The professional identity of leaders in a group practice: A qualitative Study

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Abstract

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Context: Gedurende de laatste decennia worden de uitdagingen voor de gezondheidszorg steeds groter met name de vergrijzing, de toenemende comorbiditeiten en meer pandemieën (HIV, Covid-19). Hiervoor is het belangrijk dat er een goede gezondheidszorg is met een sterke eerste lijn, die goed en efficiënt werkt. Spijtig genoeg zijn er ook verschillende tekortkomingen in de gezondheidszorg zoals de disease-centred zorg, de fragmentatie in de zorg en een inefficiënt kostenverloop. Om beter met de uitdagingen om te gaan en de tekortkomingen aan te pakken is het belangrijk dat de gezondheidsmedewerkers, zoals bv. de huisartsen, beter communiceren, beter samenwerken en goed hun strategie plannen. Hiervoor is het noodzakelijk dat huisartsen over voldoende leiderschapcompetenties beschikken en zich ook als een leider voelen m.a.w. dat de leiderschapsidentiteit deel wordt van hun professionele identiteit.

Onderzoeksvraag: Het doel van deze studie is het proces te onderzoeken van hoe men van louter huisarts naar leider van een groepspraktijk is gegroeid, hoe zijzelf een leider zien en wat hun geholpen heeft of juist in de weg zat.

Methode: Bij 15 huisartsen die eerst als huisarts in een solo- of duopraktijk werkten en nu als leider aanzien worden van een groepspraktijk werd een semi-gestructureerd interview afgenomen. Deze interviews werden dan thematisch geanalyseerd en gecodeerd met het programma “Nvivo”.

Resultaten: Er kwamen 7 thema’s uit de analyse. De eerste vier thema’s beschrijven de evolutie die de artsen hebben doorgemaakt: Het transitiemoment, de leiderschapsstijl, de leiderschapscompetenties en hoe ze zelf keken naar de evolutie. Het transitiemoment is het moment waarop ze zich niet langer een huisarts voelde, maar ook leider van een huisartsenpraktijk. Hierbij was het voornamelijk het verlies van het individueel zorgen voor de patiënt en het organiseren van vergaderingen momenten die de huisartsen aangaven. Als leiderschapsstijl hadden ze allemaal de shared leadershipstijl. De leiderschapscompetenties waren voornamelijk goed communiceren, flexibel zijn en 100% transparant en eerlijk zijn. De meeste huisartsen zagen de evolutie als een goede zaak, maar vonden dat de essentie van hun job het medisch handelen was. De drie laatste thema’s beschrijven hetgeen wat hun hielp of had kunnen helpen. Hierbij benoemen ze voornamelijk mentors, leren

door gebeurtenissen en een (gebrek aan een) opleiding voor leiderschapskwaliteiten te ontwikkelen.

Conclusie: De sterke professionele identiteit, waarbij autonomie en hiërarchie voorop staat en het gebrek aan opleiding in leiderschap zorgt ervoor dat de transitie van huisarts naar leider van een groepspraktijk niet altijd makkelijk verloopt. Om deze transitie beter te laten verlopen is het belangrijk dat de medisch expert de centrale rol is in de identiteit van een leider en dat men zo vroeg als mogelijk in de opleiding begint met leiderschap te integreren. Dit kan men doen door mentors aan te stellen, laten leren door gebeurtenissen en een opleiding in leiderschapscompetenties in het curriculum van geneeskunde te zetten.

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Introduction

During the last decades the challenges faced by health organisations have increased substantially. More specifically, the ageing population, associated with complex comorbidities and frailty, in combination with a higher incidence of pandemics (e.g. COVID-19) have demonstrated their adverse impact on contemporary healthcare systems (1). To address these challenges, health systems should invest in a strong primary care in order to improve their efficiency and populations' health outcomes, and reduce health inequalities(2).

Nonetheless, most health systems are characterized with several shortcomings such as fragmentation of care, disease-centred care, and inefficient cost spending, which has complicated the shift towards primary care (3-6). To tackle these shortcomings and subsequently address current and upcoming challenges, health care professionals, such as general practitioners, should be able to identify the necessary modifications in practice, communicate more actively and collaborate more efficiently, (7). Collaboration between professionals is necessary, as perspectives from different health care professionals are needed to treat patients in a more holistic way considering their multimorbidity (4, 8). In addition, health care professionals should develop high quality leadership competences to enhance resilience, effective communication and interprofessional collaboration (9).

Within primary care, it is of paramount importance that physicians possess leadership competences. Several studies indicate that clinical leadership reduces conflicts and improves job satisfaction, collaboration, patient outcomes and high-quality patient care (5, 6, 10-12). However, physicians in general tend to have poor leadership skills due to lack of training (13). For instance, 10% of the graduates feel inadequately prepared for practice, with the main areas of concern being leadership competencies such as self-awareness, self-management, effective communication, team development and strategic thinking (9, 14). This issue is being recognized by policy makers such as Accreditation council for graduate medical education, WHO regional office for Europe as they are investing in the training and assessment of leadership competencies (12, 15). Integration of leadership competencies in health professionals' curriculum can be based on contemporary initiatives such as the CanMEDS framework. although the widespread implementation of such curricula is currently lacking (12). Following the CanMEDS framework a competent physician integrates the competencies of seven roles, where the leadership role is defined as the ability to engage with others to contribute to a vision of high-quality health care and take responsibility for the delivery of excellent patient care (16).

Notwithstanding the importance of integrating leadership competencies in medical curricula, attention should also be devoted to possible identity challenges as becoming a leader also entails developing an identity in which physicians think, act,

and feel like leaders. Several studies recommend that professional identity formation of physicians should be part of medical education. Hence, curricula should focus on developing competencies as well as fostering the development of a professional identity (17). Accordingly, research should not only concern the leader competencies, but also go deeper and focus on the clinical leader identity (18). Nonetheless recent studies show that the transition in identity, from physician to clinical leader, seems less straightforward (19). Physicians may see managerialism, control and administration as threat to their professional identity in which the core task is treating the patient or the incongruity between the traditional medical values like autonomy and hierarchy and those that physicians must adopt as leaders whom are able to collaborate and to give better quality and efficiency of care (20-22).

In order to overcome these difficulties and to be able to give an identity-oriented education of leadership to have an impact on the development of prospective general practitioners, there is a need in understanding how medical leader identities are constructed (23). Yet, the literature base on how particular leadership identity is formed during education and practise remains scant (18). Therefore, the aim of this study is to investigate the underlying processes of forming a clinical leader identity throughout the perception of general practitioners and to investigate how they define a clinical leader and the facilitators and obstacles to become one.

Methods

Study Design

A qualitative research design was chosen where data were collected via semi-structured interviews. The participants were well informed about the project before participating in the study and a written copy of the informed consent was obtained. The design of the study has been reviewed by the ethics committee and a positive advice was given for this protocol B.U.N.: B6702020000376 on 02/07/2020 (see appendix A).

Setting and participants

The target population for this study were general practitioners from Flanders (Belgium). To be included, the GPs had to work in a private group practice that consists of at least three general practitioners. They had to be the first or second doctor who started working in the private group practice, as the GPs in the practices indicated the first or second doctor as the clinical leader of the practice. An online research was conducted to find the general practitioners. The participants were telephoned and orally informed about the objectives of the study before the interviews were done. The GPs were recruited until saturation was achieved. The saturation was achieved after twelve interviews and the following three interviews confirmed the saturation (24).

Data collection and analysis

An interview guide was developed and validated by a general practitioner and a researcher in the domain of identity (investigator triangulation) to obtain valuable information from the participants while giving them the time and space to express their ideas, feelings, and frustrations. Also, data source triangulation was obtained by recruiting a mixed purposive sample, differencing in age, gender, and location (rural or urban) (25). The interview guide was made of open-ended questions and follow-up questions relevant to the research question and to gain insight in the context/characteristics of our participants. The theoretical framework of Kallio et al 2016 was used to develop the interview guide (26). After the first seven interviews the interview guide was reviewed by all three researchers and slightly altered in the light of the research question. The interviews lasted just until the participants felt like there was nothing more to add and lasted between 35- 80 minutes. No follow-up interviews were carried out. Videorecording via MS Teams was used to collect the data. Data were stored on a secure institutional server. Data collection ensued until theoretical saturation following albin moser et al 2018 was achieved (24). Interviews were transcribed verbatim.

The data collection and analysis has been done in an iterative way. In a first phase the transcripts were thoroughly read. In a second phase codes and labels were applied. Those two phases of thematical analysis were repeated and led to the eventual results. The data was coded by the first author. The themes were derived from the data using NVivo. The data collection and analysis have been reviewed by three researchers (25). Raw data has been added to the results and annex to ensure the link between the findings and the data.

Results

Characteristics of participants

	#GP's	#GP's in training	#Nurses	#Secretaries	M/V	Region	Age
GP 1	4	0	0	1	M	Urban	65
GP 2	4	2	0	2	M	Urban	55-60
GP 3	9	2	1	5	M	Urban	65
GP 4*	5	0	1	2	M	Urban	65
GP 5**	6	0	0	4	M	Rural	45-50
GP 6	4	0	0	2	M	Rural	65
GP 7	4	3	1	1	M	Rural	55
GP 8	5	0	0	2	V	Rural	56
GP 9	3	2	0	2	M	Rural	63
GP 10	4	1	0	2	M	Rural	64
GP 11	4	2	0	2	M	Rural	58
GP 12	5	0	0	0	V	Urban	37
GP 13	6	0	3 ***	3	V	Urban	48
GP 14	3	2	0	2	M	Rural	49
GP 15	3	1	0	1	V	Urban	60

* Practice coach

** Practice manager

*** Nurses who work as secretaries

Table 1: Characteristics of participants

In total 20 GPs were contacted in order to participate with our study. 17 GPs agreed to participate, and three GPs refused to participate due to a lack of time. Eventually 15GP were selected, because two GPs didn't meet the inclusion criteria. Data saturation was reached after the twelfth interview. The study started with the recruiting of the GPs in October 2020 and the analyzing of the results ended in November 2021.

The GPs were predominantly male (11 male vs 4 female), with a median age of 52.5 years. The youngest GP was 37 years and the oldest 65 years. An average of 5,6 GPs work per practice. The smallest practice has 4 GPs, the biggest practice has 11 GPs. A mean of 2,3 employees works per practice, with one practice without employees and one practice with 6 employees. The difference between the urban and rural practices was found in the recruitment of other GPs. Urban practices invested a lot of time in the search of the right colleague, whereas rural practices didn't have the option to choose between different GPs.

Main results

After analysis of the results seven main themes emerged that describe the evolution our GPs went through from doctor to leader and the different factors that influenced this evolution. During the interviews the GPs talked about the advantages and disadvantages when working in a group practice relative to working in a single-handed practice. As this was an interesting result but less relevant to our research question, it is briefly described after the main themes. Same for the recruitment of colleagues and personnel.

From doctor to leader: the evolution

The seven main themes can be divided in two groups.

1. The first four themes describe the evolution they went through:

- The moment of transition, the first time they felt like a leader
- The leadership style they developed as a leader
- The leadership skills they needed to obtain to be a good a leader
- How they now perceive the evolution from a GP to a leader

2. The following themes describe what enhanced or could enhance the evolution to the clinical leader identity:

- Mentors and role Models
- Experiential learning
- (Lack of) education

1. The evolution to clinical leader identity

Moment of transition

The GPs reported different views on the moment when they no longer felt just a GP but also a leader. GP15 felt this the moment she started a practice, because she already organized a lot of things that had nothing to do with her medical education.

Five GPs (GP4;6;9;10;14) noticed this transition to leader when they were no longer working alone, had to make agreements and thereby experienced a loss of independence.

GP4: *"You have to make good agreements. When you're alone, you're alone, you don't have to agree with anyone, you can do what you want. The moment you're with two, you're not alone anymore, you must communicate everything you do and work in a structured way. It's something completely new."*

GP9: "When I worked alone, I knew what I had to do, I didn't have to explain anything to anyone. When you're working together you have to make agreements."

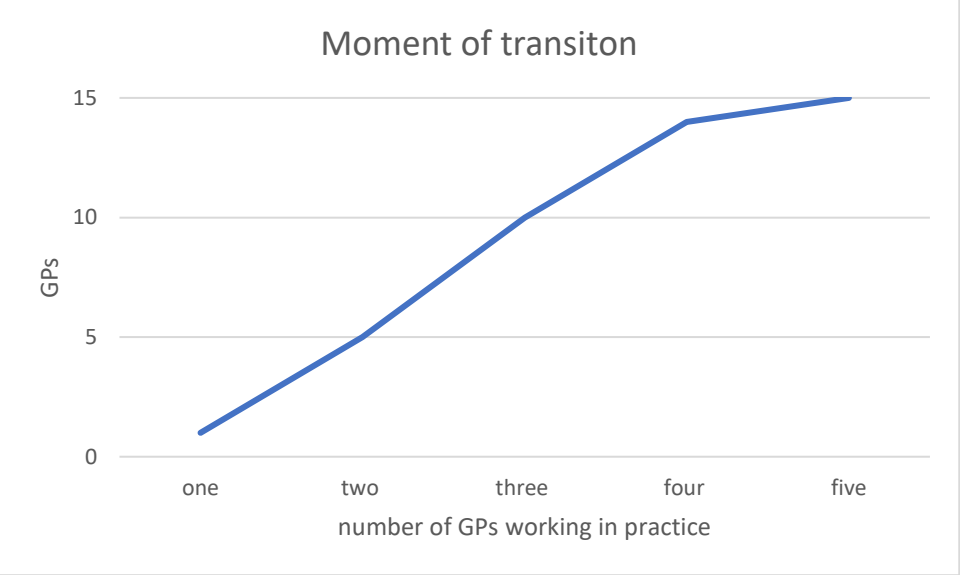
Eight GPs (GP1;2;3;5;7;11;12;13) felt like a leader when they had to implement structured meetings and manage personnel.

GP1: *"When you're with three doctors you have over 1500 patients and so there's a need to have meetings concerning the practice."*

GP7: "The feeling evolved, when we were two, you didn't have to organize a lot of things, you just had to agree with one person. The bigger we grew the more we had to organize. When we were four, we started with structured meetings, so it was once a week we didn't talk about medical issues, but really about the organization of our practice.

GP8 had this feeling when she no longer knew all the patients in the practice. The communication must be good and structured, so all patients will have good quality of care.

GP8: "*When you're with four doctors, you can have the ambition to know all the patients in the practice and you can have quick meetings. This isn't possible with five doctors."*



Y-axis shows the number of GPs.

X-asis shows which number of GPs had to work in practice before the GP also felt like a leader.

You can see that 13 out of 15 GPs felt like a leader when the number of GPs working in practice was between two and four

Figure 1: The number of GPs in our study who felt like a leader relative to the number of GPs working in practice during the moment of transition

Leadership style

All fifteen GPs believe in shared decision making. All GPs are equal and every decision concerning the practice must be discussed and approved by all (GP1;2;3;4;5;6;7;8;9;10;12;13;14;15). The GPs believe this is the only way to lead the practice. They say that it's important to watch out that no one, including themselves, tries to be the boss (GP2;3;5;6;7;8;9;10;11;14).

> *GP3: "I mean if you always want to keep things under your control, always want to be the chef or the boss, you'll never have a nice collaboration. Over time a lot of people asked me, who's the boss of your practice? And honestly, I never had the feeling there was a boss at our practice. Every decision we made, we made it together. It's true that some people have more initiative than others, but it's not because you have more initiative you have to think you're the boss."*
>
> *GP8: "Everybody has the same amount of decision-making power. It doesn't matter if you're the oldest or the youngest."*
>
> *GP5: "I think as a doctor, you are highly educated. So, to work in a structure where you can't change anything or don't have anything to say, I don't think that's possible."*

GPs (GP1;3;7;9;15) believe the organization must have a purpose that's more important than the individual interests of the GPs.

> *GP2: "We've always organized the practice with the purpose of having a better practice, giving the patients a warm feeling, improving the quality and in general to promote public health in our building."*
>
> *GP1: "It's better to have a vision in your practice where everybody can agree with and that transcends the individual. It's important to have the feeling to contribute to something bigger, it has to be more than just seeing your patients, working the hours you have work to and then go home."*

All GP's have formal and informal meetings with their colleagues, but also with their personnel.

Leadership skills

GP's mention good communication and full transparency as the key to good collaboration (GP1;2;3;4;5;6;7;8;9;11;12;13;14;15). Every little frustration must be discussed and preferable as soon as possible. Before you start to collaborate, you must discuss every little detail from your medical view to financial expectations and even your personal and private goals (GP4;7;9;12;13;14;15). They believe that most failures are caused by agreements that are not being followed (GP1;2;3;4;9;12;14), financial inequalities (GP6;7;9;13) and a lack of transparency (GP2;8;10;12). Flexibility is mentioned most as the must have characteristic to work together (GP8;10;14), some GPs believe that not all GPs are capable of working together (GP2;8;14).

GP3: "The end feeling has to be, I come to my work, I love my colleagues and we'll get through. If you talk about collaboration, you must ensure that the sun shines for everyone. You just have to have an open mind."

GP9: "The biggest frustrations come when someone doesn't keep his promises".

They believe that the key to good management is to have good communication (GP3;4;5;7;8;9;13), to let them hem have a say in the organization of the practice (GP3;5;8;13) and to show respect and interest in their personal life (GP3;7;8;9).

Nevertheless, most of the GP's already encountered issues when managing personnel. Three GPs (GP1;3;11) explicitly said that they were not good at managing personnel. GP12 answered she will never hire any personnel. GP5 avoided the managing of personnel by hiring a practice manager. Two practices designated (GP4;6) one member of the personnel to manage their colleagues.

GP8: "I think the most important thing is that they feel heard and supported."

GP7: "You always have to have respect for the people, have respect for their personal life and they have to have the feeling you respect them. We're always open for their feedback."

GP3: "We've had a lot of issues concerning the management of personnel and we concluded we're just not good at it. So, we gave the instruction to two of our colleagues to write a personnel policy, to do this in a respectful manner, to organize meetings with the personnel and to improve the communication between both parties."

GP3: "The problem is that the interests of the personnel are different from the interests of the GPs, and I don't mean financially. I mean the interests towards the organization, a GP comes, does the work he has to do, and it doesn't matter how many hours he has to work. The personnel work according to a strict schedule.

No matter which way you twist or turn it, you have two different groups who don't always pull the same rope."

GP4: "It's important to know whom you're hiring, on which conditions and that you make distinctions between your colleagues. We made a lot of mistakes out of ignorance."

GP11: "I'll never ever hire any personnel again."

The perception of the evolution

Eight GPs (GP3;4;5;6;8;11;12;13) see the evolution towards a leader in a group practice as something good.

GP5: "of course you have to put more time into practicalities, administration, and meetings, but the return on investment is positive."

GP13: "I have the feeling my patient/doctor relationship is much better now, I'm less disturbed and I work in a much calmer way."

Although three GPs experienced the evolution as something difficult.

> *GP1: "The role of a leader/manager isn't something that went natural from the beginning."*
>
> *GP14: "Being a leader doesn't clash with my role as a doctor, but more often than not it's just too much."*

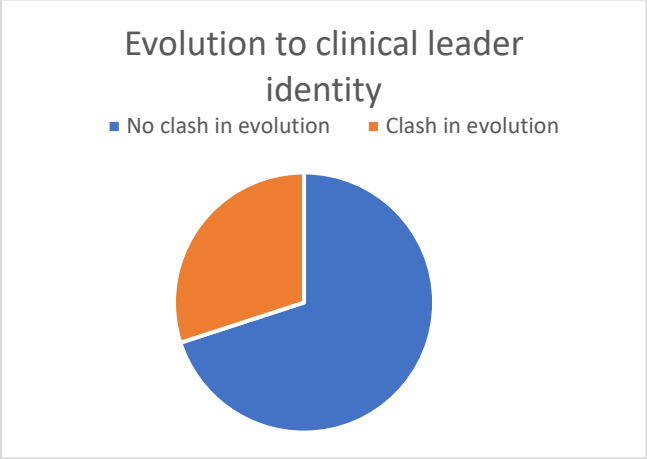


Figure 2: The number of GPs who experienced a clash in their evolution vs no clash in their evolution

GPs (GP1;3;4;5;7;9;10) believe that the most important task for them remains to be a good doctor and to focus on the medical side of their profession.

> *GP2: "Our craft is not managing or leading a practice, it's being a good doctor. We must never lose sight of that. If you want to be a good doctor, you need medical knowledge."*
>
> *GP4: "In our job we have to get rid of everything that has nothing to do with medicine. It always has to be the intention to do only medical activities."*

2. Enhancement of evolution to clinical leader identity

Mentors or role models

Seven GPs (GP1;2;4;6;9;13;15) searched external help for the organization of the practice. They did this to improve the intraprofessional collaboration. Two GPs (GP6;9) asked advice from colleagues in bigger practices, four GPs (GP1;2;6;15) asked for a coach to come and help them to improve the collaboration and GP13 looked for guidelines and took lessons about collaboration.

Experiential learning

All GPs believe they learned the most from their experiences running the practice.

GP2: "I didn't have the experience in the beginning. When I became the leader that was a difficult moment. I had to swim, had to do everything I could just to stay above surface. I didn't lose control, but I felt this was beyond my capabilities. "

GP9: "Things went wrong because I waited too long to discuss it. This is something I learned along the way. "

Education

All GPs describe that they weren't educated for the role as a leader and that it should be more in the education of young doctor.

GP8: They should be well trained in leadership. It's going to be more important because we're evolving to bigger practices and multidisciplinary practices.

GP4: It's fundamental and a gap in our education. The only thing I could when I graduated was "open your mouth and say a".

Extra themes

Recruitment

All GP's hire people (both GP's and employees) based on their personality, there must be a connection. The personality is more important than the curriculum of a person or the competences. The way to hire is to invest a lot of time to talk with the person, so that you learn to know them. This counts only when there are enough candidates. GP's who live in a more rural area sometimes just must hire the GPs that are available but have the advantage that they have references of the candidates who often live nearby. Some GP's remark that even though you take the time, it's always a risk and people can change during time

GP3: "We always did our best and invested our time to talk with a potential candidate, just to dig a little bit deeper so we get to really know the personality of the candidate."

GP8: "We just ask ourselves are we going to get along with this person. That's the most important thing, the first look, and the first feel. "

Most of the GPs (GP2;3;4;7;9;10;11;14) believe it's better to hire someone who's in training in the practice. After one year you know the personality of the person and his qualities. Additionally, they know the culture of the practice and the work method, so it's a less big risk. Three GPs (GP5;12;13) believe that it's better to hire an external GP. They say that it's difficult for both educator and apprentice to make the mental switch from an apprentice to an equal colleague, that there is a difference of being an apprentice and being an equal colleague and that both personality as vision, especially with young people can change over time.

GP3: "I'm convinced that hiring an intern is the best thing to do. They know how we work, how we collaborate, how we are organized."

GP4: "It's the formula for success."

Advantages of a team

GPs (GP1;2;4;5;7;8;9;11;12;13;15) have a positive feeling towards collaborating and working together in a group practice.

The main advantages the GPs describe are the support you get from your colleagues both emotionally as professionally, that it helps to do work more evidence based and to get more medical expertise into the practice and the peer control you have so you won't cross your own limit.

> *GP12: "Just the feeling you know you can fall back on someone."*
>
> *GP13: "My best move was to collaborate, it pushed me to work more evidence based."*

Two GPs (GP10;14) described they are currently having negative feelings towards collaborating and GP2 describes the downsides he experienced before.

> *GP14: "At this moment it's just too much, but that's the thing you have with working together. I would rather just come to the practice do my consultations, my blood samples, my home visits and just go home."*
>
> *GP10: "From my point of view, I was used to work alone. Sometimes I see a particular treatment of my colleague that I don't agree with. In the beginning I gave a comment, but now I've learned I can't do that. They don't appreciate it. The younger colleagues believe that they know everything, it's not to criticize them, but they really think they know everything.*

Discussion

The evolution to clinical leader identity

The aim of this study is to investigate the underlying processes of forming a clinical leader identity throughout the perception of general practitioners and to investigate how they define a clinical leader and the facilitators and obstacles to become one. Based on the results after data-analysis GPs appear to hold strong medical identities, which are deeply embedded in their professional identity. This follows the CanMEDS framework where the medical expert is the central physician role (27). For most of the GPs the loss of the individual responsibility was the transition moment to feel like a medical leader, which aligns with the views of Berghout et al (21). They no longer felt just a doctor but also a leader, when they lost this independence and must organise structured meetings to take better care for their patients. This disrupting in old values like autonomy and hierarchy is necessary to make the change in identity, so the stronger these values are embedded in the professional identity, the more difficult the change in identity is realised (22, 28). This is an argument to implement the formation of leader identity as early as possible in the education of young doctors. As the professional identity is already strongly adopted before the leader identity development it will be more difficult to make this change in identity and to develop healthcare leaders who see medical leadership as important as their clinical work (29). Group projects, self-assessment tasks, leadership programs or other actions to stimulate the values of leadership and to disrupt old medical values should be considered to help the change in identity. This is acknowledged by the GPs in our study who state that effective communication, transparency, and flexibility should be a part of their professional identity to take on leadership roles and thus is an important part of the clinical leader identity.

All our GPs believe in shared decision making in which GPs are equal and every decision concerning the practice must be discussed and approved by all. In literature this type of leadership is named as shared leadership (30). This finding follows numerous other studies that doctors who are individual responsible for their patients won't thrive in an environment with authoritarian leadership (7). Even more, several studies show that shared leadership increases team satisfaction and efficiency, this is in line with our findings (31, 32). This finding might be interesting to further investigate.

Our study shows that most GPs perceive this evolution towards being a leader as something good. They feel comfortable in the role as a leader and have the feeling they are well developed in this role. The GPs who don't feel like a leader admit that it doesn't feel natural and that it's something extra they must do next to being a doctor. In other words, it seems like they didn't yet develop the clinical leader identity. This finding is according to the identity literature that states that a strong professional identity helps to practice with confidence and is important to be successful in a

professional role (33). Therefore, this study follows the conclusion of Anderson et al 2015 that the clinical leadership challenge is not only a competence challenge but just as much an identity challenge (17). Doctors may have all the qualities to be a good leader, it is of paramount importance that they also feel like a leader in order to be a good leader (33).

In addition to this it is important to know following the findings of koskiniemi et al 2019, that to develop leadership within doctors, one must stay close the professional identity of doctors and see the clinical work as the core value of the identity (34). This follows what we found with the GPs in our study. They believe that the most important task for them still is treating the patient and be a good doctor. Therefore, an empirical confirmation of the CanMEDS framework can be made that as a medical expert the physician integrates all CanMEDS roles including the role of leader, so the features of the medical identity are also the core of the clinical leader identity (27). This also has advantages, a clinical leader who acts as a good doctor will rather be followed by other doctors as he is seen by one of them. Other studies confirm that the professional credibility and the clinical knowledge is important to exert influence (35, 36). Another advantage is that there will be less struggle from the professional medical identity to clinical leader identity as the core value stays the same(37, 38). This is an argument to make just subtle changes to the medical identity to obtain the clinical leader identity in order to not generate strong resistance.

These findings also raise the question if it is not better to have doctors or medical professionals in leadership positions than non-medical leaders or managers or at least to say that further research is needed to answer this question.

Enhancement of evolution to clinical leader identity

By analysing the underlying process of the GPs in our study several options have been found to enhance the clinical leader identity formation that are in line with previous findings in literature (12, 18, 39). As all our GPs state that they weren't educated for the role as a leader, an implementation of leadership training or programmes in the education of young doctors should be considered. Especially because GPs who feel unprepared for the role as a leader are more likely to have pessimistic feelings like anxiety, cynicism (19). It is confirmed by Sadowski et al that a widespread implementation of such curricula is lacking (12). The CanMEDS framework can be helpful in this matter, as the challenges to implement this contemporary initiative are equal to the challenges faced when implementing other leadership training or programmes in the curriculum (16). Following Frank et al more research should be done to prove that leadership education won't hamper the medical traineeship and there should be support for frontline teachers to have a successful outcome(16). Other universities could follow the undergraduate medical education for the 21sth century project, where universities design innovative curricula to help medical students develop leadership competencies and enhance teamwork

(40).This could be done by implementing workshops on leadership where they need to discuss health plans and health care strategies, have group projects with self-and team-assessment exercises or obliged internships at a managed care organizations head quarter where they work with medical directors (40).

Another way to enhance the clinical leadership identity is via role models. The GPs in our study actively search for role models or people who guide them, because they feel they are acting short on leadership. They acknowledge the importance of these mentors and role models in helping in becoming a leader. This in line with the findings of Cruess et al that the process of professional identity formation is facilitated when having role models or mentors(41, 42). At Ghent university students get appointed a staff member as a mentor to help them throughout their whole medical education, this can be an opportunity to appoint them doctors with the clinical leader identity. For graduated doctors lectures or courses by doctors with the clinical leader identity should be considered.

The GPs in our study indicated that experiential learning helped them to become a better leader, this in line with the literature (18, 41). Experiential methods can have more effect than didactic methods in the change of behaviour, attitude, and identity (43).Therefore, reflection on past experiences by the GPs themselves or together with a leadership coach can help them develop the leader identity and prevent making repetitive errors. Also guided moments of reflection can help the GPs in their future struggle to be a good leader.

Strengths and limitation of this study

The objective in this study was to investigate the underlying processes of forming a clinical leader identity throughout the perception of general practitioners and to investigate how they define a clinical leader and the facilitators and obstacles to become one. It's a qualitative study where all results and analysis were discussed with three researchers to ensure more objectivity in the interpretations of the interviewer and to obtain investigator triangulation. Data source triangulation was obtained recruiting a mixed purposive sample, differencing in age, gender, and location (rural or urban). During the study an iterative approach was adopted to obtain more qualitative data to the research question Raw data has been added to the results and annex to ensure the link between the findings and the data.

A theoretical saturation was achieved in this sample, but caution should be exercised when generalizing these results to other samples like community health centers or group practices in other countries. The sample population are GPs working in a private group practice, where in other countries most group practices are owned and run by the government. This has consequences in the way they lead the practice and the responsibilities they must bear. They also become informal leaders of the group practice, whereas government-run group practices mostly have formal leaders. Studies should be conducted with GPs in other samples to confirm our findings.

It’s difficult to compare the work environment of GPs with the work environment of specialists in hospitals. There is little literature about the underlying processes of the medical leader identity with informal medical leaders in hospitals, more studies about this topic should be conducted.

Conclusion

It is important to focus on the development of leadership competences as well as the development of the clinical leader identity to help doctors to act and feel like a leader. The strong medical identity with values like autonomy and hierarchy along with the lack of training of the leadership competencies makes the transition from doctor to clinical leader more difficult than it seems. Therefore, to stay close to the medical identity this study follows the CanMEDS framework to let the medical expert be the central role in the clinical leader identity. As it is difficult to disrupt the old medical values, the clinical leader identity formation should be developed as early as possible. This formation could be enhanced by role models/mentors experiential learning and leadership education. Staff members could be appointed as a mentor during education or doctors with the leader identity could give lectures/courses about leadership. Experiential learning with reflection about the past experiences and guided moments of reflection can help to become a better leader. Innovative medical curricula with group projects including self- and team-assessment exercises or internships in the management of health care organisations is another way to enhance the leader identity. Further research is necessary to confirm if the medical expert needs to be the core of clinical leadership or if non-medical leaders could exert clinical leadership. Other ways to enhance this formation to clinical leadership are needed to be investigated as good clinical leadership is essential to address the increasing challenges health organisations are facing.

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Appendix

Leadership style

GP9: "If you begin with an inequality, you'll create problems. I understand I'm the oldest of the group, so naturally the oldest must be the wisest and the one with the most experience, but that's not always true. Sometimes I say to my colleagues, it's not because I have the most experience that I'm right or that my suggestion is better than yours."

GP2: "You have to create a team, so you can have a team driven decision model."

GP9: "You have to have a common goal. It's important to discuss this goal, before you start to work together."

Leadership skills

GP8: "You can't read anyone's mind, so it's important to be open and transparent."

GP3: "We show each other respect and give each other the space to discuss and to differ in opinion."

GP13: "You have to be open and direct in your communication."

GP6: "Eventually we came in a relationship, where we only communicated with little brief notes."

GP2: "In my opinion we agreed that she would take all the responsibility, but she was frustrated that she had all the responsibility but not all the decision-making power. She was frustrated that she got more and more responsibility, more workload and this all went together with problems in her family life."

GP15: "When you work together you will always have ups an downs and I believe these ups and downs are often partly dependent by the personal situation of you and your colleagues."

GP8: "I think you have to have a special gene that allows you to work together."

GP8: "Flexibility is the core quality you have to possess as a GP."

GP9: "We try to be there for them and have a friendly relationship, even though we're in a boss/employee relationship."

Identity clash between being a doctor and being a medical leader

GP10: "I'm not a leader's type."

G4P: "It never felt as a burden, I always found it challenging."

Core of medical identity

GP1: "It would be easy if the tasks we have to do in the weekend that have nothing to do with medicine would be taken from us, so we can focus on our core business namely helping our patients medically, psychologically and socially."

GP7:" Paying the bills, hiring personnel, I have nothing to do with these things, I'm a doctor."

GP7: “I’m convinced that as a doctor you have to limit yourself to your core business. You only have to do that for which you were educated.”

Recruitment

GP5: “The most important thing for us is our gut feeling en does this person fits in our group.“

GP1: “I think it’s difficult to look through someone, we’ve had colleagues who were very compliant in the beginning but change over time.”

GP9: “I think a lot of associations failed, because they didn’t know each other. From the beginning on they didn’t know who my colleague is and do we even fit.”

GP6 rural: “The wife of my son knew her very well. So, we knew she was from a good family.“

GP9 rural: “We don’t have a choice. You must be glad when you have a candidate. “

GP7: “That’s ideal, you know their motivation, you know their weaknesses and you know their ambition.”

GP15: “It’s hard to change from educator/intern position to equal colleagues.”

GP1: “Once your equal colleagues, you see that people change or develop a different vision.”

Advantages of a team

GP9: “When you work alone there’s no one who says stop. You don’t always notice that you’re doing it the wrong way. So, the best thing I did was to start collaborating.”

GP1: “I like the fact you work as a part of a bigger whole. Also, the meetings are very interesting, I have the feeling you always learn something new.”

GP2: “You lose your independency and the moment it doesn’t go well; you have to consider every word you say and every move you do. These are not pleasant times. “

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