How professional identity shapes youth healthcare

Ann Dadich
School of Business, University of Western Sydney, Parramatta, Australia, and
Carmen Jarrett, Fiona Robards and David Bennett
Youth Health and Wellbeing, NSW Kids and Families, Sydney, Australia

Abstract
Purpose – The primary care sector is experiencing considerable change. How change and uncertainty are accommodated by the professional identity of medicine has not been examined. The purpose of this paper is to address the youth healthcare as an exemplar as this field is often a source of uncertainty for general practitioners (GPs).
Design/methodology/approach – Using heterogeneity sampling, 22 GPs participated in focus groups to explore perceptions of youth healthcare, factors that help and hinder it, and training needs. Analysis of the research material was guided by a theoretical model on professional identity.
Findings – GPs described tensions that challenged their professional identity – the challenges of working with young people and their complex issues, the extent to which youth healthcare sits within the purview of general practice, and the scope of training required. These tensions appeared to destabilise professional identity. Some participants had customised their identity by enriching understandings of and approach to general practice. Participants also reported work customisation as a way of managing the complex demands of the general practice role. Deepened insight appeared to bolster perceived capacity to support a complex patient cohort.
Research limitations/implications – Participants are not representative of the primary care sector – furthermore, the methodology limits the generalisability of the findings.
Practical implications – To bolster youth health, mere clinician training is insufficient. Youth health requires explicit support from governments and training providers to be incorporated into the healthcare landscape.
Originality/value – This study extends current research on professional identity by examining youth healthcare within the changing context of primary care.
Keywords Primary care, Professions, Health services, Young people, Roles, General practitioners
Paper type Research paper

Introduction
The purpose of this study is to theorise and, as such, better understand the processes associated with professional identity reconstruction among general practitioners (GPs) during a period of healthcare reform (Pratt et al., 2006; Ashforth and Mael, 1989; Sluss and Ashforth, 2007). From a medical sociological perspective, and building of previous research (Currie et al., 2010), the study also presents a “contextualized analysis of professional dynamics and identities, considering the interaction of macro-level influences and micro-level practice” (p. 941), which surround the implementation of a broader, policy-driven remit for primary care clinicians (Department of Health and Ageing (DHA), 2010a; Standing Council On Health (SCH), 2013).

Given contemporary challenges, including the rising rates of non-communicable diseases, the rising costs of hospital care, and ageing populations, many governments have endeavoured to reform, and ultimately strengthen their nation’s primary care.

The authors wish to acknowledge and thank Peter Chown and Linda Ramsbottom for their respective contributions to this study. This research received no specific funding.
sector (Skinner et al., 2009; Willcox et al., 2011; Leggat et al., 2011; Gauld, 2011; Maarse and Paulus, 2011). They have vied for ways to improve the organisation, management, and delivery of healthcare (Geyman, 2003). For instance, Australia is currently witnessing “the single biggest healthcare reform in a quarter of a century” (Rudd and Roxon, 2007, p. 2), the essence of which is healthcare that is “funded nationally and run locally” (DHA, 2010d, p. 25). Towards this aim, the national government is working with state and territory governments to broaden the scope of the primary care sector (National Health and Hospitals Reform Commission (NHHRC), 2009). Despite the potential value of these reforms, their capacity to meet the complex needs of particular patient groups – like young people – remains to be seen. As recently indicated in the Lancet (Resnick et al., 2012, p. 1565), attending to youth health represents a sound investment. Yet there is a dearth of research on how clinicians might reconcile macro change with micro practices – this study helps to address this void.

This study is important for both theoretical and practical reasons. Theoretically, it is the first to apply a model of professional identity (Pratt et al., 2006) to examine youth healthcare during a time of considerable healthcare reform – as such, this study extends and contemporises understandings of identity reconstruction. Practically, although this study acknowledges the importance of GP-training in youth healthcare, this is likely to require strategies that initially help GPs to recognise youth healthcare as a sound investment.

Before presenting the research and the associated findings, this paper commences with a review of healthcare reform (as a macro context), youth healthcare (as a micro context), and professional identity, with particular reference to medicine, the theoretical model that informed the analysis of the research material, as well as the rationale for its use (Pratt et al., 2006). Following the presentation of empirical research, the paper concludes with a discussion of the associated theoretical and practical implications.

**Literature review**

**Healthcare reform**

Healthcare reform permeates many nations (Boselie, 2010; Warwick, 2007; Pettersen and Nyland, 2012). Adapted from industry (Woodward et al., 1999), healthcare reform is the platform for discussing ways to improve the effectiveness and efficiency of healthcare services. It focuses on “core or fundamental business processes, promoting deep radical redesign, predicting dramatic results, all with a process orientation” (Walston et al., 2001, p. 390). One sector experiencing such reform is primary care.

As the first-port-of-call for many patients, primary care services, including general practices, are considered the linchpin of the healthcare system (Kringos et al., 2010, Friedman, 2008). They can serve as the conduit to a myriad of secondary and tertiary healthcare services – as such, they hold a pivotal role. This is confirmed by the personal, organisational, and economic benefits associated with a strong primary care sector. At a personal level, this includes improved clinical outcomes (Macinko et al., 2007; Starfield et al., 2005). Organisational benefits include greater provision of effective care; reduced hospital-centrism, whereby “health systems [are] built around hospitals and specialists” (World Health Organization (WHO), 2008, p. 11); and reduced demand for specialist services (Baicker and Chandra, 2004; WHO, 2008). Related to these are economic benefits – more specifically, the reduced cost of care (Fleming et al., 2000). As Phillips and Bazemore (2010) concluded, “Decades of discussion, research, and implementation have taught us that investing in primary care results in healthier individuals and nations” (p. 809).
Recent social and technological trends have spurred increased interest in ways to improve the primary care sector. For instance, the prevalence of chronic and complex health issues (Gulley et al., 2011; World Health Organization (WHO), 2002), as well as greater opportunities for community-based (non-hospital) care (Kern et al., 2011; Abernethy et al., 2011) have incited policy makers and practitioners alike to reconsider ways to improve the effectiveness and efficiencies of primary care.

Within the primary care sector, reform has manifested in numerous ways. These include new contractual obligations (Peckham, 2007), different governance arrangements (Foley, 2011), the introduction of a regulated market (Gross et al., 2007), the establishment of organisations responsible for both service delivery and professional development (Gauld, 2011), the introduction of payment capitation and patient rostering (Hunter et al., 2004; Glazier et al., 2009), increased reliance on e-health systems (PricewaterhouseCoopers, 2001), and greater support for collaborative care models (Druss and Mauer, 2010). Of particular significance are the calls for primary care to alleviate the strain on public health services by supporting priority populations of patients – for instance, current reforms within Australia will see greater primary care to vulnerable populations, including people with mental health and/or substance use issues (Bywood et al., 2011). Similarly, a government sexual health strategy advises, “The size of some priority population groups is such that a strategic objective for specialist clinics and Area-based sexual health programs must be to work with general practice to reduce barriers to access” (NSW Health, 2006, p. 2).

Collectively, the aforesaid changes (among others) suggest an increasingly complex role for primary care clinicians. For instance, despite a mean patient-consultation time of approximately 15 minutes (Britt et al., 2012), Australian GPs are responsible for promoting and reinforcing prevention, early intervention, and connected care (NHHRC, 2009), all while establishing relationships with new organisations, like Medicare Locals, which oversee local health planning (Doggett, 2012; DHA, 2010c), familiarising themselves with regulatory changes that dictate the patient services that will (and will not) be subsidised by the government (Australian Practice Nurses Association (APNA), n.d.), and ensuring compliance with evidence-based practices (Thistlethwaite et al., 2012; Royal College of General Practitioners (RCGP), 2012).

The capacity of clinicians, like GPs, to fulfil this role is often stymied by an array of interrelated factors, many of which are acknowledged in extant literature. For instance, at the macro level are complex bureaucratic arrangements and accountability mechanisms (Gauld, 2011); at the meso level is limited workforce capacity (Blount and Miller, 2009; Del Mar, 2011; Kevat and Raman, 2013), perhaps partly due to the limited value placed on general practice (López-Roig et al., 2010); and at the micro level are increasing patient demand (Cunningham, 2011), changing patient expectations (Lord, 2003), diminished confidence in the physician-patient relationship (Aasland, 2001), as well as the increasing complexity of health issues – like those experienced by young people (Resnick et al., 2012).

Youth healthcare
Akin to other nations (Baltag and Mathieson, 2010; Healy et al., 2013), the Australian primary care sector represents the first-port-of-call for many young people, aged 12-24 years, seeking healthcare (NSW Health, 2010). Relative to other clinicians, Australian young people are likely to consult GPs for support and counsel (Booth et al., 2002), especially for sensitive matters, like mental health issues (Rickwood et al., 2007). In total, 70-90 per cent of young people access primary care at least once a year,
primarily for respiratory or dermatological concerns (see Tylee et al., 2007). GPs are therefore well-placed to promote youth health.

Despite young people’s seeming acceptance of GPs, the wellbeing of young people is far from ideal. Recent national data indicate that 60 per cent of Australians aged 12-24 years experience at least one chronic health condition, with growing rates of diabetes; 35 per cent are overweight or obese; and the prevalence of Chlamydia has risen almost fivefold since 1998, with almost two-thirds of Chlamydia infections occurring among young people (Australian Institute of Health And Welfare (AIHW), 2011). Furthermore, 26 per cent of Australians aged 16-24 years experience mental illness, including anxiety disorders, substance use disorders, and to a lesser extent, affective disorders. Given the prevalence and complexity of youth health issues, GPs are likely to confront conundrums that challenge, if not strain their existing knowledge and skill-base. This is especially because several factors are known to thwart GP-capacity to deliver optimal care including inadequate: time, flexibility, skills, and confidence in working with young people (Kang et al., 2003). For instance, although young people are willing to discuss issues that affect their health, such as nutrition, drugs and sexuality (Rutishauser et al., 2003), primary care practitioners do not always raise these issues (Degenhardt et al., 2005; Ozer et al., 2004). As such, young people do not necessarily receive the care required to address their health issues.

In addition to the personal and social costs associated with poor youth health are economic costs. Admittedly, these costs are difficult to calculate because many health and mental health issues can be precursors to much more disabling disorders in later life. However, if recent reports are indicative, it can safely be assumed that poor wellbeing among young people is likely to contribute to the rising cost of public healthcare (Laugesen and Glied, 2011). For instance, a report that focused solely on youth mental illness concluded that, accounting for lost productivity, welfare payments, forgone tax, service costs, carer costs, funeral costs, as well as lost wellbeing, the economic impact of youth mental illness is estimated to be over $AUS 30,000 per person per year (Access Economics, 2009).

The current Australian healthcare reforms may help to address, if not avert some of the personal, social, and economic costs associated with poor youth health. For instance, given the espoused role of GPs in prevention, early intervention, and connected care (NHHRC, 2009), young patients are likely recipients of such support. As a critical developmental stage, adolescence provides opportunity to reduce, if not avert serious health issues (Lerner and Galambos, 1998; Bennett and Kang, 2011). Furthermore, the current reforms draw GP-attention to priority areas, including mental illness, substance use issues, and sexually transmissible infections (NSW Health, 2006; Bywood et al., 2011), all of which are relatively prevalent among Australian young people (AIHW, 2011).

However, what is yet to be understood is how these macro, systemic changes are reconciled with the micro practices through which GPs deliver patient care. That is, how GPs negotiate this dynamic tension and reconstruct their professional identity.

Professional identity
Professional identity is the persona assumed by one who holds expertise or specialised knowledge. The professional identity within medicine is particularly robust (Shuval, 2000; Sullivan, 2000) – this is aptly demonstrated by the value placed on professional autonomy and efforts to retain it (Marjoribanks and Lewis, 2003; Kälble, 2005; Ten Have, 2000). Although well recognised in medical sociology (Gross et al., 2007;
Pratt et al., 2006), the role of professional identity is seldom considered in the context of systemic change. With few exceptions (Fitzgerald and Teal, 2003), there is limited empirical research on the role of this construct in the face of reconfigured processes—furthermore, general practice appears to be beyond the scope of studies published to date. This is a notable gap particularly because, “understanding different professional cultures is crucial for understanding each profession’s response to the reforms” (Degeling et al., 2003, p. 649). Given the increasing importance of general practice, and the changing nature of its scope, this paper helps to address this void.

To understand professional identity, it is important to first understand what constitutes a profession. Although there is no universal definition (Millerson, 1964; Freidson, 1994), the management of professional knowledge typically distinguishes a profession from other occupations. This implies three aspects—formal training, legal status, and self-governance. As Klass (1961) aptly explained, conceived and born within universities, professions are bestowed with monopolistic rights as well as self-governing privileges. Following from this, professional identity is an awareness of the role and functions that one performs or is expected to perform in a social context as a member of a particular profession (Sharma, 1998; Olesen, 2001). Although the relationship between an individual and their profession is grounded within a personal context, there are gendered, generational, and cultural relations interlaced with educational and employment structures. These personal and social structures give professional identity its general and specific meanings.

This understanding of professional identity suggests that it essentially concerns the self and the self in relation with others—be they individuals or organisations. This is indicated by Olesen (2001) who views professional identity as an ongoing concern of the professional involving work practices, social interactions with colleagues and clients, and sense of place within the professional institution and the professional discourse. Similar themes emerge from the large body of research by Alvesson (2000, 2001, 2010), Alvesson and Willmott (2002), Kärreman and Alvesson (2004). For instance, Kärreman and Alvesson (2001) describe identity as, “useful as a bridging concept between individual, group, professional and organizational levels” (p. 61). The construction of this bridge is said to involve the examination of: the central characteristics that define the individual and/or their organisation, the sense of coherence that emerges from different experiences, the degree of distinctiveness, as well as direction or orientation. Correspondingly, in their review of identity scholarship in organisation studies, Alvesson et al. (2008) refer to three broad theoretical perspectives—“how individuals locate themselves as social and organisational beings, how individuals endeavour to construct a sense of self, and how identity is accomplished through the operations of power” (p. 12). Professional identity is thus socially bestowed, socially sustained, and socially transformed (Gouldner, 1957; Goffman, 1959; Marshall, 1998). More simply, it involves a perception of self, a perception of others, and a perception from others.

Given such reinforcement, professional identity can be long-lasting (Illich, 1977; Rentmeester, 2008; McLaughlin, 2001; O’Flynn and Britten, 2006; Johnson, 2000; Freidson, 1988). Within healthcare (Pate et al., 2010), particularly medicine (Shuval, 2000; Sullivan, 2000), professional identity appears to be enduring (Marjoribanks and Lewis, 2003; Källbre, 2005; Ten Have, 2000) and dominant (Apker and Eggly, 2004; Tjora, 1999). For instance, in their conceptual examination of professional identity among nurses, Öhlén and Segesten (1998) concluded, “it will remain intact even if the existing role collapses” (p. 725). Similarly, in their study on professional power within
medicine, Currie et al. (2012) found “knowledge elites”, who hold a specialist role, perform institutional work to manage, if not supplant threats to their role. The apparent endurance of professional identity within medicine may be partly due to the elite identity it represents, which requires high academic ability, the confidence to provide expertise to other professionals, and involvement in ambiguous and intellectually demanding work (Alvesson and Robertson, 2006).

However, notwithstanding individual variation (Davidsen and Reventlow, 2011; Prosser and Walley, 2007), the seeming potency of professional identity within medicine may be changing, if not struggling (Sveningsson and Alvesson, 2003). Professional identity is now challenged by unprecedented change (Iedema et al., 2003; Fitzgerald and Dadich, 2006; Parry and Murphy, 2005). In addition to the previously noted healthcare reforms, this includes scientific and technological advancements; government pressure for home-based care; public pressure for greater transparency; changes in doctors’ work practices; and the emphasis on team-based care (Okie, 2012).

Related to these is the rise of evidence-based medicine (Greenhalgh and Wieringa, 2011) and the perceived threats to clinician autonomy (O’Halloran et al., 2010; Cohen et al., 2004).

Within general practice, the effect on professional identity is aptly demonstrated by “a crisis of status” (Del Mar et al., 2003, p. 26). The roles, responsibilities, and standing that GPs once held is “rapidly evolving” (Okie, 2012, p. 1849); in fact, it is argued that the GP of today will be obsolete by 2025 (McKinlay and Marceau, 2008). According to Del Mar and colleagues., this crisis is demonstrated in five ways. First, relative to other medical practitioners, GPs attract fewer earnings, even for comparable services. Second, they are typically positioned beyond the purview of a hospital-centric healthcare system, which, according to the WHO (2008), maintains its resilience largely due to “professional traditions and interests as well as the considerable economic weight of the health industry – technology and pharmaceuticals” (p. 11). Third, general practice attracts relatively fewer recruits. Fourth, intellectual activity and research outputs in general practice are limited. Finally, and perhaps most significantly, patient trust is dwindling – as Del Mar and colleagues surmise, “our patients are losing confidence in their GPs’ ability to know them as a whole person (e.g. their values and beliefs), to coordinate their care, and to provide it continuously”. These symptoms collectively suggest that GPs have become ‘an endangered species’ (Beaulieu et al., 2008, p. 1153). Although this can have significant implications for public health (Starfield, 1994; Starfield, 1992), a mismatch between ability and work-related tasks can induce stress (Lin and Hsieh, 2002). Thus, if GPs are to fulfil their unique and pivotal role as providers of comprehensive and continued care (Starfield et al., 2005), some intensive care may be warranted to minimise, if not avert work-related strain and diminished wellbeing.

Theoretical framework. To better understand the ways in which professional identity evolves, Pratt et al. (2006) offer a useful theoretical model, which has particular relevance to this study (given its inclusion of primary care clinicians). Following a six-year study involving medical residents in three specialties – primary care, surgery, and radiology – Pratt and colleagues found work-related tasks give rise to integrity assessments, whereby professionals seek to find balance between their work and their identity. This involves two interdependent learning cycles (see Figure 1).

During the first cycle (as illustrated by the white arrows), the individual familiarises with, and performs the tasks expected of them. Furthermore, they receive formal and/or
informal feedback to shape their performance, which in turn, forms and shapes their professional identity.

However, it is during the second cycle (as illustrated by the black arrows) that the individual learns about, and attunes their professional identity. According to Pratt et al. (2006), integrity violations between work-related tasks and identity generate a second cycle, in which identity is altered. These violations represent a perceived misalignment between “what physicians did and who they were” (p. 235); among primary care clinicians, this was exemplified by those who “saw themselves as ‘coordinators of care’ for patients” (p. 245). To manage these work-identity integrity violations, identity was customised accordingly. As the authors explain, “When who you are does not match what you do, another possible outcome is change in your sense of who you are” (p. 253).

Pratt et al. (2006) also identified the strategies used to construct professional identity in the face of these violations. They concluded that trainee doctors resolved the violations by customising their professional identity – that is, tailoring this identity to “fit the work at hand, and not vice versa” (p. 242). This was achieved via three strategies – enrichment, patching, and splinting. Identity enrichment occurs when work-identity integrity violations are relatively minor and as such do not require a considerable overhaul of professional identity – but rather, the individual develops a deeper and more nuanced understanding of their professional role. Patching suggests the work-identity integrity violations have given rise to holes in an existing or developing identity that need to be filled – from this, a composite identity may emerge. As the label might suggest, splinting involves protecting and supporting a fragile identity – this involves reverting to an earlier identity until the developing identity can stand on its own.

This theoretical model offers a useful lens through which to examine professional identity during a time of systemic change. This is for two key reasons – namely, its direct relevance to primary care, and its focus on the management of work-identity integrity violations. In reference to primary care clinicians, Pratt et al. (2006) did not
observe significant violations, largely because of the neophyte status of the trainees; as such, they concluded that primary care clinicians customise their professional identity chiefly through enrichment. However, the authors expected that more experienced practitioners would have greater autonomy, which would allow for greater work (rather than identity) customisation or “job crafting” (Wrzesniewski and Dutton, 2001). As such, this study considers whether and how experienced primary care clinicians use enrichment, patching, and/or splinting to manage work-identity integrity violations.

Building on, and contemporising the work of Pratt et al. (2006), this paper asks, how do GPs reconstruct their professional identity during a period of considerable healthcare reform? This is achieved by using youth healthcare as a microcosm to reveal the complexity of the GP-role as a lived experience (Frost et al., 2010). This follows the advice of Sveningsson and Alvesson (2003) who suggest that to understand identity in-depth, “we need to listen carefully to the stories of those we claim to understand and to study their interactions, the discourses and roles they are constituted by or resist – and to do so with sensitivity for context” (p. 1190). Youth healthcare represents an appropriate context for this study because the promotion of youth health requires: prevention, early intervention, and connected care (NHHRC, 2009); interagency collaboration (Kang et al., 2006); as well as familiarity with medico-legal issues and patient services that are government-subsidised, and as such, likely to be accessible to young people (Chown et al., 2008). GPs were thus consulted to understand the ways in which they engage with young people, negotiate sociocultural and historical processes, and customise their professional identity accordingly. This process was guided by, and therefore builds on a theoretical model of identity customisation, detail for which is provided later (Pratt et al., 2006).

Methods
To understand how GPs engage with young people and negotiate their professional identity with sociocultural and historical processes, this study employed interpretative phenomenological analysis (IPA) (Eatough and Smith, 2008; Smith et al., 2009). IPA facilitates a process of sensemaking, helping to reveal how individuals comprehend their personal and social world; this involves an examination of the meanings particular experiences hold for them (Smith and Osborn, 2008). Although the philosophical and theoretical origins of this method are beyond the scope of this paper (see Smith, 1996; Smith et al., 1997), suffice to say, IPA is phenomenological in that, “the experiences of the participant are described from their own perspective” (Dean et al., 2005, p. 627). This approach recognises individuals as active participants engaged in a dynamic interplay of subjective interpretation. As such, it recognises both the research participant and the researcher as jointly shaping the ways in which experiences are understood – and each brings their own conceptions, expectations, and assumptions to this exchange (Brocki and Wearden, 2006). As Larkin et al. (2006) explain, IPA helps to: map out participants’ experiences; contextualise and understand these experiences; reveal “a renewed insight into the ‘phenomenon at hand’” (p. 117).

Although IPA has its critics (see Parker, 2005), it was deemed appropriate for this study for three key reasons. First, it is particularly suitable when the focus of study is complexity, process, or novelty (Smith and Osborn, 2008), all of which reflect the nature of primary care for young people during a period of considerable healthcare reform. Second, it is especially appropriate to research in health psychology, which recognises
wellbeing, and the processes that promote it, as socially constructed (Brocki and Wearden, 2006). Third, IPA is a relatively accessible approach, largely due to the “comprehensible language and straightforward guidelines” (Brocki and Wearden, 2006, p. 101) used to describe it. For instance, Smith et al. (1999) describe a “basic method” to explore shared themes from a small number of participants – however, sample size is largely determined by conceptual and practical considerations (Smith and Osborn, 2008). Collectively, these three reasons suggest IPA, particularly the basic method (detail for which is provided later in this section), was appropriate for this study. (see Smith et al., 1999, for advice on an alternative approach to IPA).

To examine GPs’ “lived experience and how individuals are making sense of that experience” (Frost et al., 2010, p. 445), four focus groups were facilitated with GPs practicing in the Australian state of New South Wales (NSW) at time of study (February to March, 2009). In addition to their coherence with the chosen method of IPA (Palmer et al., 2010), focus groups were deemed appropriate because of limited GP-availability and GP-preference for networking opportunities (NSW Centre for the Advancement of Adolescent Health (CAAH), 2008). To ensure the representation of diverse experiences and views, heterogeneity sampling (Trochim and Donnelly, 2006) was used to recruit participants from four divisions of general practice. These are professional bodies that support GP-members through the provision of training, resources, and opportunities to collaborate with other health professionals (General Practice NSW, n.d.). More specifically:

Divisions […] provide services and support to general practice at the local level […] to achieve health outcomes for the community that would not otherwise be achieved on an individual GP basis. All Divisions provide core programs to address:

• access;
• prevention and early intervention;
• supporting integration and multidisciplinary care; and
• an increased focus on population health and the better management of chronic disease (DHA, 2010b, para. 1-2).

The divisions were purposefully selected to include an urban division known to actively support and promote youth health programmes; a rural division known to actively support and promote youth health programmes; an urban division known to provide limited support to youth health programmes; and a rural division known to provide limited support to youth health programmes. Information pertaining to division activity in youth health programmes was garnered from division reports (Hordacre et al., 2007) and previous research (NSW CAAH, 2008).

The four divisions invited GP-members to participate in the study via e-mail and post. Interested members were asked to contact the researchers for further information. As a quality improvement project, the project was endorsed by the local Service Improvement Unit and clearance from an ethics committee was not required.

In all, 22 experienced GPs (that is, not registrars) participated in four groups, each of which was facilitated by one or two researchers. To optimise the group dynamic (Krueger and Casey, 2008; Liamputtong, 2011), each group involved four to eight GPs (two groups involved five GPs). Although demographic information or professional experience were not surveyed, each focus group included male and female participants,
all of whom had practiced as a GP for several years and identified as active division members with varying levels of interest in youth health – some participants were relatively knowledgeable and skilled in this field, while others were less confident. Participants were recompensed for their participation.

Discussion with several NSW GPs prior to the focus groups suggested that the concept of professional identity was unlikely to be part of GP vernacular – this reflects the research of Pratt et al. (2006), where the participants did not appear to explicitly speak of their professional identity (or indeed, their identity). For this reason, and guided by Pratt and colleagues, the focus groups concentrated on GP-work and perceptions of this work. More specifically, four key themes were explored; namely: the ways in which GPs engage with young people, perceptions of youth healthcare, the factors that help and hinder effective service provision to young patients, findings of which are reported elsewhere (withheld for blind review), as well as additional training required to bolster knowledge and skill-base. With participant consent, focus group discussions were recorded via an audio-recorder and notes. Collecting research material using two techniques helped to maximise accuracy in the research findings. The focus groups lasted approximately 90 minutes each.

To explicate the concept of professional identity, analysis of the research material was informed by the theoretical model of identity customisation (Pratt et al., 2006). As discussed, the model recognises enrichment, patching, and splinting as strategies to resolve work-identity integrity violations. These themes were considered during a thematic analysis of the research material. More specifically, and in accordance with the basic approach to IPA (Fade, 2004), two members of the research team independently reviewed the transcriptions of the audio-recordings several times. They developed notes on key observations. They engaged with the research material to identify themes through a process of abstraction – these included categories that were similar to the work of Pratt et al. (2006) – notably, enrichment, patching, and splinting, as well as categories that differed from these themes. Consistent with IPA (Smith and Osborn, 2008; Smith et al., 2009; Pringle et al., 2011), the themes were firmly anchored in GP-accounts of their lived experience through the use of quotes and metaphors in theme descriptions. The researchers extracted, listed, compared, contrasted, and synthesised their constructed themes, ensuring demonstrations of both convergence and divergence. They asked questions about the themes to reveal connections and clustered the themes accordingly to form sub-themes and super-ordinate themes. And they developed a narrative of the participants’ experiences and the meaning ascribed to these experiences. This description is not to suggest a linear approach – but rather, this iterative process is described as such for clarity.

Results

Work-identity integrity violations

The findings suggest that the provision of youth healthcare unveils discrepancies or violations between the espoused role of the GP and what occurs within the confines of a clinic. Despite being responsible for prevention, early intervention, and connected care, the participants appeared to struggle when supporting young patients and these struggles revealed the intricate dynamics of their professional identity. Furthermore, the struggles destabilised the seemingly robust nature of the medical professional identity. At times, this was a source of tension and stress.

Discrepancies between the espoused and bona fide roles of the GP were demonstrated in five key ways. These include: youth reluctance to engage with GPs,
GP-reluctance to engage with youth issues, the time-press of general practice, current billing arrangements, and the limited service networks to draw on. Each is addressed in turn.

First, according to the participants, working with young patients can be challenging and difficult. They can be hard or unwilling to engage, as well as ‘hard to read’. Youth concerns about confidentiality breaches, particularly when the GP has contact with family members, can stymie efforts to establish and/or maintain a good working relationship:

That’s the area which is difficult actually – engaging ones who actually come in but they’ve already actually decided what your role is going to be before they come in and they may or may not feel confident that you are going to be the one they want to discuss these things that will go back to their parents or actually in some way disadvantage them.

It’s trying to tease out of younger people exactly what the problem is. You’ll get monosyllabic one-word answers to all of your questions and even though you try to make them open so that it does require more than a yes, no [...] type of answer, it’s still very difficult to get the information out.

Young patients may have serious health issues that they do not initially reveal. This heightens the importance of GP-empathy. Patient disclosure of these issues may depend on GP-ability to reassure a young patient that they are indeed trustworthy:

The main thing is you’ve got to be very careful that you’re non-judgemental because the adolescents are really setting you up to make a decision before they actually come with the other things.

Second (and conversely), some participants were averse to the issues young patients presented with, finding them disconcerting. Alcohol and/or drug use, sexual health, and mental health were difficult terrain for some, clouding their interest in youth healthcare:

I think dealing with adolescents is fairly intimidating for most doctors who haven’t had experience because we tend to grow up in very conservative families and sometimes we have to deal with kids that are right out there and have a lot of problems and it’s initially quite terrifying.

Third, the primary care context also stymied youth healthcare. The time-press under which GPs work coloured the way they related to young patients:

I think you have to face the fact that because a lot of GPs are so busy, they don’t want to open that can of worms, so they don’t actually want to be training in youth health because they’ve got enough on their plate and they just do general practice.

You think, “I want to get out of here on time”; “I wouldn’t mind having lunch”. How many of us here work full-time? I don’t; there’s no way I could. But if you’re working full-time, forget it.

Fourth (and related to the time-press), is the fee-for-service system. The bulk-billed, 15-minute consultation evident within Australian primary care (Britt et al., 2010) hindered participant ability to unpack the complexity that young patients often presented with:

As GPs working in like, “Oh my God, who’s next?” [...] We feel we need to work [...] with only the problem the patient comes in with, whether they’re adolescent or not.
Some participants questioned their capacity to fill their professional role when supporting young patients. One noted that they did not routinely conduct psychosocial screening with young patients, even though they know they “should”:

We know HEADSS [the psychosocial screening tool for youth (Goldenring and Rosen, 1988)] and we know we should, should, should. We know that about 300 different things […] You just don’t do it because we go, “I don’t want to open that can of worms; I’m going to let that one go”.

Fifth, exacerbating these issues was the limited availability of ancillary services. Working with young patients exposed shortcomings in the network of services. The participants were not always able to source expert clinical advice or refer young patients to appropriate services. Drug and alcohol services or mental health services were sometimes difficult to access, if not non-existent. Unable to serve as a broker to other services, the participants were often left in a quandary:

One of the things that we do as GPs, is we recognise as early as possible what we need to do for this person when they come in, and if it involved referral, we’re already thinking about making the referral and we need to know how to refer. It’s easy enough with cardiology, but with adolescents, where do you go?

Participants readily described the challenges they experienced when working with young people and the complex issues they presented with, and many of these challenges were exacerbated by the context of primary care. At times, participants struggled to engage with young patients – as one participant noted, “adolescence is difficult; some kids are difficult”. When compounded by the time-press of general practice, current billing arrangements, and the limited service networks to draw on, some doubted their capacity to effectively support young patients. They described having little to offer this patient group and could not always foresee the difference they could potentially make to these young lives. These doubts revealed discrepancies between the espoused role of the GP and the reality of youth healthcare. Some participants found their role as a GP (sensu lato) difficult to fill when attending to the needs of young people, as youth healthcare represented a thorny element of primary care. This in turn incited a reluctance to engage with young patients. Because their services were typically in high-demand, the participants were disinclined to add to their workload. They doubted their ability to engage with young patients and make a difference, and as such, avoided youth healthcare, or described peers who did this.

Despite these challenges, participants spoke of strategies that enabled them to work with young patients, effectively and/or efficiently. Reflecting the work of Pratt et al. (2006), they appeared to customise their professional identity through a strategy of enrichment. That is, they developed a deepened understanding of the primary care practitioner role, appreciating both its breadth and depth; this is explicated and demonstrated in the following section. However, there was no suggestion that the participants splinted or patched their identity to manage the perceived discrepancies between their role as a GP and the reality of youth healthcare. In addition to enriching their professional identity, and extending previous work with primary care clinicians, participants also customised their work – this suggests attempts to defend against change and retain their professional identity. Both identity and work customisation strategies are examined.
Identity customisation

Some participants questioned their ability to manage the complex issues that young patients present with:

Trying to find out how to do those sorts of things and encourage adolescents to keep their health going is not something that I feel very successful at as a GP.

Despite these perceived challenges, participants asserted their capacity to practice as time-poor GPs. Given their extended professional experience, they described lessons they had garnered throughout their career – while the role of professional development was recognised, so too was clinical experience and credible peers:

At the end of the day, it’s the hands on experience that makes all the difference.

It packs a lot of punch [...] when somebody who I have some respect for as a peer says, “I use this”.

Participants also asserted the valued role of the GP for young patients. They pointed to the breadth of their knowledge and their extensive skill base, which reminded them, “wow, I actually do have something to offer here”. This suggests that participants perceived themselves to be well equipped for their role, even when it was challenging:

I think a lot of people have more skill than they know and if there was just a way to very quickly and succinctly give people that confidence and just somehow create this moment of enlightenment that, “I can actually do something here and I might be able to hold this situation until help comes”.

The doctor has to be very, very flexible in working out when to strike and when not to strike, what to take on today, what to leave for tomorrow. You’ve got to look at it and observe.

These reflections of the GP as a credible expert with much to offer – particularly to young patients – suggest a deep, nuanced understanding of the professional role; that is, enrichment (Pratt et al., 2006). Confronted by the challenges associated with youth healthcare, the participants appeared to experience misalignment between their work and their identity. This disconnect was managed by extending and reinforcing their understanding of the GP-role. As a strategy to customise the GP-identity, self-affirmations served to remind the participants of the knowledge and skill-base they had accumulated; these affirmations also deepened their appreciation for the expertise they brought to patient consultations, particularly when supporting young people. Although not observed by Pratt et al. (2006) in junior primary care clinicians, for the more mature cohort in this study, another strategy in response to work-identity integrity violation – namely, work customisation, was also evident.

Work customisation

According to Pratt et al. (2006), work customisation is an alternative strategy to resolve work-identity integrity violations for professionals who have completed their training. According to the participants of this study, work customisation strategies were used to survive the competing demands of general practice. For instance, in the face of high-demand for their services, some of the participants purposefully selected their patients. This was exemplified by the ad hoc referrals of patients deemed to be difficult, as well as purposeful plans to specialise with particular patients. These strategies enabled the participants to alter their patient-load and customise the type of work they
engaged in. The trend of GP-specialities was raised, unprompted, in all four of the groups. One participant described the dynamic that leads to a specialist interest as follows:

It’s an attrition thing, right? The ones who are still providing comprehensive care, the numbers are decreasing and a lot of burnout, a lot of people will actually suddenly hit the wall and say “Okay, I’m going to work, I need to earn an income” so they will actually get into a sub-speciality or decide to cut out the hard bits because as you know the government doesn’t reward those consultations or they don’t have to put out because they’re already very busy so they’ll take the straightforward conditions.

There was some debate about the extent to which the tendency to specialise, or to eliminate difficult work – like youth healthcare, was understandable or to be resisted. On one hand, the right for GPs to choose and follow particular interests was proposed:

People have different interests and you’ve got to realise that not everybody’s interested in dealing with adolescents, so I guess we all need to have a baseline because you can’t control who walks through your door; but obviously some people have more of an interest.

On the other hand, selecting patients can also be seen as counter to the notion of general practice serving whole communities:

I’m mildly resentful of people who begin to sub-specialise without providing a total service […] It puts me offside and I must say I begin to reject that sort of medicine.

This debate demonstrates tension between the professional’s perquisite of autonomy and the espoused role of GPs in all aspects of health. Although GPs may experience considerable pressure in their work, they also retain the right to discretion in how they manage, customise, and conduct their work:

Patients are self-selected already to some extent; it’s part of general practice; and yes we self-select the patients, but there aren’t that many general practices that are not going to get a share of adolescents.

In sum, in the face of work-identity integrity violations, the participants in this study managed these experiences by enriching their professional identity and/or tailoring their work practices. This highlights two points of difference from previous research (Pratt et al., 2006). Although these participants did not speak of splinting or patching their professional identity, they did have opportunity to alter what they did and how they did it. The theoretical and practical implications associated with these findings are discussed in the following section.

Discussion
Primary care is experiencing considerable reform with a commensurate increase in role complexity (Goetz Goldberg, 2012). Among the diverse challenges that GPs face in their working lives are issues related to professional identity – an important dimension of successful medical practice seldom considered in the context of systemic change. For reasons identified in this paper (namely, young people constitute a priority population with significant and increasing health problems; GP-services are frequently sought by young people; GPs have a pivotal role in prevention, early intervention, and connected care; and research into youth health represents sound investment), youth healthcare is an appropriate context in which to examine professional identity.

Professional identity is shaped by perceptions of self, perceptions of others, as well as others’ perceptions of the professional (Sharma, 1998; Olesen, 2001). As a relational
concept (Kärreman and Alvesson, 2001), it represents a connection between the
individual, group(s), profession(s), and organisation(s). As such, professional identity is
socially constructed and socially sustained.

According to Alvesson et al. (2008), identity research is important for three key
reasons. It can help to understand individual and organisational experiences; it can
reveal issues associated with cultural and political irrationalities; and, given the
relationship between identity and behaviour, it can help to identify solutions to
organisational issues, whereby situations might be purposefully engineered to
produce preferred behaviours (typically those deemed to be effective and/or efficient).
As one modest step towards improved primary care, particularly for young people,
this study examined how experienced GPs reconstruct their professional identity
during a period of considerable healthcare reform. This follows the suggestion
that identity (re-)constructions evolve in response to change – whether such
change is small or considerable (Ibarra, 1999; Thomas and Linstead, 2002;
Lutgen-Sandvik, 2008).

This study is the first to examine youth healthcare using a theoretical model of
professional identity. Following the research of Pratt et al. (2006), which identified three
key strategies to manage work-identity integrity violations, the study considered how
GPs reconstruct their professional identity during a period of considerable healthcare
reform. This involved an examination of GP-perceptions of their work, their
relationship to this work, and how they managed instances of disconnectedness
between their work and their identity.

The study demonstrates that, during a period of reform, the GPs in this study
used both identity customisation strategies – particularly enrichment, as well as work
customisation strategies, like patient referral and specialisation, to manage
work-identity integrity violations. They described youth healthcare as a source of
uncertainty, with the challenges and tensions related to working with young people
and their complex issues destabilising their professional identity. Beyond the more
generalised “crisis of status” (Del Mar et al., 2003, p. 26) among GPs, youth healthcare,
like a canary in the coalmine, can identify shortcomings in the health system. This was
demonstrated, for example, in terms of time pressures, inadequate remuneration for
extended consultations, and limited service networks. Given these challenges, the use
of work customisation strategies by GPs – like the purposeful selection of (relatively
less difficult) patients and specialisation – may reduce youth access to timely and
appropriate care.

In contrast to the trainees involved in previous research (Pratt et al., 2006), the
practitioners in this study were well-established in their roles. It was therefore possible
to observe the identity and work customisation practices of mature GPs in relation to
youth healthcare. Pratt and colleagues discovered that “identity construction was
triggered by work-identity integrity violations: an experienced mismatch between what
physicians did and who they were” (p. 235). Similarly, this study found that identity
management was activated by disparities between what the GPs perceived as their role
and skill-base, and what they were presented with in the clinical setting. Furthermore,
this study revealed gaps between what is said and what is done; it also identified
strategies to resolve these dilemmas.

The practitioners’ measures to customise their identities were reflected in evidence
of the development of a deeper, enriched, and more nuanced understanding of their role.
This also involved learning who they are as a primary care practitioner, juggling
the ideals of the primary care role with the actuality of the pressures and compromises
of busy general practice, especially when attempting to address the needs of young people.

Building on previous research (Pratt et al., 2006), findings from this study also revealed work customisation strategies to manage violations to work-identity integrity. This included purposeful selection of the type of healthcare offered (e.g. specialisation) and the type(s) of patients who were supported (e.g. to eliminate difficult work). These strategies suggest tension between professional autonomy and the expansive remit of the GP-role. This tension over the trend for GPs to specialise is not fully captured in the framework developed by Pratt et al. (2006); these authors suggest that work-identity integrity violations are managed by customising work and/or customising identity. This study points to the ongoing negotiation between the ideal of general practice and the right to professional autonomy as evidence of the competing influences on GPs.

In the busy world of general practice, GPs are required to balance competing demands while maintaining a coherent and workable professional identity. Tensions within the ideals of the primary care role are particularly evident when they consult young patients. For the experienced participants of this study, both identity and work customisations were available to them; they were able to adapt their work, not just their ideas about their professional role.

As part of a larger research programme on youth healthcare, the purpose of this study was not to build theory as such. Nevertheless, it is possible to posit the implications for promoting youth access to primary care. Given that GPs have the professional autonomy to choose their work, those who struggle to maintain their professional role may be reluctant or unable to assume more difficult work, like youth healthcare, unless they are better supported to do so. Offering GP-training in core youth healthcare may provide the skills and encouragement to work with young patients; however, this may not be sufficient to ensure that GPs routinely offer youth-friendly services (Ambresin et al., 2013). As one participant stated, “I think that I’d just say from the heart […] let’s not overwhelm us because there are competing needs and this is a big one and there are others, so you just have to be careful”.

With some GPs customising their work to reduce “difficult” elements, there is the ongoing risk that young people will not receive optimal primary care at their hands. At a practical level, the answer in part lies in the potential for training to increase GP-skill and confidence, which in turn may strengthen a professional identity that more comfortably embraces youth healthcare. Given that professional identity is linked to such factors as self-efficacy and work satisfaction (Roberts et al., 2012; Fox, 2013; Cowin et al., 2008; Bernstein, 2000), this also has potential implications for practitioner wellbeing. However, at a theoretical level, future research is required to determine these relationships and further develop the theoretical model – more specifically, what supports are required to bolster (and sustain) GPs’ professional identity, particularly in the context of youth healthcare; how does their professional identity influence their wellbeing; and (perhaps most importantly) how does their professional identity influence the wellbeing of young people?

Promoting youth healthcare as a moral obligation for GPs is both difficult to implement and unlikely to succeed. More effective drivers for change include both GP-preferred (bottom-up) and policy-initiated (top-down) approaches. In the first instance, changes that are mindful of GP-perspectives and that enhance professional identity are more likely to be successful. For example, to encourage GP-consultations with young people, the participants in this study highlighted a need for supportive
networks (especially in areas of mental health and substance use issues), longer consultation times, and better remuneration. If youth healthcare is deemed relatively less difficult, GPs might be less inclined to customise their work to avoid working with young people.

With few exceptions (Jarrett et al., 2011), GP-training typically affords little attention to youth healthcare. Funding for the development and delivery of such training remains problematic; however, unless and until it is considered a key priority by both governments and training providers, GPs are unlikely to perceive it as an essential or even desirable part of their professional identity. In other words, despite the well-documented need for GPs to become proficient in youth health, the simple delivery of training in this area does little to encourage the completion of this training. The mere development of clinical skills does little in the absence of systemic change to promote youth health. Opportunities for such change may include contractual arrangements, which do not diminish perceived control or autonomy among GPs (McDonald et al., 2008); greater emphasis on team-based care; as well as educational reform (Okie, 2012).

Despite the value of the findings presented in this paper, three key methodological limitations deserve mention. First, the recruitment method and the resulting small number of participants reduce the generalisability of the results. Although the small participant number aligns with the chosen method, caution is warranted when attempting to extend the lessons further afield (Smith and Osborn, 2008). Second, because participants were self-selected, there is no claim they constitute a representative sample of primary care clinicians. Third, the use of IPA may limit our understanding of how GPs reconstruct their professional identity during healthcare reform – this is largely because the method reflects a dynamic interplay between the participant and researcher. The interpretive approach used to analyse the research material indicates that the findings reflect the interaction between the researchers and the participants. They also reflect the authors’ interpretation of these interactions. As such, the lifespan of the identified findings may be limited. This provides a platform for further research that employs different approaches, like for instance, longitudinal research.

The modest design of this study has revealed noteworthy implications. More specifically, if GPs consider youth health to be an important aspect of their professional identity, they may be more inclined to complete training in this area, thereby increasing their skill base and confidence, and strengthening their professional identity. As a consequence, they will be better placed to provide evidence-based care and, most importantly, provide young people with the care they want, need, and deserve.

References
Access Economics (2009), The Economic Impact of Youth Mental Illness and the Cost Effectiveness of Early Intervention, Access Economics, Melbourne.
Australian Institute of Health And Welfare (AIHW) (2011), Young Australians: Their Health and Wellbeing, Australian Institute of Health and Welfare (AIHW), Canberra.


Chown, P., Kang, M., Sanci, L., Newnham, V. and Bennett, D.L. (2008), Adolescent health: Enhancing the Skills of General Practitioners in Caring for Young People from Culturally Diverse Backgrounds, GP Resource Kit, NSW CAAH (Centre for the Advancement of Adolescent Health) and TMHC (Transcultural Mental Health Centre), Sydney.


NSW Centre for the Advancement of Adolescent Health (CAAH) (2008), Gp Strategy: Advancing Adolescent Health Through General Practice, NSW Centre for the Advancement of Adolescent Health (CAAH), Westmead.


About the authors
Dr Ann Dadich is a Senior Lecturer at the University of Western Sydney. She is also a Registered Psychologist and a Member of the Australian Psychological Society. Her scholarly passion lies in health service management research, with particular focus on knowledge translation. This is demonstrated by her publishing record, which includes over 100 refereed journal articles, book chapters, and conference proceedings. Further confirmation of the quality of her research is found in the awards she has received to date. Dr Ann Dadich is the corresponding author and can be contacted at: A.Dadich@uws.edu.au

Dr Carmen Jarrett is a Analyst – Research for NSW Kids and Families, where she has researched youth health services, including the training needs of GPs and the impact of training in youth health on GPs.

Dr Fiona Robards is a Senior Analyst for NSW Kids and Families, where she leads policy development and implementation, and capacity building for youth health services.

Professor David Bennett is a Senior Clinical Advisor for NSW Kids and Families. David is an Adolescent Health Physician with a major interest in the development of accessible and responsive health services for young people and their families.

For instructions on how to order reprints of this article, please visit our website:
www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com