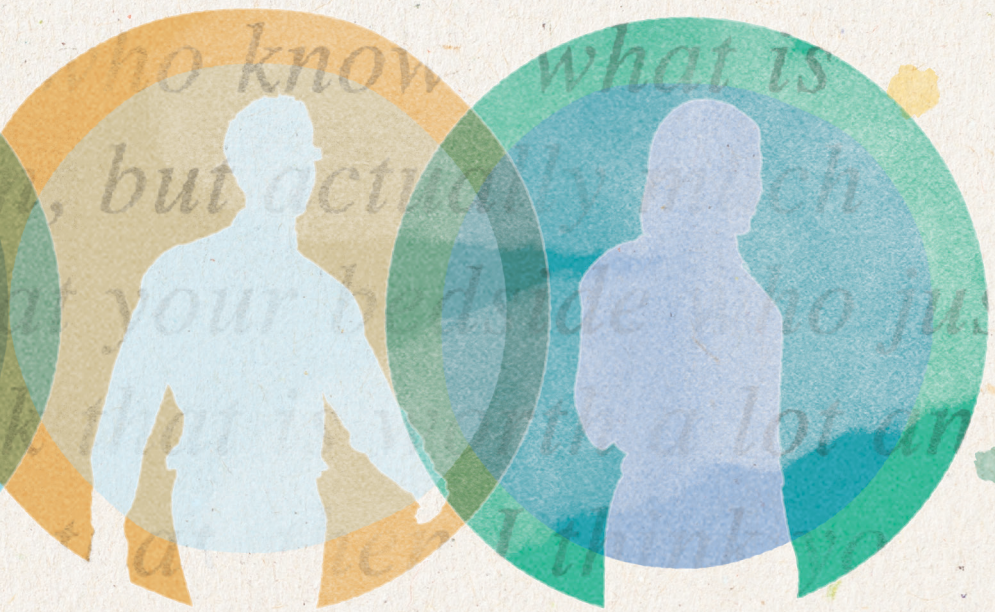
Good health for all: an ethnographic study of frontline professionals in general and mental healthcare and social welfare

Heteren, F. van



Positionality statement

Reflections on my position in the research field

I acknowledge that I, as a scholar, with my own personal story, shape the research process and my perspective on the social world (Schwartz-Shea & Yanow, 2013; Ybema, 2009; Trangbæk and Cecchini 2023), which is why the knowledge I produce in this dissertation will always be a partial view (Schwartz-Shea, 2014). I entered the research field as a trained anthropologist and public administration scholar. I have a strong background and interest in research into health in a broad sense of the word, which means that I had been doing research into topics related to inclusion, gender and well-being during the years before the research for this dissertation. However, I am not medically trained, while most of my respondents are. Knowing that health is an important theme in my research and that I work at a public health department, at rare moments, respondents confused me for a medically trained 'insider'. Such situations meant that they would forget that I was only a researcher, and share information that they may also have shared with colleagues or trainees.

I entered the field with a relatively privileged position, due to my educational background, my considerable health, and familiarity with institutions. At the same time, I was an outsider, depending on building a network with trust en reciprocity in the research field. Not being medically trained, it was all the more valuable that I could spend considerable time in the research field to get familiar with the various frontline professionals, their work and especially their professional jargon. This time spend at the workplaces of respondents enabled me to ask questions and to become familiar with their daily work.

My background in themes like diversity, inclusion and gender shaped my focus in the beginning of the research. I was curious how care and social welfare work in practice, while hoping to better understand what this could eventually mean for people in vulnerable situations. I would describe my position as that of a familiar outsider, whose curiosity encouraged reflection among research participants. Being an outsider and relatively unfamiliar with the research setting was valuable at first, as it allowed me to question things that others might take for granted. This position led me to ask questions about everyday routines and assumptions that were reflected upon by respondents. Over the course of the PhD trajectory, however, my view of care gradually changed. I developed a deeper understanding of the complexities and dynamics that frontline professionals experience in their daily work. At the same time, my position in the field also changed, as I gained more knowledge of the context and became more embedded in practice. This growing familiarity helped me to better understand the context in which the research took place, which was helpful in developing, conducting and interpreting the later stages of the research.

More specifically, my position as a familiar outsider inevitably shaped both the data collection and the interpretation of the findings. First, this positionality allowed me to see practices and ask critical questions that might have remained unquestioned by insiders. Second, my background and personal interests may have shaped what I found salient of further exploration. I have aimed to strengthen the validity and interpretation of the findings by remaining reflexive throughout the research process, by actively considering my own assumptions, alternative explanations, and seeking feedback from research participants and peers.

Reflections on conducting interdisciplinary research

My research as well as my role is interdisciplinary: I research how frontline professionals collaborate across professions and organizations, and my own work crosses academic disciplines. Doing interdisciplinary research brought valuable insights, but it also brought challenges. In the beginning of this doctoral research, it was challenging to find a fitting academic journal to publish my work in, as many academic outlets are still discipline oriented. After finding the right journal for the first empirical chapter, it became clear to me that the value of what I was doing was being acknowledged by the academic community.

Moreover, as an anthropologist and public administration scholar in a mainly medical and public health oriented context, I had to adapt to different communication styles, especially when it came to productively discussing epistemological assumptions and methodological approaches. This meant that I had to actively claim my space, not only by listening and adapting, but also by demonstrating the value of my approach and qualitative methods. Although qualitative research is increasingly recognized in public health, especially within my department, I still experienced clear differences — particularly at the beginning of my research in 2019 — in how knowledge was constructed. One recurring theme of discussion was the use of socioeconomic status (SES) in research. Some epidemiological or public health colleagues used SES as a socio-demographic variable, either as a control variable or as one of the main independent variables in a multivariate model, while I approached it as a socially embedded category (Wright et al., 1999). I think the approach in this dissertation is valuable in the sense that I unpacked how SES was understood and used by respondents in their everyday work context. This, however, requires unpacking the concept and clearly understanding what it constitutes of, rather than working with it as an umbrella term without clarity about its actual meaning (Van der Waal & De Koster, 2015). Different perspectives like these led to valuable interdisciplinary discussions within the department. One of the ways in which I felt able to add value with my approach was through my involvement in co-hosting a qualitative research platform at the Leiden University Medical Centre (LUMC) and initiating an interdisciplinary network that brought together scholars from public administration and public health.

Within my supervisory team, which was inherently interdisciplinary, I initially found it challenging to steer the research direction, especially since my background lies mostly in anthropology and public health was a new domain. While the freedom I was given was demanding at times, I gradually grew into a more leading role in shaping the research projects. Working in this interdisciplinary team became increasingly valuable, as our contributions to the collaboration grew to complement and inspire each other clearly.

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Appendices

Appendix A1: Table with respondent characteristics

Respondent ID	Job position	Professional discipline
R1	Out-patient attendant	Social
R2	General practitioner	Medical
R3	Community police officer	Social
R4	Social case manager municipality	Social
R5	Client supporter	Social
R6	Out-patient attendant	Social
R7	Practice nurse mental healthcare	Medical
R8	General practitioner	Medical
R9	Recovery coach mental health	Mental
R10	Recovery coach mental health	Mental
R11	Mental health worker with police	Mental
R12	Manager multidisciplinary approach at municipality	Social
R13	Social psychiatric case manager	Social
R14	Community sports coach	Social
R15	Community sports coach (and dietician)	Social
R16	General practitioner	Medical
R17	Case manager social support law municipality	Social
R18	Prevention officer mental health	Mental
R19	Mental health worker	Mental
R20	Community sports coach	Social
R21	Community gardener	Social
R22	Police officer, specialist on people suffering confusion	Social
R23	Social psychiatric nurse	Mental

Appendix A2: Interview guide[5]

Overarching topics	Goal	Topics interview questions & probes
Before the interview	Explaining nature and aim of research, reassuring confidentiality, handling of data, and seeking permission and consent	· Explaining aim of research project · Explaining handling of data · Asking for permission to audio record interview · Asking for informed consent
Introduction	Acquiring contextual knowledge Setting the scene of the interview and role expectations	· Professional background and experience · Current job and daily activities
Health views	Acquiring knowledge about health views	· Kinds of health views held · What is done to achieve this · Why is this important · Other desired outcomes · Changes over time
Health views in collaboration with other professionals	Acquiring knowledge about working with other professionals	· Kinds of professionals and organizations they work with · How forms of collaboration are organized · How the types of collaboration mentioned are experienced · How health views may align · Importance of collaboration for reaching health views

5 The interview guide was adapted to the specific professional contexts and after the first few interviews. The interview guide differed slightly for those working in different specializations.

Appendix A2: Interview guide6 *Continued*

Overarching topics	Goal	Topics interview questions & probes
Health view in interaction with clients	Acquiring knowledge about working with clients	· Importance of client values and ideas · Situation in which client could be helped well > Why and how · Situation in which client could not be helped well > Why and how · How health views may align with clients > Weighing importance of client preferences · Experience of interaction with clients
Closing	Exploring other themes left unmentioned but of potential importance for the research Explaining overall planning of research project and thanking respondent for participation	· What are important values in their work? · Any other themes that respondents would like to address · Explaining further planning of the project

6 The interview guide was adapted to the specific professional contexts and after the first few interviews. The interview guide differed slightly for those working in different specializations.

Appendix A3: Code table of generic description of health conception dimensions

	Mental healthcare Gr=211; GS=6	Medical healthcare Gr=137; GS=4	Social welfare Gr=464; GS=13	Totals
Contextualization of other problems Gr=41	8	12	24	44
Contextualization of social context Gr=40	9	8	20	37
Defining_ competence Gr=66	20	4	39	63
Defining_ mental Gr=35	10	6	18	34
Defining_ physical Gr=10	3	2	5	10
Alignment_ being approachable Gr=13	3	5	5	13
Alignment_ seeking alignment Gr=62	17	18	28	63
Totals	70	55	139	264

The number of quotes coded with a health conception dimension per type of professional.

Appendix A4: Co-occurrence code table of health conception dimensions

	Contextualization of other problems Gr=41	Contextualizatoin of social context Gr=40	Defining health competence Gr=66	Defining health mental Gr=35	Defining health Physical Gr=10	Being approachable Gr=13	Seeking alignment Gr=62
Contextualizationof other problems Gr=41	0	4	2	4	2	0	8
Contextualization of social context Gr=40	4	0	5	2	1	1	7
Defining competence Gr=66	2	5	0	9	2	0	4
Defining health mental Gr=35	4	2	9	0	2	0	4
Defining health physical Gr=10	2	1	2	2	0	0	2
Being approachable Gr=13	0	1	0	0	0	0	2
Seeking alignment Gr=62	8	7	4	4	2	2	0

Co-occurrence is established when respondents mention two dimensions in the same story within an interview.

Appendix A5. Table with (main) respondents' tenure

Respondent number	Domain	Profession	Educational level
A	Healthcare	General practitioner	University
B	Healthcare	General practitioner	University
C	Social welfare	Social worker or client supporter	Higher education
D	Mental healthcare	Mental health worker and social worker in mental healthcare	Higher education
E	Social welfare	Social worker with elderly people	Higher education
F	Mental healthcare	Social psychiatric nurse	Higher education

Appendix B1: Observation guide with operationalization

Health promotion role dimensions	Operationalisation	Example from fieldwork
Type of involvement: reactive health promotion	Observe any text on a situation in which a frontline professional perceives a problem or symptoms to be clear and demarcated enough to respond to directly. During illness visits or conversations regarding specific symptoms, professionals educate or advise their patients about behavior, lifestyle or possible risks (McAvoy, Kaner et al. 1999). Reactive health promotion is firmly focused on disease risk-specific practices in favor of behavioral, disease-focused, lifestyle-oriented determinants of health. Such strategies fail to incorporate broader societal, economic, ecological, and political dimensions of health promotion (Runciman, Watson et al. 2006, Whitehead 2006, Casey 2007).	A client has clear symptoms of allergies and asthma and the GP reacts to this by prescribing medicine that should be used when specific symptoms appear.
Type of involvement: proactive health promotion	Observe any text on a situation in which a frontline professional proactively performs an intervention without specific worrying symptoms in this direction expressed by the client. Professionals could even interfere in case of seeming high risk. Proactive health promotion could, for example, include proactively changing the problem in a way that the professional thinks is more relevant to the client (McAvoy, Kaner et al. 1999). Or by proactively trying to figure out what an underlying problem is.	1. GP giving advice that does not directly fit with the problem the client came with. The GP thinks this is more relevant to the client or that this is what the client could mean. 2. GP interfering in someone's life by giving unsolicited advice about, for example, the use of birth control for someone at high risk of unwanted pregnancy.

Appendix B1: Observation guide with operationalization *Continued*

Health promotion role dimensions	Operationalisation	Example from fieldwork
Perceived ability health promotion role: able	Observe text on frontline professionals who feel able, skilled and/or responsible to promote health of their clients. They feel they have the right knowledge and facilities to do so and they perceive it to be their task.	'It is my task to help with anything in the social environment. You can ask me anything, because it is my job to help you. Don't hesitate.' (social worker)
Perceived ability health promotion: unable	Observe any text on frontline professionals who don't feel able or skilled and/or not responsible for health promotion.	1. 'It is not my role, to write such nonsense statements, but no one else will do it.' (GP) 2. 'It is not our role to help you so comprehensively. It is your own responsibility to get to know how your phone works and how to use it for your finances.' (Social worker)
Perceived ability health promotion: collaborative	Observe any text on frontline professionals who do take on health promotion activities, but only when they can collaborate with other stakeholders.	'I think this client has real problems but I'm not sure how we can help them apart from listening to them. I refer them to the practice nurse so they can help find an experience expert to connect with.'
Perceived importance health promotion: emphasize	Observe any text on frontline professionals who emphasize the importance of health promotion activities. They are motivated and willing to promote health.	'One thing that really motivates me in my work is to help people get healthy, to care.' (GP)
Perceived importance health promotion: skeptical	Observe any text on frontline professionals who are skeptical about health promotion and its results. They expect that it won't really help and are thus neither motivated nor willing.	'If I help them with this task, then they will never learn to do it independently and they will come back over and over again.' (Social worker)
Professional identity aspects	Operationalization	Examples from fieldwork
An individual's self-definition	Observe any text on an individual's self-definition as a member of a profession (Adams, Hean et al. 2006, Chreim, Williams et al. 2007).	'I identify as a real caregiver in heart and soul.' (Mental healthworker).

Appendix B1: Observation guide with operationalization *Continued*

Health promotion role dimensions	Operationalisation	Example from fieldwork
Professial uniqueness	Observe any text on what makes the professional unique on their own and how they become meaningful relative to others through clear goals, norms, beliefs, values, interaction styles and member interdependencies that are associated with a role in work situations (Ashforth 2000).	'Its is my goal that when people leave here they they feel lighter. It makes no sense to judge, therefore I go into what people find important.' (Mental healthworker).
Cultural expectations	Observe any text on the cultural expectations about how to behave in a social position (Burke and Stets 2009).	'I like to indicate boundaries around my professional expertise, towards clients and towards other professionals. I would rather do what I am good at.' (Mental healthworker).

Appendix B2: Table with hours of observation per respondentgroup

Respondent group	Hours of observation	Days of observation	Formal semi-structured interviews
Mental healthcare	65 hours	14 days	1
General healthcare	45 hours	11 days	1
Social welfare	40 hours	9 days	1

Appendix B3: Conversation/interview guide

Briefing/appointments
Discussing confidentiality, anonymity and introduction to interview
Professional roles
What is your professional background?
What is your work experience like?
What are your core professional roles?
Health promotion
What are health promotion roles (or not) according to you?
What does heatlh promotion mean to you?
Do you believe health promotion is a core task as a professional? Why/ why not? What is more important?
Professional identity
How would you describe yourself as a professional?
How do you value these roles and tasks (or not)?
What meaning do you give to these roles and tasks?
What do you find most important in your work with clients with combined psychosocial problems?
What are you good at, what do you contribute to your job?
Do you think you are competent/ the right stakeholder to work on health promotion? Why/ why not?

Appendix B4: Persona

	Persona
Respondent A, professional in general healthcare	
Observed health promotion roles	I use a *reframing health promotion* role
This is how I fulfill my role	I would rather just fix something that I understand and that is manageable and preferably medical, which aligns with my professional strengths. Otherwise, I can refer a patient so someone else who can offer help. I fulfill my health promotion role by setting boundaries regarding what is and isn't my scope of responsibility and I consider it important to focus on the aspects that align with my professional strengths.
Example of how I fulfill my professional role in health promotion	*'If I disagree with [a patient about wanting antibiotics], I sometimes still prescribe antibiotics, but at least I have had my say. I provide advice based on what I consider important, but I am accommodating. I don't engage in constant debates, as work should also remain enjoyable.'*
My professional identity is	***The pragmatic professional*** I am a pragmatic general practitioner, a fixer, I like extreme medical cases, I value setting boundaries around what I can and cannot do for a patient and I value that we can manage our general practice as a business.
Example of my professional identity	***The pragmatic professional*** *'Yes, I think I am an all-round general practitioner, with a focus on more pragmatic, hands-on work. That means that I am relatively more inclined to do things and less to have long conversations. […] Maintenance of psychiatry, I have somewhat less affinity with that. […] Which means that I often do the more urgent care like injections and treatments and I think I'm also stronger in the musculoskeletal system. […] I like extreme medical cases. So, I can relish someone who's living in a dirty house with rats and pus coming out of their ankle. Yes, so I feel like, nice. There may be some general practitioners who thinks, 'Yuck, do I have to go there?'. But there is often relatively a lot to do there, so there's a relatively high impact of what you do. It's a combination of wonder, the bizarreness of the syndrome, or the extreme aspects, I find that interesting and intriguing. How someone ended up in such a situation and what the background is. Yes, so that, and the same goes for when people are really seriously ill, I often find that fascinating. It just becomes more medically interesting, I think. So someone who says, 'No, I'm not feeling quite right in my well-being," I find less interesting than someone who is really in the midst of a big psychosis, constructing entire theories about how they are going to improve the world… I find a genuine first psychosis to be a very, very interesting medical picture."*

Appendix B4: Persona *Continued*

	Persona
Respondent D, professional in mental healthcare	
Observed health promotion roles	I use a *customized health promotion* role
This is how I fulfill my role	I fulfill my health promotion role by prioritizing being accessible to patients through platforms like WhatsApp. I furthermore do so by working with tailored treatment rather than focused solely on one diagnosis. I help patients in the way that works for them. The goal is that people leave here feeling like a heavy burden has been lifted off of them.
My professional identity is	***The responsive professional → holistic*** I am an accessible, responsive professional who values adapting to what the patient needs and who intends to foster a strong therapeutic relationship. The *caring professional → holistic* I am someone who truly wants to assist people that are really in need.
Example that shows my professional identity	**The holistic professional** The respondent is undergoing training as a Cognitive Behavioral Therapist, and she finds it very informative. She expresses that this should be mandatory, stating, '*My conversational techniques are now very different. Instead of just skirting around issues, I now have more knowledge to really address and assist. It's transformative. What I find important is to be there for people, especially those with multiple diagnoses. While there is a lot of stigma about our patient group, I think we can really help them here. In finding a solution I think it is really valuable that we can work on finding a fitting treatment here instead on just focusing on one diagnosis like depression. […] I will try to go with what works for the patient, it doesn't have to be my solution. […] Thereby, I try to protect the patient, both from themselves and from other professionals.*'
Respondent F, professional in mental healthcare	
Observed health promotion role	I use a *customized health promotion* role
This is how I fulfill my role	I fulfill my health promotion role by letting the patient know that I am there as a consistent support for them instead of wanting to fix things. The essence of my work lies in ensuring that everyone has someone who cares for them, looks out for them, and shows concern. And by building a connection without immediately wanting to judge or solve things. The reason being that '*every individual's journey in receiving care is unique. I might tidy up here, but that would not be helpful for her. We are working on recovery in different ways*'.

Appendix B4: Persona *Continued*

	Persona
My professional identity is	The *caring* professional → holistic I am a natural-born caregiver. The *present* professional I value being present for my patients and their needs. Thereby, I bring genuineness, authenticity and loyalty into my interactions.
Example that shows my professional identity	***The holistic professional*** *'The presence approach, yes […]. That's actually kind of the basis of what I do, within the pressure of business and management. We have a big caseload with complex cases. But being there for people and keeping a part of my agenda free to map out the worrying cases, to have some sort of free space to ring the doorbell three times. It is not possible teamwise, but Ideally I reserve a few hours a day for this. This way I can really invest in a relationship without immediately providing assistance, but based on being there for people and listening to what someone needs and just radically being there for them without judgment. Presence theory is thus the basis of providing good care, by getting to know someone well first. Based on that understanding and that very strong relationship, you can get very far.'* *'I'm not different as a human than as a professional, only the profession sits over it like a layer. And of course a few things that I am or I am not in my private life, you obviously don't take with you in your profession. But that authenticity and that I make contact with people and this authenticity they feel that. And the loyalty and being there for someone. […] So I'm always myself, I'm the nurse and the care provider at work, while I'm at home I'm also normal. Well, in my private life I also take care of other people and then you can say that in any case I'm a social person, I don't know how to say it, but it is not that different from how I am in real life, but I think that is quite necessary because the [clients] then feel that it is serious, and that you are not coming to pretend, or play a game or something. […]*

Appendix B4: Persona *Continued*

	Persona
Respondent B, professional in general healthcare	
Observed health promotion roles	I use a *customized health promotion* role
This is how I fulfill my role	I fulfill my *customized* health promotion role by having informal conversations, *building a relationship*, and trying to *understand the patient's environment*. For instance, 'I ask many questions to the patient to gain a better understanding of the situation and to clarify any uncertainties that may be related to the problem. This way, I aim to uncover the true nature of the issue at hand and the right approach by taking the patient and their concerns seriously. I provide them with the opportunity to (re)gain control over the care process.' I fulfill my customized health promotion role by doing more when this is necessary. For example, by 'engaging in conversations while someone waits for specialized psychological help.'
Example of customized health promotion role in data	The client's mother explains that the doctor's file says it is jaundice, but that this '*is not the case […]. [The child] suffers from a painful stomach and ribs, and has thin stools every day*'. The professional asks if there are things that the child cannot do because of her complaints. The child suffers during gymnastic class, where she cannot participate without pain. The respondent asks follow-up questions to figure out when and how the child suffers and how the mother observes this. Then the respondent explains that it is difficult to figure out what is going on based on what they know. There are many complaints but there is no clear pattern. They agree to do serveral more tests during the next appointment. Respondent to client and mother: '*It's always a matter of weighing up together what is more annoying, all these tests or the complaints.*' This story is exemplary of customized health promotion in which professionals find it *important* to work closely with clients and their enviroment by asking questions to figure out what is important to the client regarding their physical complaints, but also in other life areas.
My professional identity is	***The holistic professional*** I am an involved professional who listens, and who is motivated to and interested in solving complex issues. I am willing to extend the boundaries of my profession when this helps me to better help the patient.

Appendix B4: Persona *Continued*

	Persona
Example that shows my professional identity	***The holistic professional*** '*That I let people take control themselves. Yes, I think that also reflects a bit on how I approach life. Of course, that says something about me as well. […] That's the interesting aspect of our general practitioner profession- where does the boundary lie between what is within the realm of a general practitioner, and where does the line between societal responsibility and your role interpretation lie? I think that's the beauty of our profession; every general practitioner has to determine that for themselves. There's no right or wrong, but it varies for everyone. I can easily imagine that there are colleagues who say 'You come here with back pain, so I only treat the request present to me'. That is also very legitimate. For me, it's slightly different if it turns out that the person keeps coming back with that back pain and apparently isn't helped with the answer I give to the initial request. Then I want to explore further. […] [What I find enjoyable about my job here is that] it's about the whole concept of humanity, I think. […] It is clear that health, for me, is not only physical. It's also about how people function in other life domains. In that sense, the holistic nature of the general practitioner profession is what I chose many years ago. […] That is the basis of the general practitioner profession, I believe. The strength of our profession is that we have the opportunity to get a much broader view of those life domains because each domain influences health*.'
Respondent E, professional in social welfare	
Observed health promotion roles	I use *customized and reframing health promotion* roles
This is how I fulfill my roles	I fulfill the *customized* health promotion role by making sure that '*my solution doesn't have to be theirs*.' '*However, boundaries can be complicated, and sometimes I go beyond what is strictly required for a client. When a client comes here in distress, I will not turn them away. At the same time, I find it important that clients take responsibility and initiative*.' I fulfill the *reframing* health promotion role by helping with everything related to the social aspect. For instance, '*this woman came here with pain issues, but I think she is actually afraid and lonely and she should start volunteering again. […] We are from prevention, so these are things that we should take notice of*.''

Appendix B4: Persona *Continued*

	Persona
Example of reframing health promotion role from data	The professional and I greet the woman who sits in her mobility scooter when we arrive outside her building. She had forgotten that the social worker would visit today, but she says that she is happy that we are here. We walk and talk together for more than an hour. The client says that she: '*would like to keep walking with her until […] [she] can walk independently again.*' Later, the professional tells me that: '*She will probably never walk independently again and I cannot help with the instability in her legs. […] I think this is actually a loneliness issue. When I have not visited her for a week I can really see that she is lonely, depressed and sad and she really feels better after I came by. Walking with her is a way for me to talk with her and to monitor her social isolation*'. In this example, respondent E reframes a physical problem of not being able to walk independently due to a sore leg into a problem of social isolation. The respondent understands that the client experiences insecurity when walking due to pain in her legs. As a social worker, the respondent is not able to help with the legs, but she can help with a related social problem: loneliness.
My professional identity is	The *proactive* professional → pragmatic I am a doer, which means that I am driven to get things done. I go the extra mile for a client and I push boundaries to make things happen for a client. The *respecting* professional → pragmatic I value respecting the clients' solution, but they should also respect my professional suggestions. The *flexible* professional → holistic What I appreciate about this job is the flexibility to shape how I approach each task and focused on which domain […].

Appendix B4: Persona *Continued*

	Persona
Example that shows my professional identity	***The pragmatic professional*** *'I work on everything related to the social. Sometimes I think, if you put in a little extra effort, you can get people over a hurdle, to something, and then you can actually help people. […] Well, people don't need to get down on their knees or bring flowers, like, 'oh, thanks.' Just seeing how people progress or when they say 'you've really helped me overcome my fear of public spaces, you know, by taking me out with someone,' then I find it okay. But don't take me for a ride [when I have put a lot of work in your care].'* ***The holistic professional*** *'In that sense, I can really empathize with how it is for people, that you can really feel lost. Well, and that does create a bond. […] If I know it helps, I mention [that I have been ill too and how I dealt with that]. […] Well, I think I'm a good listener. I find it important to pay attention to the client. I try not to force my solution down their throat, so I listen to their problem and my solution doesn't have to be the client's solution.'* *'And this was not my task, but I think this is also social work. That's what I appreciate about this job, that I can shape my role the way I want to.'*
Respondent C, professional in social welfare	
Observed health promotion roles	I use *customized and reframing health promotion* roles
This is how I fulfill my roles	I fulfill the *customized* health promotion role by having longer conversations during one on one appointments with clients who are able to express their problems. '*Then, I enjoy assisting with psychosocial issues*.' I fulfill the *reframing* health promotion role by assisting people in addressing their material concerns to the extent of our capabilities. '*During the open office hours, we only do short social questions. Then, professional boundaries are central to me, otherwise, I end up dealing with minor tasks that are not within the scope of my education*.' However, often, '*I cannot really fix their problems, but all I can do is listen*.'
My professional identity is as follows	The eager professional → pragmatic I am eager to help when I can truly make a meaningful impact for a client who takes ownership of their own wellbeing. The eager professional → holistic What motivates me is when I can help people by having longer conversations about their problems that go beyond just material stuff. What I really like is to listen, when I know I can really mean something by empowering them.

Appendix B4: Persona *Continued*

	Persona
Example that shows my professional identity	***The pragmatic professional*** *'I can't help someone who doesn't take ownership of solving their own problems. Otherwise, I end up doing small tasks that I haven't studied for. It's important for me to set boundaries on what is and isn't my responsibility. When a client pressures me, I won't work harder. I want to help, but only if I feel like I can truly make a difference. [...] This profession is not what it has been, I don't feel taken seriously anymore. I feel like I can't do the work that I want to do.'* ***The holistic professional*** *'Addressing relationship issues is a significant aspect of my work because it can have a profound impact on someone's life, relationship problems.'*

Appendix C1: Observation guide dimensions of collaboration

Collaborative dimensions by schot, Tummers et al. 2020.	**Operationalization**	**Example from fieldwork**
Creating spaces	1. Note down any observations on a situation in which a frontline professional creates spaces in relation to *external actors* such as managers and other institutions (Nugus & Forero, 2011).	GPs and social welfare professionals set up and participate in interprofessional meetings.
	2. Note down any observations on a situation in which a frontline professional creates spaces *internally* by (re)creating the organizational arrangements for collaboration.	
	3. Note down any observations on a situation in which a frontline professional works around existing organizational arrangements by *creating alternative, informal information* channels (Gilardi et al., 2014).	
	4. Note down any observations on a situation in which a frontline professional creates another type of space	

Appendix C1: Observation guide dimensions of collaboration *Continued*

Collaborative dimensions by schot, Tummers et al. 2020.	Operationalization	Example from fieldwork
Bridging gaps	1. Note down any observations on a situation in which a frontline professional bridges a gap between *professional perspectives* on how to best treat clients (Chreim et al., 2013; Falk et al., 2017).	A GP calls a sports coach in the hope that she can persuade him of the benefits of the exercise program.
	2. Note down any observation on a situation in which a frontline professional overcomes s*ocial gaps* by strategic communication in light of diverse personalities and communication preferences (Timmons & Tanner, 2005).	
	3. Note down any observation on a situation in which a frontline professional bridges c*ommunication divides* by actively transferring and translating professional knowledge or information from one professional to another, as well as about making oneself available to others (Dahlke & Fox, 2015; Schot et al., 2020; Williamson et al., 2012).	
	4. Note down any observation on a situation in which a frontline professional bridges *task division* gaps by conducting tasks that are not part of their formal role and help other professionals (ibid.).	
	5. Note down any observation on a situation in which a frontline professional bridges another type of gap.	
Negotiating overlaps	1. Note down any observation on a situation in which a frontline professionals negotiates *between work roles and responsibilities in general* (Lingard et al., 2002; Schot et al., 2020).	A GP explains that she cannot wait to start with a new program, but, according to her, it is not her role, but the role of municipality to start it.

Appendix C1: Observation guide dimensions of collaboration *Continued*

Collaborative dimensions by schot, Tummers et al. 2020.	Operationalization	Example from fieldwork
	2. Note down any observation on a situation in which a frontline professional negotiate overlaps in *individual care processes* (Schot et al., 2020).	
	3. Note down any observation on a situation in which a frontline professional negotiates another type of overlap.	

Appendix C2: Interview guide semi-structured interviews interprofessional collaboration

Themes	Questions
General introduction	General/introductory question: what does interprofessional collaboration mean to you in your work?
Interprofessional collaboration: *bridging gaps* 1) Professional perspectives 2) Social gaps 3) Communication divides 4) Task division	Thematic questions: 1) (How) do you experience knowledge gaps between you and other professionals when working with clients with combined problems? How do you deal with this? 2) How do you experience social gaps? And how do you try to overcome these? (personalities, communication preferences) 3) How do you experience communication gaps? And how do you try to overcome these? (knowledge, information, availability) 4) How do you experience gaps related to task division? (help each other beyond formal role etc)
Negotiating overlaps	1) How do you experience negotiating overlaps between *work roles and responsibilities in general?* a. Does working together create ambiguous overlaps into who does what, and who is responsible for what? And in individual care processes?
Creating spaces	1) How do you experience creating spaces in relation to *external actors* such as managers and other institutions? (non-clinical/ management related issues/relationship building). 2) How do you experience creating spaces *internally?* (by (re) creating the organizational arrangements for collaboration, working around existing organizational arrangements by *creating alternative, informal information* channels).

Appendix C2: Interview guide semi-structured interviews interprofessional collaboration
Continued

Themes	Questions
Professional values/professional identity	How would you describe yourself as a professional? a. What are you good at?- what do you contribute to your job? b. What is important to your work? c. What is the best thing about your job- can you give an example? d. Can you say what is the worst/toughest part of your job- example? e. Can you remember why you chose to do what you do? Do you still feel like that today?
Notions of role as a health-promoting professional	What does health mean to you? a. What do you associate with the word health? b. What about your work? How is health part of your daily work? How do you try to work towards this idea of health for clients with combined problems? c. Do you believe that health-promotion is one of the key tasks as a professional? Why/why not? What is more important?

Appendix D17: Personas and interview questions

Introduction questions

1. How did you grow up? How would you describe your own social status?
2. How would you describe yourself as a general practitioner?
3. What do you find important in your work?

Personas

Patient 1

A 45-year-old man comes to your consultation at the general practice. From his file, you know that he has been here before for sleep problems. To relax in the evening, he regularly smokes a joint with friends. He has a group of friends he has been close to since childhood and is very attached to them. Today, he comes in with complaints of chest pain. When he enters, it feels like a whirlwind has come in. After a short conversation with the patient, the following information comes to light: the man has had a lot of energy lately, which prevents him from sleeping well. He also experiences significant chest pain and doesn't understand the cause. He often worries about his pain in the evening when he is home and notices it especially when he feels very busy. He feels hyper and tired at the same time. Due to poor sleep, he doesn't feel refreshed. The patient indeed looks visibly tired, which you can see from the bags under his eyes. Sometimes, intense training at the gym helps him fall asleep, but he cannot do this every day because of his work. Upon further questioning, the patient also reveals that he has seen the mental health nurse for his sleep problems. The nurse suggested he talk to peers who are also hyper, which he is considering. Due to his sleep and pain issues, he cannot always make it to work on time. Fortunately, his own construction busyness is doing well, so he doesn't have to worry about money. Since dropping out of school early, he has worked in construction and, after gaining years of experience, has had his own company for a few years. His brother works with him in the company, and he is also close to other family members. His family means a lot to him. The patient is curious about your opinion on the chest pain and if you have a solution for it. The man look nervous. Furthermore, he has a blank medical history regarding heart abnormalities in the family, and you find no abnormalities during the physical examination.

Patient 2

A 46-year-old man comes to your consultation at the general practice. Before calling him in, you check his file. He was here last year when he had a burnout and temporarily stopped working at his own law firm. He is now back at work and has never had

7 Note that the vignettes and interview questions have been translated from the original Dutch.

to worry about income. You know that he is educated, articulate, and often asks many questions. You see that he is here for chest pain. After a short conversation with the patient, the following information comes to light: the man feels miserable. He cannot find balance. He had a burnout a while ago, which still affects how he can perform his job. Now he is experiencing chest pain and wonders where it comes from. The man has clearly thought a lot about it and, upon further questioning, reveals: 'I was always very actively involved in everything. Now I'm back at work, but it's still not going well. I'm seeing my psychologist again. She has held a mirror up to me, and I think I need to let go of my old, very active life. She also recommended relaxation exercises, which help somewhat. But what I regret is that I can no longer do fun things with friends in the evening, like playing badminton or going to a party. I value spending time with my good friends.' When you ask him why he can't do these activities anymore, he says it is mainly because of the chest pain. Because of this pain, he is afraid of overexerting himself. When he recently went to a friend's birthday party, the chest pain made him leave early, which he found very unpleasant. He feels like an outsider when he has to leave early. The patient is worried and wants to know what you think about his chest pain. He looks tired. From his file, you know that he has no family history of heart abnormalities, and your physical examination finds no abnormalities.

Patient 3

A 45-year-old patient comes to the general practice for a consultation. You know from his file that he has struggled in the past to find balance in his energy levels. You sometimes doubt whether this patient fully understands what you discuss with him, as he does not always seem to follow you advice regarding the regular intake of medications. After a short conversation about his situation, the following information emerges: the man has made an appointment today due to persistent chest pain. The pain is so severe that he is really worried about what it could be. After further questioning, the patients also reveals that the pain is hindering him. He needs all his energy for his sick partner, who cannot take care of herself at the moment. His partner wants him to leave her because she feels she can no longer be a good partner. At the same time, she is very controlling and jealous. The man has no family, friends, or neighbors who are concerned about them, and they have no children. Additionally, he does not want to burden others with their problems. The man is very tired. This has been the case since the accident he had while working at the cleaning company where he was employed. Since contracting Covid, he has been on sick leave. Last week, the company doctor called, and they will call him back soon after he has spoken with the general practitioner. The man is now afraid that they will want him to return to work. What makes him even more nervous is that he does not fully understand where his income currently comes from. If his income were to stop, he would be in serious trouble. It is already a struggle to make ends meet but he knows how to live with little. He has an air fryer and knows what fast food he can make

in it every day. What is wearing him down is not knowing what to expect, as he simply cannot work right now due to the chest pain. The man wants to know what is causing his chest pain. You find that the patient looks nervous and confused. He has no family history of heart abnormalities, and you physical *examination* finds no abnormalities.

Questions asked each time after the respondent reads one of the personas

1. What is your first impression of this patient? And why do you have this impression? What is it based on?
2. What would you like to ask this patient? Follow-up: What would you do if you knew this?
3. What alarms you? (only if something seems alarming to you)
4. What is your level of concern for this patient?
5. What could be influencing the patient's pain symptoms?
6. What kind of treatment plan would you develop based on what you know? Follow-up: I understand from previous conversations that it is impossible to rule everything out (medically), but are there specific things that take priority in this case? And what has less priority? Why? Can you give an example? What would be your preference, regardless of what the patient may want or find important? What would you like to convey or advice to the patient?
7. Under which circumstances would you take more action?

Additional questions asked after discussing the last persona

1. Can you reflect on how you compare your impression of these patients?
2. (Why) are you more concerned for one patient than for the other?
3. Why do you choose one treatment plan for one patient and a different plan for another?
4. Are these personas very different situations for you? What makes them different? To what extent do you recognize this in your own work?

Appendix D2: Code table8

Table D2. Examples of quotes and initial interpretation per reasoning

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
Status preservation reasoning		R1, r2, r3, r4, r5, r8, r10, r11, r13, r15
	'With the second [high SES] man, his work is not going well, which is worrisome for a lawyer. And with the third man, his work is also not going well. But that is not the most important thing here. The difference between working and not working is not very significant for him in terms of income. So, in that respect, you can easily create some space and calm by keeping him on sick leave a little longer if necessary. Until the other issues are resolved. [The high SES man has risk of] social decline. Suppose he relapses [with his burnout], he will lose a lot. And then many small things can start to unravel. He might get into trouble with his partner, or at the very least, his self-esteem will take a huge hit.' (R4) → Respondent four argues that patient three does not have much to loose right now in terms of money. He is in a bad situation, but, according to him, this situation is stable bad. → Helping the second patient is more urgent to this respondent, because his situation is less stable and the risk of decline regarding various SES dimensions is big.	
	'Sometimes it's not entirely... It's not entirely logical, but it's about the part where he says: "What I find unfortunate is that I can no longer do fun things in the evening with friends, like play badminton or go to a party. I enjoy spending time with my friends." So, then I think: it's not okay that that's not possible.' (R1) → Respondent one argues that the social status of patient two should be preserved.	

8 Note that the quotes from the interviews have been translated from the original Dutch.

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
	'*But yes, that social circle… Look, if you say, 'He wants to quit that, 'then it's difficult to competely abandon your friends as well, because, in my opinion, that actually causes more stress and more problems. […] So you need to be able to maintain that social bond and then see whether he can, well, whether he can possibly leave cannabis use out of it. If that is at least part of what he's asking for help with, of course. Because, yes, I don't want to give him advice or force him into something he's not open to.*' (R2) → Respondent two argues that the first patient his social status should be preserved, because his friends and family are an important part of his life. If he looses that, that may cause even more stress and more loss regarding his overall health. The respondent thus sees the social dimension as more imporant than the fact that the patient smokes cannabis within this social circle.	
	'*But this man will be called back by today or tomorrow by the occupational health service, and he wants an answer now. […] Yes, but also [more pressure] on himself. There's less oversight. There are also actually […] more issues at play. I mean, it's very unfortunate if you can't go play badminton with your friends, but if your partner is threatening, or at least making statements like this, this it's a bit of a different caliber*' (R10). → Respondent 10 argues that patient three is in an unstable situation and that it seems that there is a lot to lose for this patient in terms of social status. The patient may lose their partner if problems are not solved soon.	

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
Social distance reasoning		R1, r3, r4, r5, r7, r10, r 11, r12, r13, r14, r15
	'This is really my natural habitat, so to speak. I come from a working-class background, you could say. And I think I can relate very well... Well, I don't even have to adapt myself to it. I fit into this setting and speat the same language as the people here. I think I understand them. I think I can grasp and recognize many of their problems. [...] I also notice that the people I see more frequently are the ones I can help better.' (R14) → Respondent fourteen argues that the patients who he can understand better are the patients who he can help better.	
	'I pictured a patient with a somewhat similar story. [My first impression is] ADHD. Or at least hyperactive. This is definitely someone who's always going at full speed. And the fact that he used joints to calm down fits with that. That he's doing well in construction- I can completely see that too, because you can really go full throttle there.' (R4) → Respondent four recognizes another patient's situation in the first patient. The respondent uses this recognition to reason around the patient.	
	'I automatically tend to get people from a lower social background, people with psychiatric issues, alcohol problems, financial issues- this is the group that naturally crystallizes around which GP they feel comfortable with, and I notice that I get a large part of that group. [...] I can really stand beside someone and help them further, and I definitely enjoy the medical aspect as well, but it's mainly the relationship, the long-term connection you have with someone, that makes the work so enjoyable and special (R7).' → Respondent seven argues that they make the social distance smaller by connecting with the patient, which ensures that they can help patients further.	

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
	'*I consciously have no expectations. I want to know more first. […] To be honest, probably because I know how many times I've dealt with healthcare providers who had a conclusion before I even entered the room* (R10).' → Respondent ten identifies with patients with bad experiences with prejudiced professionals. Therefore, the respondent tries to work with patients without any prior expectations.	
Together reasoning		R1, r2, r3, r4, r5, r7, r8, r9, r11, r12, r13, r14
	'But he's quite a smart guy, and I think he probably realizes that both your work and your mental state could contribute to these kind of complaints. So, I would really want to know, why did you make this appointment today?' (R1) → Respondent one interprets patient two as a smart guy who has a busy job. The respondent seems to think that this patient knows that his mental and physical state are connected.	
	'And then you look at what he needs to make this situation bearable. Because no one can sustain being a caregiver continuously without support. And also: what do you want, cleaning accident? So, we really need to look at how we can help this man. Apparently, there are also concerns about his income.' (R3) → Respondent three interprets patient tree (low SES) as someone who needs their help as he cannot help himself. The respondent uses the lower educated cleaning job as an argument.	
	'Yes, I'm not going to ask exactly how things work in his office […]. But he's an intelligent man, so that story should come up on its own, and I honestly expect that. He'll probably know himself why he has a burnout. So, the conversation about that will naturally come up.' (R4) → Respondent four interprets patient two (high SES) as someone who will know what is going on, because he is intelligent.	

Table D2. Examples of quotes and initial interpretation per reasoning *Continued*

Observed SES reasonings		
	Illustrative quotes from data	***Respondents per reasoning***
	'My experience with these kinds of patients is that you can make an appointment with the cardiologist, but they either don't show up or they don't understand what was said [...]. But then you can do a lot from the practice, but the best thing is if sometimes is first addressed in the social and societal aspect, like having a mentor or buddy, or someone who can guide them in those other areas.' (R8) → Respondent eight interprets patient three (low SES) as someone who his lower educated and may not understand his care and the care system. Therefore, he needs to be taken by the hand.	