: 1. perceived norms and how they can be negotiated 2. the use of role modelling and mentoring and 3. the role of bonds of trust. We hypothesised above how these three themes might be interrelated, but further research is needed to explore this. We suggest a narrative approach for this research. As the above-mentioned themes are about multifaceted experiences, they need to be understood in the context of the narratives of residents and supervisors. Through these narratives we hope that interpretations of the experienced reality can be unveiled.

Second, in Study 3 we found that three interrelated factors; 1. clinical experiences; 2. clinical supervisors; and 3. residents' self-assessment, are at play in forming a professional identity. As described above, the other factors of the theoretical PIF framework developed by Cruess et al.(5) were touched upon during focus group discussions, but these three appeared to be most important in the PIF of residents in our studies. However, we encourage further research to point out the precise relevance of the other factors Cruess et al. propose(5) to residents' PIF.

Moreover, we would strongly recommend studies focused on PIF in other residency contexts as well as studies that explore other stakeholders' perspectives, including educators outside the clinical workplace and patients.

Recommendations for practice

The findings in this dissertation have implications for stakeholders involved in healthcare practice: patients and physicians and for stakeholders involved in training practice, as well as residents, faculty, and clinical supervisors, and are discussed consecutively below.

Patients

Our first study might provide patients with language to describe expectations and discontent about the care provided, especially when confronted with the unprofessional behaviour of healthcare workers. Regrettably, not all adverse outcomes or instances of patient dissatisfaction are fed back to physicians(7, 8). However, because one can only improve when aware of shortcomings, healthcare workers need patients' feedback. Therefore, we encourage patients to share their thoughts on how their healthcare can be improved. Moreover, patient's thoughts on the professionalism of healthcare workers must also be actively researched as advocated above.

Physicians

Our first study shows that patients can provide unique and important insights into patients' expectations and confirmed previous findings that unmet expectations were drivers for many complaints(61-69). An important way to align expectations is to actively address expectations

during consultations. Therefore, we urge physicians to communicate clearly about examination, treatment, potential complications and prognosis and actively address patient expectations during consultations(61).

The fact that patient complaints can serve as a valuable source of information to stimulate reflection on how to improve health care quality fits perfectly in what currently is called "a lifelong commitment to excellence"(70, 71). We call for physicians to further use patient complaints as input for training purposes. Learning from the lapses they reveal might take a new turn and touch upon deeper layers when studying them through the lens of PIF. Because a considerable proportion of patient complaints relate to professionalism issues, we specifically recommend Continuing Medical Education training concerning professionalism and the devastating consequences that can be caused by lapses in professionalism.

Residents

The above-mentioned recommendations concerning training apply without restriction to residents. For residents however, this dissertation especially provides recommendations concerning PIF. We strongly recommend residents to clarify their own PIF thus far and actively plan their further PIF. We recommend residents to take an active stance in asking to make the often-implicit norms of clinical supervisors explicit and recommend they discuss these norms. Furthermore, we recommend that residents take their role in actively shaping a bond of trust between with their clinical supervisors aiming to facilitate their own PIF.

Faculty

Our four studies urge explicit training regarding professionalism. Whereas our first studies did so mainly with regard to professional and unprofessional behaviour in practice, the other three studies show the need for a focus on unprofessional behaviour and PIF in the curriculum. Curriculum revision is an excellent opportunity to integrate the relatively new concept of PIF into the curriculum.

We recommend faculty actively use the 4 I's model, which was primarily developed based on research in UGME aiming to overcome the 'failure to fail' problem. It does so by guiding educators in how to document unprofessional behaviour, and in doing so, provides directions

for effective remediation. Based on the results of our Study 2, we have reason to believe that the same applies to PGME. But we recommend faculty to not only use this model when confronted with unprofessional behaviour of residents that clinical supervisors were unable to remediate. It should also be used to train clinical supervisors in the use of the 4 I's model, aiming to facilitate accurate description of unprofessional behaviour of residents and in doing so facilitate timely identification of the issue and thus reduce the ' failure to fail' problem(1, 72).

Studies 3 and 4 demonstrate the importance of clinical supervisors in supporting resident's PIF. Methods for translating the knowledge gathered into ways of actively supporting residents' PIF are needed. Since supporting PIF seems to demand other skills from supervisors in addition to just teaching knowledge and skills, supervisors need to be trained in when and how to apply these different skills across the different stages of PIF(73-75). Furthermore, supervisors must be taught about establishing bonds of trust and how to support PIF, even if the bond between supervisor and resident is considered suboptimal. Supervisors must also be taught (or stimulated) to not only discuss their norms with their residents but also discuss the challenges generated by these norms. In doing so, supervisors have to be stimulated to fulfil their role as coaches through respecting residents' subjectivity.

The finding in our third study, that residents' professional identity is more likely to be influenced by doing the work than by being taught, might (re)open the debate on time distribution between days in practice and the day-release program, or on the content of the day-release program, when revising the curriculum.

Clinical supervisors

We also recommend clinical supervisors to actively use the 4 I's model, again to facilitate timely identification and thus reduce the 'failure to fail' problem(1, 72). As our study (and earlier studies) have shown, unprofessional behaviour is indeed often difficult to pinpoint(1, 2, 76). We hope and believe that the descriptors of the 4 I's model can provide clinical supervisors with a language to adequately describe unprofessional behaviours among residents which can facilitate timely identification of issues and thus reduce the problem of 'failure to fail'(1, 72).

Study 2 suggests there is scope for clinical supervisors to develop their remedial skills, especially when confronted with residents whose introspection is hampered, or for whom the usual PIF approach is insufficient. Here again we would like to draw attention to the comprehensive multi-level professionalism framework, which we described earlier(77). This framework which is well suited to the training practice can serve to guide the remediation of unprofessional behaviour by encouraging reflection on all of the important levels that influence professionalism(77). Together with the 4 I's model this additional framework can help to distinguish between residents having a problem with introspection, or supervisors themselves being insufficiently aware of their own limitations.

The results of two last studies in particular should make clinical supervisors realise the importance of their role in the PIF of residents. Supervisors are to a large extent responsible for building a safe supervisory relationship. And again, imposing norms is at odds with this. By contrast, supervisors must learn about establishing bonds of trust to support PIF and need to discuss their norms as and the challenges generated by these norms, with their residents.

Study 3 also recommends a reciprocal supervisory relationship which evolves in a similar manner to a resident's PIF. Supervisors need to be trained in using different supervisor competencies across the different stages of the resident's PIF (73-75). The residents we spoke with in Study 3 painted a picture which leaves room for improvement, especially in the last period of residents' training. In this period supervisors should devote themselves to their role as a coach – thus respecting residents' subjectivity - and give residents room to negotiate perceived norms around providing care, as advocated earlier(74, 75).

Conclusions

Unfortunately, unprofessional behaviour of physicians is an everyday reality. Aimed to gain insight into patients' expectations regarding the professionalism of GPs, we first studied unsolicited patient complaints. It appeared that a substantial proportion of unsolicited complaints concern professionalism issues. This dissertation provides insight into how patients experience unprofessional behaviour of physicians.

Further, it provides educators with appropriate language to describe the unprofessional behaviour of residents, which matches that of the 4 I's model. This language can contribute to the early identification of professionalism issues and the remediation of lapses in professionalism.

Because "kill it before it grows" – as the saying goes – implies more than early detection and remediation but also a focus on the formation of a professional identity, this dissertation also provides insights into the PIF of GP residents from the perspectives of both supervisors and residents. According to residents, identity formation occurs primarily in the workplace as they move from doing the work of to becoming a GP and negotiate perceived norms. Residents feel that a tapestry of interrelated influencing factors – most prominently clinical experiences, clinical supervisors, and self-assessments – which changes over time, is felt to exert its influence predominantly in the workplace. Their supervisors have an image of the professional identity they are supporting and work toward that goal through role-modeling and mentoring. Supervisors believe that a bond of trust between supervisor and resident is a prerequisite to properly support residents' PIF.

To safeguard the future of General Practice as a profession a dialogue must be initiated between the generations of GPs about how professionalism can be practiced given the challenges in balancing professional and personal roles.

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