Making do by getting real: Psychological contract violations and proactive career agency among medical professionals

Mahima Mitra • Sue Dopson • Timothy Hoff

Background: Health care professionals face greater uncertainty in their careers as traditional jobs wither and new, organizationally controlled jobs proliferate, reducing economic security and professional autonomy.
Purpose: We apply psychological contract and self-efficacy theory to examine the career agency of early-career physicians. We ask the following: (a) What are the unfulfilled expectations and emotions experienced by young physicians at the training and early career stages? (b) What are the forms of career agency exhibited by young physicians in response to unfulfillment?
Methodology: We conducted a study on 48 U.K. early-career primary care physicians, known as general practitioners. The sample comprised both trainees as well as newly qualified physicians. Data were collected through in-depth interviews and focus group discussions.
Results: Physicians interpreted their early-career experiences based on predominantly ideological expectations around what it means to be a successful professional. However, the realities of practice resulted in highly emotional experiences of violation that were associated with a "reactive" agency and job behaviors that were more transactional and less relational.
Conclusion: This study identifies the expectations of early career professionals, which helps understand how and why psychological contract violations occur. It also expands the conceptualization of career agency from a positively framed aspect of professional behavior to one that includes haphazard and self-serving elements.
Practice Implications: Our study highlights several implications of the shifts in physician career agency for primary care practice. It discusses the potential effects of the purposeful self-interest among doctors on professional identity and power, as well as patient care.

Key words: Career agency, early-career physicians, psychological contract violation, self-efficacy theory

A series of events is changing how physicians may enact their careers: the corporatization of the medical profession, hyperstandardization and measurement of work, and increased outside interference in professional decision-making (Hoff et al., 2016). Employment opportunities become restricted as traditional jobs wither and new, organizationally controlled jobs proliferate, reducing professional autonomy (Krisher & Boak, 2018). For example, physicians are increasingly not owning medical practices, relying less on judgment and more on checklists when treating patients, and conducting day-to-day practice with greater government and professional regulation. Modern physicians thus face greater uncertainty in their careers, which raises the question of how the medical profession can promote career continuity and viability in the long term while the sustainability of careers is being threatened. This is key for understanding the critical role of the profession in providing physicians opportunities for growth and development while balancing between the demands of work and nonwork life.

Managers of heath care settings understand that workforce recruitment and retention is a key challenge in the delivery of excellent service. The COVID-19 pandemic has made that even truer. Less attention has been given, however, to the role physician perceptions of career fulfillment play in this challenge. Although it is known that career satisfaction links to organizational commitment and turnover intentions (Gregory et al., 2007), which impact both health care quality (Ranucci & Berry, 2021) and hospital organizational success (Trybou et al., 2016), the specific educational and workplace interventions that can forge greater trust between health care managers and physicians remain underexplored. We argue that such enhanced trust is in part dependent on better understanding how younger physicians think about and act

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toward their careers and how important issues of career sustainability are for them.

This study seeks to generate insights into the motivational challenges generated by a mismatch between what physicians expect to see versus what they find when they enter a health care workspace. It provides the opportunity for health care managers and organizations to consider an important avenue for dealing with recruitment and retention challenges and offers initial thoughts on what concrete actions might be taken to ensure a more trusting, stable, and productive relationship between employees, employers, and educational providers that involves attending to the varied and pragmatic expectations of doctors. The lessons generated can also be useful for thinking about other members of the health care workforce.

Within this context, our interest lies in examining the specific adaptations individuals make in response to threats to career sustainability early on in their careers. Indeed, an evidence base relating to this aspect is only newly emerging (e.g., see Chudzikowski et al., 2020; Hirschi et al., 2020). Examining agency and adaptations at an early career stage is useful for several reasons related to increasing our knowledge about the physician workforce. First, previous work suggests that workers at different career stages define success and satisfaction differently (Wang et al., 2012), implying that the skills and resources prioritized and adaptations made to feel satisfied vary by career stage. Second, focusing on physicians beginning their working careers can allow for a closer examination of how those newly christened into their professions enact career agency in the context of a smaller experiential base upon which to draw. We are specifically interested in the role of subjective, emotional factors such as values and beliefs around being a doctor and how these influence early-career decision-making. Finally, examining these mechanisms at the early career stage aligns with the reality that an increasing number of doctors now begin their careers as salaried employees of larger organizations (British Medical Association, 2022; The Physicians Foundation, 2018). As such, talent management processes need to be streamlined to develop insight into the learning and developmental needs of a new generation of doctors, now more reliant on organizations than before for their career fulfillment.

Against the backdrop of the current crisis in U.K. general practice (Simon et al., 2018), this article examines how young general practitioners (GPs) in the English National Health Service pursue career choices based on tensions experienced between the work context, ideological expectations around being a medical professional, and a need to control their future career fates (Guest & Rodrigues, 2017). The English primary care context bears many similarities to the U.S. context—a deleterious work situation exacerbated by increasing workloads alongside a greater shift toward salaried employment. The U.S. context is distinct from the U.K. context in that U.S. primary care physicians can self-determine their employment options more than U.K. GPs. Using the dual theoretical lens of psychological contract (Morrison & Robinson, 1997) and self-efficacy theory (Bandura, 1997), we find that the gap between insufficiently met ideological contracts (Thompson & Bunderson, 2003) and perceived reality produces emotional responses in physicians that facilitate more self-interested career choices. The career agency exhibited is characterized as more transactional and less profession- or patient-centered and has implications for physician identity and patient care. It also has implications for talent management of doctors that health care organizations must consider.

Theory

Changing Work Contexts and Career Agency Among Young Physicians

Changes in health care have created uncertainties and complexities in physician career and job choices. They have expanded the range of employment opportunities, roles, and organizational settings available and introduced competing cultural norms within medicine regarding the correct way to structure and enact one's career. A major change is the ubiquity of salaried employment for physicians (British Medical Association, 2022; The Physicians Foundation, 2018). Additional trends create fertile soil in which young physicians may become more agentic in their early-career thinking: rising clinical workloads as demand grows, continued physician shortages, and increasing administrative workloads with record levels of burnout and career dissatisfaction (Fisher et al., 2017; The Physicians Foundation, 2018). In addition, larger health care organizations, for example, the National Health Service in the United Kingdom or Kaiser Permanente in the United States, hold great sway in determining how medical work is organized, coordinated, and delivered, aided by information technology and standardized care guidelines.

Psychological Contracts, Self-Efficacy, and Physician Career Agency

Although professionally inexperienced, young physicians develop expectations around their education, what being a doctor means, and how their careers should be constructed and rewarded (Maudsley et al., 2007). As advantaged workers, they come to training with goals, beliefs, and values that contribute to expectation formation and form the basis of "psychological contracts" or understandings established by individuals about what is owed to them by multiple stakeholders in their career ecosystem (Baruch & Rousseau, 2019). Expectations are subjective, may not be understood by the organization, and cover multiple beliefs—ideological (professional mission, principles, and values), relational (socioemotional rewards and incentives), or transactional (economic rewards and incentives; Thompson & Bunderson, 2003). For young physicians exposed to volatile health care environments, two types of preformed beliefs may shape, specifically, the ideological psychological contract at the "preemployment" stage (Rousseau, 2001): first, traditional beliefs emerging from medical professional identities, such as expecting high status and societal recognition, and second, personal beliefs emerging from their generational identity, which emphasizes doing work that has meaning but fits as part of a balanced life (Deloitte, 2018).

Emergent expectations may also be shaped by the individual's self-concept, which varies by career stage and affects the construction of professional identities over time (Driver, 2018;

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Low et al., 2016). They can derive from individuals' need to develop and maintain high degrees of self-efficacy and self-direction in careers while learning what being a professional means (Leung, 2008). Self-efficacy is an important ingredient in the creation of a competent professional as it forms the core of an individual's need to control, thereby feeding into the formation of ideological contracts at an early stage (Baruch & Rousseau, 2019). Physicians already exert significantly high levels of control over their work than other occupational groups and are likely to be proactive in their career at an early stage because of being achievement-oriented, highly educated, and part of a prestigious profession (McDonald, 2014). Confident about shaping their environment to have their expectations met, physicians may exercise agency by relying on cues from their immediate environment, including older colleagues and fellow trainees, and the learning that comes from real-time training and socialization (Baruch & Rousseau, 2019).

That said, young doctors' evolving ideology is challenged by uncertain work environments that threaten the fulfillment of professional ideals. The potential for misalignment between ideological expectations, a need for self-efficacy, and the surrounding context means that the psychological contracts of young professionals are prone to violations (Morrison & Robinson, 1997). These occur when the individual believes that obligations owed to them by a stakeholder are unlikely to be delivered in the present or future (Robinson & Morrison, 2000). A "violation" differs from a contract "breach"—a cognitive assessment of failure to meet obligations—in being focused on the emotional and affective response embodying the perception of a breach (Morrison & Robinson, 1997). For doctors, violations are more likely to occur when unmet expectations upset their developing identities as autonomous experts (Bunderson, 2001). Once in practice, they may experience decreased control because of being salaried, dealing with financial restrictions, and managing high workloads (Hoff et al., 2016). Exhibiting greater career agency can allow them to engage in a proactive socialization process and regain the control lost when entering a new work environment (Ashford & Black, 1996).

A key to advancing theories of physician career enactment in volatile work contexts is to explore how career agency is shaped by unfulfillment at the preemployment stage. Building upon recent work on psychological contracts and career agency (Lam & de Campos, 2015) and the individual factors such as personality, values, and beliefs that contribute to psychological contract experiences (Bunderson, 2001; Low et al., 2016; Raja et al., 2004; Thompson & Bunderson, 2003), two questions guide this study: (a) What are the unfulfilled expectations and emotions experienced by young physicians at the training and early career stages? (b) What are the forms of career agency exhibited by young physicians in response to unfulfillment?

Method

Research Design

This study examined U.K. early-career GPs—one among multiple U.K. postgraduate medical specialties that runs as a 3-year program, usually split into equal time spent as a GP specialty registrar across general practices, as well as in hospital rotation posts. Participants were drawn from six different training programs located across 4 of 14 regional deaneries offering general practice training. A qualitative research design helped explore participants' early-career experiences and decision-making and the meaning they attached to their actions (Denzin & Lincoln, 2018). An idiographic approach (Jupp, 2006) helped focus on the individual-subjective perspective and understand the specific factors—perceived expectations, emotions, and values—that combined with situational realities in formulating career agency. Data sources included interviews and focus groups, supplemented by analyses of changes to GP work and training. The study was approved by the authors' institutional ethics review boards.

Sample

The sample comprised 48 early-career GPs drawn from six U.K. general practice training programs (Table 1). A purposive sampling strategy identified two categories of participants: (a) trainees in the second or third year with at least 3 months of placement experience and (b) newly qualified GPs who had completed training within the last 5 years. Recruitment proceeded sequentially via regional training programs

TABLE 1: Interview sample characteristics

In-depth interviews: 27 early-career GPs affiliated to 6 U.K. training programs			
Group		*Gender*	
Trainee	18	Male	10
New GP	9	Female	17
Mean age		*Training/work status*	
Trainee	31 years	Full-time	13
New GP	38.4 years	Part-time	14
Medical degree		*Physician parents*	
Undergraduate	16	Yes	3
Graduate	11	No	24
Total GP experience including training			
<1 year	14		
1–3 years	6		
Over 3 years	7		
Focus group discussions: 4 groups with 21 trainees affiliated to 2 training schemes			
Status		*Gender*	
Trainee Year 2	18	Male	7
Trainee Year 3	3	Female	14

Note. GP = general practitioner.

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and key informants known to the authors. Trainees were introduced to the research in one of two ways: (a) a study overview talk delivered at training locations and (b) individually targeted e-mails. Recent graduates of the same training programs were also invited to participate via e-mail. To sample purposively on several different criteria such as training stage and location, everyone contacted completed screening questionnaires prior to being interviewed.

Data Collection

Data were collected in two phases. The first comprised in-depth interviews with trainees and newly qualified GPs. An interview protocol was developed and piloted with three trainees. Twenty-seven additional one-to-one interviews were subsequently conducted in person, by phone, or virtually, outside of participants' working hours. Interviews lasted from 45 to 60 minutes and focused on expectations relating to training and medical careers, perceptions of current work or training realities and their alignment with expectations, and career decisions and intentions.

The second phase, comprising focus groups with trainees only, began once the interviews had been preliminarily analyzed. They helped gain additional insights on emergent themes linking expectations, experiences, and career decision-making. Focus groups were selected at this stage to facilitate a rich discussion among groups of participants and allowed the sample size to be increased more readily than one-to-one interviews that had a slower uptake. Sampling and recruitment strategies applied were the same as for the interviews. Discussions were scheduled as an additional session to trainees' weekly teaching and varied from 60 to 90 minutes. They were audio-recorded and transcribed, and focused on (a) emotions felt about being a GP and having key expectations met or unmet and (b) early-career decision-making given the emotions and expectations identified.

Analysis

Data analysis was inductive and iterative and followed principles of grounded theory research (Strauss & Corbin, 1990). This meant that interviews progressively focused on the interplay between career expectations, experiences of nonfulfillment, accompanying emotions, and subsequent career decision-making. It also enabled theoretical sampling (Strauss & Corbin, 1990) to be undertaken to include both more experienced trainees and those having started practice within the last 5 years. Interview themes subsequently determined the questions asked in focus groups, enabling data saturation and triangulation of study findings. Data were transcribed by a professional service and analyzed using ATLAS.ti v.8.3 in four stages. In the first phase, an initial 10 interviews were read and open-coded by the first author, with other co-authors reviewing and jointly resolving any disagreements. This identified early themes and descriptive codes relating to work expectations, experiences of training and work, and the interlinked emotions. The authors were struck by the predominantly negative emotions being reported by trainee GPs, which led to an interest in examining whether newly practicing GPs also had similar experiences.

The second analytic stage involved an iterative data collection and analysis process. This generated axial codes that aggregated early themes into the following higher order categories: (a) groups of expectations aggregated by key values; (b) the cues determining expectations, clustered by personal ideological and work environment-related sources; (c) emotional responses to experiences clustered by valence and quality; and (d) career and job adaptations classified by form and function. The third phase in the study checked the analytic categories developed for robustness by conducting four focus group discussions with 21 additional trainee GPs from within two of the six training programs originally sampled. These data were analyzed as part of the existing coding scheme, which evolved, in the third analytic stage, into the final coding paradigm. This illustrated how expectations interacted with knowledge of external circumstances and drove specific career and job adaptations. The fourth and final analytic stage tied up results with psychological contract and self-efficacy theory and developed a processual understanding of how expectations interacted with "real-world" experiences and knowledge of external circumstances to drive a variety of career decisions. The final coding paradigm pointed toward a highly subjective, emotionally driven, and self-efficacy-laden process of early career construction.

Results

Both trainees and new GPs primarily anticipated three expectations from a medical career: that work provides meaning, that the career enables self-determination, and that they develop practice competence. The evidence for all three groups of expectations was strong, with each category discussed by at least three quarters or more of participants and reported on average four or more times within each interview.

Career Expectations

Participant expectations developed from cues received from two sources in their external environment. First, the rapidly evolving health care delivery environment characterized by complex patient profiles, shorter appointments, and greater financial pressures and accountability. Second, the training context that determined the skills, knowledge, and experiences required to be a successful GP. A third set of cues, emanating from physicians' personal life, fed into ideological expectations. These related to assumptions around being a physician in society, personal values relating to lifestyle and work–life balance, and the significance of nonwork elements in life.

"Meaning of work" expectations. This group of expectations derived from physicians' ideological psychological contract and referred principally to two things: finding work enjoyable and satisfying, and feeling valued and protected as a respected professional. Work satisfaction expectations derived from a medical ideology and included time to develop a continuing care relationship, knowledge and skills to practice high-quality medicine, opportunities to learn and grow within clinical practice, and obtaining support while also practicing independently.

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For me, it is first retaining enjoyment for the job—something that I want to do, rather than going into work each day dreading it, or getting to the point where I just do not like seeing patients…. And not have a life that is so utterly dominated by the job that everything else falls by the waysides. (Steve, trainee)

Expecting value, respect, and protection as a professional was rooted in a more traditional ideology that placed physicians at the apex of cultural legitimacy and autonomy vis-à-vis the public. Value and respect were anticipated as "normal" outcomes of investing in a highly regarded profession. Expectations relating to being protected arose from the more challenging aspects of everyday practice, including the public's belief that physicians should be outstanding at work, and contemporary shifts in medicine, including increased medico-legal risks, workloads, and a litigious culture. For example, "I have got to work somewhere where they appreciate you and they do not treat me like a criminal if something goes wrong" (Ramona, trainee). Also: "The level of respect that doctors were given meant that you felt a real sense of vocation and professionalism. …[But] the face of medicine has changed with the new contract [mandated 'work after hours']…. It is difficult to then ask people to make…personal sacrifices in that context" (Sabrina, trainee).

"Self-determination" expectations. These expectations emphasized a desire for autonomy and control, particularly, striking work–life balance, and achieving professional stability. The need for work–life balance reflected an ideological–relational psychological contract rooted in deeply personal values, on the one hand, and a direct response to a dynamic service context, on the other. For example, not overwhelming other priorities in life and pursuing nonwork activities to avoid burnout: "I want time to do other things too and not to be squashed and pressured, to enjoy the things that I like doing otherwise" (Anne, trainee). Also: "This does not have to consume every area of my life" (Amber, trainee).

In seeking professional stability, GPs expected to find security in both their own careers as well as their practice contexts, signaling both transactional and ideological psychological contract elements. For example, they sought financial stability through "guaranteed" jobs, clear contractual arrangements, and autonomy to make decisions on "after-hours" work. In desiring a stable work environment, they expected to freely choose future work settings, especially who employed them and in what manner: "I would like a job that provides security…a reasonable income…work[ing] reasonable hours…safely and provid[ing] a decent service to your patients" (Rita, trainee). Also: "I wanted to go into a job and establish myself in a place and be there for a long time[…]not be wound down and worn out within a matter of months…." (Rabia, new GP).

"Competence" expectations. This category included being adequately trained or skilled and providing consistently high-quality care. Expectations around the first related to a transactional psychological contract and included overall job preparedness and confidence. GPs desired high-quality, reliable teaching that was relevant to the realities of their future job and covering enough ground to serve a range of capabilities and contexts upon qualification. They also expected individual-level support from trainers rather than relying on self-learning mechanisms like online teaching. For example: "I expected to have a broader base to feel confident going into [the next training year] and beyond. Feeling like I have seen what I need to, to move forward [in my career]" (Female 1, trainee). Also: "[They should be] telling me stuff that is relevant to things I will do in general practice—which group of people I should be referring, or what blood tests I should [be running]—I might actually do some of that" (Male 1, trainee).

There was also an expectation, rooted in an ideological–relational psychological contract, to provide consistently high-quality care focused on making accurate diagnoses with minimal errors. GPs wanted enough time to gather and synthesize patient information, use up-to-date evidence-based guidelines, and offer the clinically best option instead of a resource- or time-constrained one. They also desired to fulfill patient expectations by developing a strong relationship: "I would like longer, flexible time with patients. I do not want to have six people waiting, me two hours behind, and saying, 'I can't deal with more than one problem, come back.' I have lost the ability to have a relationship" (Rachel, new GP).

Violated Expectations and Accompanying Affective States

Participants drew upon diverse cues for assessing whether their expectations were being met currently or would be met in the future. Cues were obtained by observing colleagues and their own training and job experiences. Unfulfilled expectations, expressed through negative valence emotions—primarily frustration, fear, anxiety, or resentment—were labeled "perceived contract violations" (Figure 1). Nearly all participants reported violations of one or more kind. Interestingly, the cognition of violation and its emotional experience were interlinked. In some cases, the recognition of an expectation as having been unmet triggered a negative emotional response. In others, the acknowledgment of a negative affective state brought about the realization that a violation of expectations had occurred. This complex mix of the rational with the less rational made physicians' responses somewhat less predictable.

Unfulfilled "meaning of work" expectations. Both trainees and new GPs strongly felt that expectations around meaningful work were already unfulfilled given existing or past experiences at work. They realized that certain workplace realities awaited that could not be changed or easily accommodated, most specifically high work volume. Frustration came from the pressure to manage workloads while losing opportunities to practice high-quality medicine. Sadness came from a lack of meaning and fulfillment in everyday life, having made no "real difference" in prioritizing administrative over clinical tasks. This caused some regret about choosing a GP career.

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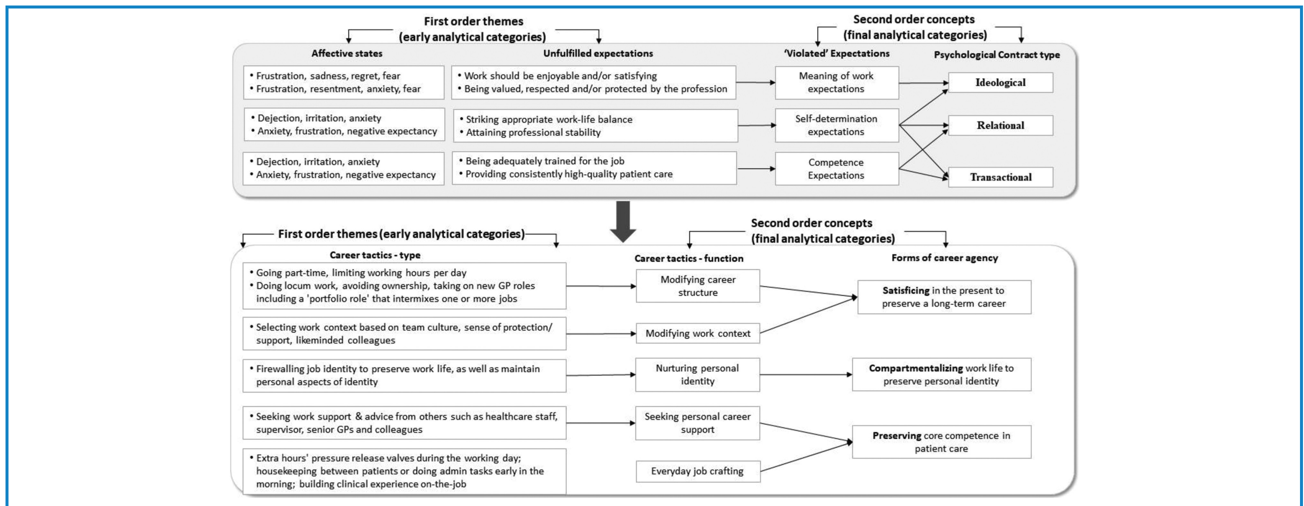

Figure 1. Data structure.

> *You come away with the feeling of "What's the point? [after] having seen twenty patients in quick succession…[A]fter each patient you regroup, start again, put on your best smile, give them your full attention, [and] try and do your best, yet it does not feel enough. It affects your ability to cope with stress, enjoy the job and be the best that you can be if you are feeling that frustration. (Jena, new GP)*

Most GPs also experienced nonfulfillment of their need to be valued, respected, and protected as a professional. Underlying these were unfulfilled ideological beliefs and a challenging work context that placed the assessment of occupational risk increasingly at the individual level, making it more a personal calculation and linking it to feelings of control. Frustration was expressed about feeling undermined in practicing clinical roles independently. Resentment was reported by trainees who felt their job placements were inadequately administered. Anxiety arose because of feeling unprotected in managing the high risks of independent medical decisions. Reflected across experiences were perceptions that their self-efficacy was being undercut.

> *I left being a GP for a while, I was that demoralized from the whole experience. I could not believe that on a multi-level basis the government would allow GPs to just work and work, there is just no off button! [T] his is not what I thought GP was all about, and I just left for a few months. (Rabia, new GP)*

Unfulfilled "self-determination" expectations. GPs also felt strongly unfulfilled when it came to work–life balance and autonomy expectations. Anxiety arose from decision fatigue from seeing multiple patients every day, observing senior colleagues struggle with burnout, and the inability to balance work with nonwork life. Irritation was caused by a relentless workday—high patient volumes, overrun appointments, and overtime work. Reflected across experiences was a sense that their internal locus of control was adversely affected at times, that is, that they were not fully in charge of dictating the circumstances under which they went about their workday.

> *Seeing the partners who have been in those roles for 10–15 years and how stressed they are [is] something that I had not really thought about. You realize how much of their lives they are spending doing their job, staying late, doing extra work on weekends, burning out and leaving. (Roxy, trainee)*

> *I am tired of making sacrifices and not seeing family…. It is real life, you do it once or twice, that is okay. But there is so many years of doing it! (Female 2, trainee)*

Unfulfilled "competence" expectations. GP trainees felt especially concerned about whether their training was enough for becoming a competent physician. Their emotions were varied and unproductive, ranging from frustration, anger, and resentment to fear and anxiety. For example, they were frustrated by teaching and hospital placements that they believed did not provide useful skills or knowledge for future practice. They were anxious about not being sufficiently competent in community orientation or areas like cancer and hematology. They felt angry when their training was disorganized, with sessions either canceled or missing instructors. They felt anxious about not being fully prepared to direct their future careers autonomously.

> *General practice [has] such a large scope…it is an area that we do not get taught a lot about. Each day I am seeing something new and coping with more uncertainty…I think that plays a lot into the fear of what I do. (Jake, trainee)*

A final example of nonfulfillment centered around providing consistent, high-quality patient care. Most GPs, both

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trainees and newly practicing, felt anxious and frustrated by the time pressures they believed would always impact their decision-making in deleterious ways for patients. They feared missing critical details or making mistakes while trying to keep to appointment times and maintaining focus despite decision fatigue. Frustration came from the thought of never having the kind of time they wanted with patients, now or later in their careers.

> *[Y]ou feel like you are firefighting…that sense of being overwhelmed and a loss of control because most medics are on some level perfectionists and want to do the absolute best for every single patient. But when you apply huge amounts of pressure to the service, you cannot do the job as well as you want to. (Sabrina, trainee)*

Career Agency Following the Violation of Expectations

Trainee and new GPs responded to their unfulfilled expectations through a mixture of career agency enacted in three ways (Figure 1): (a) a "satisficing approach" to make do with early work choices while pursuing a long-term career, (b) everyday survival tactics to maintain a core interest in patient care, and (c) compartmentalizing work life to preserve personal identities.

Satisficing in the present to preserve a long-term career. The satisficing approach involved GPs making choices that would be sufficient to sustain a career in the present while also preserving career longevity and satisfaction in the longer run. All participants utilized agency in this form by controlling either their career structure or the immediate work context. For example, choosing to reduce exposure to patients through part-time work and shorter workdays.

> *I would have worked full-time as an unmarried man with no family to support. But I have no desire to do that based on two years of training. I will go part-time or work…shorter sessions because I would like to have a life at some point…do [something] meaningful…. (Male 2, trainee)*

Another choice entailed avoiding traditional settings such as practices where they might be expected to invest as owners and instead working in noncommittal settings such as urgent care centers on part-time contracts. Others aimed to become a "portfolio GP," working in multiple jobs or roles simultaneously rather than holding one full-time salaried job with a steady patient panel. Reflected in these highly agentic decisions were self-interested attempts to gain back control over the immediate work environment and make future careers more palatable.

> *You have got more control as a locum [contract physician]. You say what you want to do, which days you want to work and…what you do within the day. Whereas if you are salaried, you have to do what is dumped on you, it is quite a pressurized environment so there could be a lot coming your way…. It is [not] flexible and well-paid. (Jim, new GP)*

Everyday work tactics to preserve core competence in patient care. This form of career agency incorporated "survival tactics" that enabled the preservation of physicians' core interest in high-quality patient care through either everyday job crafting or by finding a well-supported work environment. The former included modifying the workday to build in "pressure relief valves" for tasks that did not involve direct patient care. For example, creating housekeeping time-outs between patients, coming in earlier in the morning prior to starting the patient care schedule, or staying late to complete outstanding tasks.

> *I come in and start off with get[ting] some admin out of the way, just to feel like I know where I stand before… seeing patients. […]And then more time over lunch for admin or home visits. And…finishing with admin at the end to clear…it as I go. (Keira, trainee)*

The latter included proactively reaching out to others for support. For instance, joining a medical practice with a mentorship or "buddy" system or liaising with specialist hospital services for advice when needed.

> *I go to a Balint and First Five Group [peer support groups]. These are important to…avoid burnout, retain a sense of perspective, and have a bit of an offload about…difficult patients. (Jena, new GP)*

Compartmentalizing work life to preserve personal identity. A final way in which many young GPs exerted career agency involved modifying behavior to firewall their personal identities. This minimized negative emotional states by increasing control at the individual level by, for example, not taking any work home and engaging in nonwork activities regularly to bracket their day-to-day work life. Firewalling their identity in this way preserved their work self by giving them physical and emotional time away from the job and returning to it fresh the next day. It also allowed GPs to engage with other aspects of their identity that they valued, for example, their social and family life.

> *Socially and at home, I want to leave work behind. You need the emotional space. I find work exhausting, I am not going to lie, it is a relentless day…. I was "me" before I was a "doctor." (Rachel, new GP)*

> *It is a form of escapism…. Remodel[ing] your life a bit to feel that you have some control over your destiny. Pursuing other avenues could feel like a bit of a relief or a release. It is trying to build excitement in the prospect of another life, without having it. (Kim, trainee)*

Discussion

Contributions to Theory

This study has examined the emotionally unfulfilling experiences of early-career physicians and the forms of career agency exhibited in response to them. It makes two scholarly contributions to

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the management studies literature focused on professions and career sustainability. First, it casts light on two sets of factors affecting psychological contract fulfillment specific to the early career stage. The first of these factors includes workers' ideological psychological contracts that can drive the desire for work meaningfulness, the need to self-determine, and develop competence. In this study, these expectations arose from physicians' specialty training experiences but, interestingly, were also brought "preformed" to the training based on cues received from the social environment. This illustrates the salience of the preemployment and early socialization phases (Rousseau, 2001) in physician psychological contract formation. A second factor that shapes emergent career expectations is an individual's self-concept, which has also been reported to vary by career stage (Low et al., 2016). In our sample of early-career doctors, this was characterized by the drive to self-determine and control future careers and derived from the importance given to valued elements of their identity. Threatening these elements led to career decision-making increasingly driven by a desire to gain back control (Guest & Rodrigues, 2017). As such, highlighting the dual role of self-determination and control in shaping physician career decisions brings concepts such as individual self-efficacy into the study of how professionals adapt to changing circumstances in their work environments.

A second contribution of this study is that it demonstrates that the forms of career agency exhibited in response to unfulfillment experiences are shaped by the career stage at which professionals are located (Martin & Lee, 2016), supporting the view that agency is temporally varied (Lam & de Campos, 2015). However, in contrast to conceptualizing career agency as a positively framed aspect of professional behavior (Lam & de Campos, 2015), this study presents a new self-interested side to physician agency that is rooted in expectation management and a drive for greater personal control. Such self-interested agency led GPs to exhibit career behaviors that were transactional, focused on the short term, and potentially destructive for their ideological expectations in the long run. The forms of agency displayed were also unique in being less cognitively driven and more emotionally laden (Baruch & Rousseau, 2019). The physician agency in our study had a reactionary flavor—an emergent panic that left them with few choices other than considering quick and less well-thought-out career decisions, without room for trial and error or cues from the outside world. The significant role played by affect in shaping career agency indicates physicians' immersion in high-velocity health care environments as creating the type of uncertainty that moves them to respond in less rational or deeply experiential ways (Eisenhardt, 1989). This is different from previous research that finds agency as being more carefully thought-out and adaptive considering unmet expectations, particularly for highly trained professionals (Lam & de Campos, 2015). This study suggests a "situational" dimension to early career construction for doctors that is derived from their own rapid assessments of and reactions to promises they believe are eroded.

Practice Implications

Our study has broader implications for the talent management of physicians seeking sustainable medical careers and how employers and managers should treat physicians in terms of recruitment and retention efforts. Recognizing that one size does not fit all, the approaches outlined in this section are streamlined for the early-career doctor. The nationalized health care system of the United Kingdom offers a stronger ability to effect these changes on a broader scale. The U.S. context of multiple individual employers alongside more varied employment options also presents greater variety of opportunities and mechanisms for change, although more challenging given physician employment structures. We discuss each implication in turn.

First, our study reflects the need for managers to play a more proactive role in supporting those newly establishing their careers. This entails, at a macro level, continuing to cultivate a renewed compact that redefines the symbiotic relationship between primary care physicians and employers by employing a "highly participative approach" (Edwards et al., 2002, p. 836) to individual careers. This means employers and physicians collaborating to help ensure the latter's career development and satisfaction. Managers should be communicating to young professional employees that they can use the organization to help them meet their sustainability goals and self-manage their careers (Sturges et al., 2010). This compact should also be rooted in empowering the agentic capabilities of physicians, so that the career decisions taken benefit not just their individual selves but also the organization.

Second, critical to such a reconceptualization of physician career development is for managers to provide the specific resources and opportunities that physicians seek at an early career stage. Our study indicates that these include competencies such as up-to-date diagnostic and consultation skills, safeguards against professional risk, time and workload management strategies, and opportunities that promote job satisfaction and work–life balance. The latter can be facilitated through improved workloads, job rotation and sharing options, structured time off, and flexible work benefits that match physician expectations. Building an organizational culture around such resource provision would not only enhance positive career self-management behaviors (Sturges et al., 2010) among physicians but also signal that the employer cares about the employed physician, enhancing the prospects for mutual trust. Providing these types of resources and opportunities can help mitigate some of the negative workforce trends being seen today with respect to doctors, across all health care systems, such as early burnout and career regret, greater turnover in the primary care physician space, job dissatisfaction, and increasingly part-time work patterns (Bugaj et al., 2020; Dyrbye et al., 2018). Physicians often feel they are alone in dealing with the adversarial settings in which they work. This collaboration between physician and employer can help lessen this feeling. Existing literature points toward several structures and systems through which physician managers can build the career resources outlined above. These include, for example, professional development centers that provide career guidance, counseling, and mentoring; individualized

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career tracking systems; dual-ladder systems that allow doctors to traverse between, for example, medical versus managerial paths; variable benefit packages that allow them to pick and choose based on their personal needs; and succession planning programs (Wilhelm & Hirschi, 2019).

Finally, and focusing specifically on the promotion of sustainability at the early career level, it is for health care organizations to play a more omnipresent and meaningful role during doctors' education and training. This is especially pertinent in the context of medical education given, in our study, the lack of concerted organizational support or facilitation provided to trainee and newly established GPs as they went about making self-directed career choices. Clearly, our study showed that the training of this professional group leaves much to be desired when it comes to coping with the realities of medical practice, regardless of whether it is the U.K. or American context. For example, we found young GPs as feeling unprepared, less autonomous, and generally more powerless than they had previously imagined and therefore increasingly frustrated and disillusioned. This is seen in young American primary care doctors, as well. Notwithstanding the role that education providers should play in this regard, health care organizations could add even more value by engaging with local training programs and national accreditation bodies to provide a more realistic view of the demands of work and better align education and training for such realities. There are partnerships to be had here as well with medical schools and residency programs. There are several mechanisms through which this can be achieved, for example, by enabling the creation of an "ecology of professionalism" (Goldstein et al., 2006) that keeps training curriculum and experiences closely connected with the prevailing practice context, incorporating management skills as a critical element within the training curriculum, and bringing together insights from future employers that help trainees shape the direction of their careers early on. As such, managers should creatively engage with training and education to shape and influence the development of the physicians that will form the future talent of the profession.

Limitations and Future Research

This study was exploratory and used a smaller interview data set to consider a complex set of phenomena, namely, the linking of expectations, emotional responses, and agentic behaviors. Future studies could undertake a more fine-grained analysis by substrata such as gender and past work experience to illuminate these dynamics further. In addition, linking back participants' adaptive career thinking to perceived violations was complex and might be more reciprocal than is presented in the findings. Future research might wish to explore this reciprocity between participants' emotional responses to perceived violations and the adaptive career thinking following it, specifically the role played by the more self-reflective, cognitive aspects of decision-making that might accompany the more immediate emotionally driven decisions following violation. Furthermore, there was not enough opportunity to triangulate study findings—the analysis of perceived violations based entirely on the views of early-career professionals without considering alternate actor perspectives, which future research might wish to incorporate. Another aspect that future research might wish to explore relates to further examining the self-determination expectations that might be unique to young medical professionals. Although this study indicated the value placed on related dimensions such as autonomy and control, it may be worth understanding what drives this need for self-determination considering the prevailing career rhetoric which operates in a context that is increasingly structured, managed, and controlled. It might also consider the effect of high-velocity environments, such as those described in this study, and additional situational factors that impact professionals' notions of the world and examine whether they steer career agency in certain ways. Relatedly, future work could follow up with these same professionals in 5–10 years' time and study how the career choices made by them shape their work identities.

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