On becoming a GP: professional identity formation in GP residents

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‘Het is gezien’, mompelde hij,

‘het is niet onopgemerkt gebleven.’

Gerard Kornelis van het Reve

Chapter 7

Summary

This thesis presented 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 (PIF) 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.

In **chapter 1**, we introduced our readers to the research field of PIF and its precursors. PIF is a relatively new framework in which physicians' professionalism can be discussed. Where we used to discuss professionalism in terms of virtues (the good physician as a person of character) or behaviour (the good physician as a person who demonstrates competence), medical education research now focuses on identity and its formation (the good physician as a person who integrates into his or her identity a set of values corresponding with the physician community with the result to think, act, and feel like a physician).
We outlined the two main lines of thought out this dissertation:
1. from unprofessional behaviour to PIF and
2. from GP practice to GP training.
We started our study into PIF in the context of GP residency by studying the public's expectations of GPs by means of a study on GPs' unprofessional behaviours as vented in patient complaints. Studying patient complaints and especially the burden physicians' unprofessional behaviour imposes on patients, raises the question how unprofessional behaviour and its remediation are addressed in GP training, which was the focus of the second study. Although a behaviour-based perspective on professionalism focussing on (un)professional behaviour and remediation remains indispensable, in last two studies we broadened our focus shifted to PIF in GP residency. In study 3 we studied PIF from the viewpoint of residents. In study 4 we studied PIF from the viewpoint of their supervisors.

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?'

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.

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?'

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. 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).

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.

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. 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 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.

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?'

Using focus groups among GP residents and the conceptual framework of PIF developed by Cruess et al. 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.

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.

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.

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.

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

Using focus groups among GP supervisors and again using the conceptual framework of PIF developed by Cruess et al. 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. 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.

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.

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'.

In **chapter 6**, we described the main findings, discussed them in the context of the literature and presented recommendations for both research and practice. Based on the studies described in this thesis, we concluded that unprofessional behaviour of physicians is an everyday reality. We provided insight into how patients experience the unprofessional behaviour of physicians. Further, we provided educators with appropriate language to describe the unprofessional behaviour of residents, which can contribute to the early

identification of issues and the remediation of lapses in professionalism. Because also a focus on the formation of a professional identity is needed, this dissertation also provided insights into the PIF of GP residents from the perspectives of both supervisors and residents. To safeguard the future of General Practice as a profession we recommended a dialogue to be initiated between the generations of GPs about how professionalism can be practiced given the challenges in balancing professional and personal roles.