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RESEARCH ARTICLE

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# Contrasting views on the careers of classic professionals: Exploring the careers of physicians

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**Abstract**

Studies into professionals' work show that their autonomy and mobility have decreased. These developments are likely to have implications for the careers of professionals. Despite these developments, the career literature continues to emphasize high mobility and strong individual agency as two core characteristics of contemporary careers. These contrasting views, together with a lack of studies into the careers of professionals, result in unclarity about the careers of professionals. This study explores the career experiences and career characteristics of classic professionals in 38 semi-structured interviews with physicians. Findings show that physicians' mobility is limited, as changing occupations and moving to other organizations is rare, and that they do not take full responsibility for their careers. These findings contribute to the literature on professionalism and careers by providing contextual knowledge on professionals' careers. This study is relevant for organizations, (HR) managers, and occupational communities wanting to implement tailored career support for professionals.

**KEYWORDS**

agency, career characteristics, career mobility, contextualized careers, job autonomy, physicians, professional careers

## INTRODUCTION

Several developments in the professional field are affecting some of the core characteristics of professionals' work, which is likely to have implications for professionals' careers. Two characteristics that distinguish professionals from non-professionals and that are subject to change are professional autonomy (Noordegraaf, 2015) and mobility or independency (Kirkpatrick & Noordegraaf, 2015). Scholars describe how professionals' full autonomy is being eroded and bounded by institutional templates and organizational policies in an increasingly institutionalized work environment (Muzio et al., 2013). This decrease in individual autonomy is likely to affect not only professionals' work in the short term but also their further careers. Less individual autonomy and a strongly institutionalized work environment can, for instance, result in less independency in making career choices. Nevertheless, even though professionals' autonomy is decreasing, professionals still have considerable autonomy compared to other types of employees (Kipping et al., 2019).

A second change in professionals' work that is likely to affect their careers is a decrease in their mobility. A persistent image of professionals in the literature is that of highly mobile, sole practitioners who work independently or in small firms or partnerships (Kirkpatrick & Noordegraaf, 2015). Nowadays, professionals increasingly work in large organizations. Some professionals are employed by large organizations, while others work as independent professionals who run private practices within large organizations. This increase in organizational dependency has reduced professionals' mobility (Noordegraaf, 2020). A reduction in mobility is likely to affect professionals' career paths and affect the range of choices open to them.

The aforementioned developments in professional work seem to contrast the developments described in the

career literature. The literature on professionalism reports a decrease in autonomy (Muzio et al., 2013) referring to reduced freedom and independence in job decisions and how work is carried out (Morgeson & Humphrey, 2006). Career scholars, instead, assert that individual agency is increasingly important in the sense that individuals take proactively charge of their careers and adapt to career events and changes which is stressed in influential career theories (e.g., de Vos et al., 2020; Hall, 2002). The use of the terms autonomy and individual agency varies to some extent, where (1) autonomy is described as a job characteristic (Morgeson & Humphrey, 2006), while taking agency refers to an action (de Vos et al., 2020), and (2) autonomy mainly relates to job design (Morgeson & Humphrey, 2006), while agency is often studied in relation to career design (de Vos et al., 2020). Despite this variety, both autonomy and agency refer to employees' freedom and control over making choices in work or career design. As such, the decrease in autonomy, as explained in the literature on professionals (e.g., Muzio et al., 2013), seems to contradict the development of increasing individual agency as described in the career literature (e.g., de Vos et al., 2020; Hall, 2002).

Moreover, while the professionalism literature describes a decrease in mobility (Noordegraaf, 2020), many career scholars describe a change from employment unfolding in a single employment setting towards boundaryless careers (Arthur & Rousseau, 1996). In boundaryless careers, employees can move across various types of boundaries (e.g., organizational and occupational boundaries) (Verbruggen, 2012). Mobility in this sense can refer to the actual movement of employees, understood as physical mobility, which can both concern possibilities for horizontal mobility (e.g., task differentiation) as well as vertical mobility (e.g., promotion possibilities) (e.g., Chudzikowski, 2012). Or mobility can refer to the capacity to move as seen through the eyes of the career actor, understood as psychological mobility (Sullivan & Arthur, 2006).

These contrasting views result in a lack of clarity regarding the careers of professionals. In addition to these contrasting theoretical perspectives, there is a lack of empirical studies examining the careers of classic professionals. As a result, it is unclear what the developments towards less mobility and autonomy in professional fields imply for contemporary professional careers.

Recently, Brock et al. (2014) emphasized the importance of devoting more scholarly attention to changing career structures and the experiences of professionals. This study responds to this call by exploring the career characteristics of physicians as classic professionals (Abbott, 1988. This study addresses the following research question: What role do two central features of careers, individual agency and mobility, play in the careers of classic professionals? These two career characteristics are examined as they are seen as the two central features of contemporary careers (Gubler et al., 2014) and are subject to change in professionals' work (e.g., Kirkpatrick & Noordegraaf, 2015). This study aims to better understand classic professional careers, by exploring the careers of physicians in a review of the literature coupled with semi-structured interviews.

This study contributes to the literature by drawing on knowledge from two distinct literature streams: the literature on professionals and the career literature. To date, these literature streams have largely developed in isolation, which is for instance reflected in separate language used. Whereas career studies refer to agency, when referring to employee's freedom and control over choices in job or career design, the professionalism literature uses the term autonomy to describe a similar phenomenon. Knowledge from both fields can complement each other and enhance the understanding of the careers of professionals. The literature on careers sheds light on the characteristics of contemporary careers as described in influential career theories (e.g., the boundaryless career theory, Arthur & Rousseau, 1996; the protean career theory, Hall, 2002; and more recently the sustainable career theory, de Vos et al., 2020). However, this body of literature fails to give attention to occupational differences and contextual influences. This is problematic as studies have shown that contextual changes can impact careers, for instance by altering personal ideas about the course of one's career, affecting career behavior, and positively or negatively affecting career opportunities (Cohen & Duberley, 2020). Further, empirical studies have shown that career experiences are context-specific (e.g., Crowley-Henry et al., 2018). As such, several calls have been made to explore the careers of specific occupational groups. Previous studies have for instance done this for the careers of migrants (Crowley-Henry et al., 2018), university staff (Van der Heijden et al., 2022), and top managers (Schmid & Mitterreiter, 2021). This study contributes to this literature by examining the careers of another occupational group, namely, that of professionals. This is done by drawing on the professionalism literature which is highly context-specific and offers relevant insights into the characteristics of professionals' work and work environment.

## THEORETICAL BACKGROUND

### Classic professionals' work characteristics

The term professional is increasingly used, and a growing number of employees have been labeled professionals (Noordegraaf, 2007). The work of classic professionals (e.g., physicians, judges, lawyers, and accountants; Abbott, 1988) is characterized by a high degree of (1) job autonomy, which is for instance reflected in the

autonomy that professionals have to regulate client and case treatment; (2) independency and mobility; (3) specialized expert knowledge and skills acquired after a long period of education; (4) professional control and self-regulation as for instance reflected in regulatory mechanisms including oaths, educational programs, and codes of conduct; and (5) the social closure of the profession as for instance reflected in selection processes organized by the profession itself (Kirkpatrick & Noordegraaf, 2015; Noordegraaf, 2007, 2016). The above characteristics more accurately characterize the work of classic professionals than that of "newer professionals" such as academics (Gander et al., 2019; Tziner et al., 2015), consultants (Kipping et al., 2019), and nurses (Noordegraaf, 2007).

The characteristics of professional jobs have altered due to a changing relationship between professionals and organizations. Professionals work in an increasingly institutionalized work environment. One group of professionals is employed by the organization, while another group works independently by running their own practices within large organizations. The group of professionals who are employed by organizations is growing. As a result, organizational influence over professional action has increased, and independent professional action has been constrained by organizational policies and regulations (Adams, 2020). This development is described in both negative terms, where the involvement of organizations is seen as an "alien intrusion" or "encroachment" (Noordegraaf, 2015), and positive terms, where professionals, described as "reconfiguring professionals" or "organizing professionals," actively find more effective ways of working within organizations (Kirkpatrick & Noordegraaf, 2015). Not only is the work of professionals being subjected to more organizational control but present-day professionalism has also become more associated with inter-disciplinary collaboration (Kirkpatrick & Noordegraaf, 2015). These developments are likely to reduce professionals' autonomy and mobility due to their embeddedness in organizations with organizational regulations and standards to which professionals must adhere. Table 1 summarizes these contextual changes, the consequent changes in the work of professionals, and the expected changes in professionals' careers.

## Contemporary career theories

The developments in professionals' work go alongside the ideas in contemporary career theories. Two career characteristics are central to contemporary career theories: career mobility and individual agency (e.g., Gubler et al., 2014). In the past, mobility tended to address linear career paths within a single organization. Contemporary career theories on the other hand increasingly stress the possibility of employment beyond a single organization and occupation resulting in organizational and occupational mobility (Forrier et al., 2009).

A second central career characteristic in contemporary career theories is the importance and presence of strong individual agency (e.g., Hall, 2002). Careers are perceived as increasingly independent of organizations, resulting in importance being attached to employees autonomously managing their careers (Briscoe et al., 2006). This new role for employees is reflected in the rise of concepts such as proactive career behaviors and career self-management that emphasize the importance of individual agency (de Vos et al., 2009).

## Contemporary career theories overlook contextual influences

Career theories tend to have a general focus and are based on broad assumptions that have obscured the complexities and nuances of careers (Clarke, 2013). A recent systematic review of van Harten et al. (2021) shows that studies examining job transitions also have such a general view as they mainly focus on employees in general and do not specify between sectors and occupations (e.g., Forrier et al., 2015; Nelissen et al., 2017; Raemdonck et al., 2012). This general view neglects that some career principles may be context- or occupation-specific. For instance, it is argued that the assumption of increasing career mobility is only applicable to certain occupational groups. This is assumed to hold for highly educated and autonomous elite groups who can make decisions about mobility (such as technical, professional, and managerial groups) and may not hold for lower-skilled workers or minorities (Crowley-Henry et al., 2019; Inkson et al., 2012).

**TABLE 1** Shifts in professional work (due to a changing context)

| Aspect of professional work | Shift in context | Changes in professional work | Expected changes in professional careers |
|---|---|---|---|
| Agency/autonomy | Professionals work in an increasingly institutionalized work environment | Increasing bureaucratic control and increased regulations | Professionals individual autonomy in making career decisions is bounded by "outside" standards and regulations |
| Mobility | Professionals are increasingly employed by, or part of, large organizations, and increasingly work in interdisciplinary teams | Professionals must collaborate, and must adhere to organizational standards and policies | Professionals mobility is reduced by their embeddedness in organizations and teams |

Other career scholars argue that this idea of strong individual agency is mainly based on North American career studies, questioning its generalizability to the European context. This idea of strong individual agency is criticized as it is argued to underestimate the importance of structural restrictions and the way in which structures, such as the labor market and institutional rules and regulations, may impact career behavior (Forrier et al., 2009). The European angle on careers emphasizes the importance of acknowledging contextual factors that are important to consider limiting individual agency (e.g., Mayrhofer et al., 2004; Mayrhofer & Schneidhofer, 2009). Contextual factors can affect the degree of control that employees have over the facets of their careers (Sulbout et al., 2021). An overemphasis on individual agency is criticized for assuming an unrealistic level of foresight and control over the course of one's career (Inkson et al., 2012) as it for instance neglects the existence of "disruptive and extraordinary events that are caused by factors outside the individual's control" (understood as career shocks) (Akkermans et al., 2018, p. 4). Some career scholars therefore argue that rather than emphasizing the role of individual agency, one should focus on the interplay between context, time, and individual action (Barley, 1989; de Vos et al., 2020). Barley (1989) has stressed this in his notion of "career scripts" referring to the dynamics between individual actions and institutional mechanisms. Barley (1989) argues that institutions (such as organizations or professional communities) encode career scripts which impose interpretative schemes, resources, and norms which affect individual career choices (Cappellen & Janssens, 2010). This emphasizes the importance of considering the influence of cultural, organizational, and institutional factors on individual careers (Akkermans et al., 2018; Gander et al., 2019).

Despite these criticisms, the assumptions of high career mobility and strong individual agency are still presented as self-evident and pervasive in twenty-first century careers (Arnold & Cohen, 2008). In this study, we examine physicians' experienced career mobility and individual agency to examine whether these core assumptions in the career literature hold in a professional context.

## Characteristics of professional careers

Table 2 summarizes the main conclusions from the literature on professionals and on careers regarding agency and mobility. This reflects what these career characteristics used to entail in traditional careers and describes what these career characteristics now encompass in contemporary careers.

In addition to the contradictory perspectives on the careers of professionals in the professionalism and the careers literature streams, findings in empirical studies further question the core assumptions in career studies concerning high career mobility and strong individual agency in professional careers. First, empirical studies show that the average organizational tenure of highly educated professionals is usually high (e.g., Venhorst et al., 2017). For physicians specifically, one study found that, in a comparison of 38 occupations, physicians were the least likely to change jobs (Hilbers, 2017). Further, Sinsky et al. (2017) found that only 1 in 50 physicians had the intention to leave medicine. Of the physicians that do leave a position, only a small minority leave their profession, while the majority leave their current practice to either retire or work in another organization. Another factor is that classic professionals are moving towards greater specialization (Crul, 2002; Mebius, 2018). These results suggest that mobility might be less common for classic professionals than is assumed in contemporary career theories. The increasingly specialized knowledge of classic professionals (Noordegraaf, 2007) may not be easily transferable to other functions, further reducing opportunities for job mobility.

Second, classic professionals may not take advantage of their strong autonomy as much as is assumed in contemporary career studies. Evidence in empirical and professional articles indicates that professionals, and physicians specifically, do not always utilize individual agency in their careers (e.g., van Leeuwen et al., 2021). Rather, studies refer to serendipitous or circumstantial career choices (Borges et al., 2012) and a lack of career planning (Löyttyniemi, 2001).

The inconsistencies between the literature on professionals and on careers, together with the outcomes of empirical studies into professionals' careers, lead to the proposition that professionals' mobility is not as high as generally assumed in contemporary career theories and that professionals do not utilize their individual agency or make autonomous career choices to the extent described in the literature on careers. The following explains the methods and empirical findings of interviews held with physicians to further explore what role mobility and individual agency play in the careers of physicians.

**TABLE 2** Career characteristics noted in the literature on professionals and on careers

| Career characteristic | Literature on … | Traditional careers | Contemporary careers |
|---|---|---|---|
| Agency/autonomy | Professionals | Individual autonomy | Bounded autonomy |
| | Careers | Organizational responsibility | Individual agency |
| Mobility | Professionals | Mobile practitioners | Less mobility |
| | Careers | Low mobility | High mobility |

# METHODS

This study was conducted among physicians of two Dutch hospitals, an academic hospital and a general hospital. Legally, hospitals in the Netherlands are private organizations providing a public service (Knies et al., 2018). The sector includes general and academic hospitals. Physicians' contract types and career possibilities vary, in part depending on the hospital where they work. In general hospitals, physicians are either employed by the hospital or are self-employed and run partnerships within hospital buildings. In academic hospitals, all physicians are employed by the hospital. Furthermore, the tasks of physicians working in academic and general hospital differ. Physicians in general hospitals mainly provide care, while physicians in academic hospitals are often also involved in research and education alongside care-related tasks. The complexity of the care delivered is also often higher in academic hospitals than in general hospitals. All physicians in the Netherlands are members of occupational professional associations. For instance, all cardiologists working in the Netherlands, regardless of which hospital they work, are members of the Dutch Association for Cardiologists.

The aim of this study is to explore the career experiences and career characteristics of classic professionals. A qualitative approach fits the explorative character of this study as qualitative studies are useful to explore new areas (Hancock et al., 2001). Moreover, qualitative data can reveal interviewees' understanding of their careers (Brinkmann, 2014). Specifically, perceptions of, and experiences with, careers were examined in the interviews.

Semi-structured interviews were held with 38 physicians from two Dutch hospitals. Semi-structure interviews employ a relatively detailed topic list that is guided by the literature (Appendix A), while remaining responsive to participants by leaving sufficient room for respondents to raise topics that are relevant to them (Bartholomew et al., 2000). This is an appropriate technique to use in this context as there is a lot of knowledge on careers in general that is used to structure the interviews, while at the same time, this technique allows to grasp new insights which is important given the lack of contextual knowledge on the careers of professionals. This qualitative interview technique allows to grasp the potential variety in career paths that physicians may have.

Purposeful sampling was used as it allows to capture diversity and variation in the sample, for instance varying perspectives and behaviors of physicians' careers (Creswell & Poth, 2007; Eisenhardt, 1989). One member of the medical staff in the general hospital and the director of the department of Quality and Safety in the academic hospital provided a list of physicians varying on age, gender, type of contract, size of department, and role in the department. These physicians were then approached for an interview. They varied in age (34–65 years old), gender (30% women), type of contract (71% employed by the hospital, 29% independently established), size of department (3–60 physicians), and roles in the department (e.g. educator, researcher, or manager) (see Appendix B for a detailed description of the respondents). These selection criteria were adopted as these aspects have been shown to affect career perceptions, career behavior, and career policies (e.g., Ballout, 2007; Shanafelt et al., 2014).

## Data collection

Face-to-face interviews were held at the participants' workplaces and typically lasted between 45 and 60 minutes. The interviews were all conducted by the same researcher. Prior to this data collection, the topic list was pilot tested in two interviews with physicians to develop and clarify the main interview questions. Further, the transcripts of the first three interviews were examined and discussed by the researcher conducting the interviews and a senior researcher to ensure the quality of the content.

Each interview started by reading through the participant consent form to inform the interviewee of issues related to confidentiality and anonymity. Following this, semi-structured questions were asked to explore physicians' career perceptions. Physicians were invited to talk about their own career experiences. To examine the degree of career mobility, they were asked about the career steps they had taken (not limited to promotion possibilities) and factors affecting their career choices. In addition, to examine the degree of individual agency and autonomy in career decisions, they were asked about their own role and actions in managing their career. They were also asked about the role of their organization and manager in offering career support.

All the interviews were audio recorded and transcribed. Interviews were coded in the program NVivo 11.4.3, which enables to code interviews and structure data according to a coding scheme. Data were analyzed using open, axial, and selective coding (Boeije, 2005). In the first stage, interviews were read several times and open coded, resulting in a list of initial codes. Next, axial coding took place where the data were categorized in themes. This resulted in a coding scheme with career mobility and career responsibility as main themes (for the entire coding scheme, see Appendix C). This coding scheme was used in the final stage to selectively code all the transcripts, to categorize the data in sub-themes. Analysis focused on words describing the frequency of mobility ([un]common, rare, often, etc.) to examine whether the respondents considered mobility *high*, and on words describing the strength of individual responsibility (mainly, predominantly, primarily, etc.) to study whether respondents perceived their individual agency as *strong*. Finally, the codes were analyzed in relation to the central research question. Please see Table 3 for an example of the coding process.

**TABLE 3** Example coding process

| Piece of transcript | Open coding: Initial code | Axial coding: Theme | Selective coding: Sub-themes |
|---|---|---|---|
| *In terms of content, it does not matter for me If I work here, in the Amsterdam Medical Center, or at the Erasmus Medical Center in Rotterdam. This may be different for physicians who have hyper-specialized work.* (P22) | Working in different organizations | Career mobility | Organizational mobility |
| *As employers, we do not support this, we do not give information on that. We should not interfere or prescribe how physicians should do this.* (P23) | Employer support in providing career possibilities | Career responsibility | Organization and Manager |

# RESULTS

The following describes the findings of the interviews about physicians' careers. Specifically, physicians' experiences with career mobility and making autonomous career decisions and taking individual agency for their careers are discussed. The role that organizations and managers play in the careers of professionals is further discussed.

## Physicians' experiences with career mobility

Physicians describe their mobility, in terms of changing jobs, specialization, or organizations, as limited. Physicians state that they are trained for a specific profession and, once they start to work after a lengthy education, changing jobs is rare (P22) and changing organizations is uncommon:

> As a physician, you work for the same boss for a long time. (P7)

Several barriers to mobility were raised. First, physicians perceived a lack of opportunities. Physicians for instance mentioned that their specialized expert knowledge limits possibilities to enter a new field (P14). The degree of specialization differs for physicians working in different hospital types. Physicians in academic hospitals usually have more specialized work than physicians working in general hospitals. A physician in an academic hospital mentioned that he could find work elsewhere but that this would be more difficult for some of his colleagues:

> In terms of content, it does not matter for me If I work here, in the Amsterdam Medical Center, or at the Erasmus Medical Center in Rotterdam. This may be different for physicians who have hyper-specialized work. (P22)

Employment opportunities are also affected by the number of hospitals within a region. There are only seven academic hospitals in the Netherlands compared to 71 general hospitals (Volksgezondheidenzorg.Info, 2018). This results in fewer opportunities to change organizations for physicians who work in academic hospitals. A physician working in an academic hospital explained that he can change hospitals but that he does not prefer to make this change:

> [Changing organizations] often requires you to move to another city, resulting in a lot of hassle. That is the case with large hospitals. For me, the large academic hospital in Nijmegen is a good possibility, or Amsterdam. Alternative organizations are limited since my specialty is only performed in large academic centers. You must like that [changing organizations] or you must be very ambitious. There must be a good reason why you would change organizations. (P14)

Furthermore, physicians mentioned financial barriers as limiting mobility possibilities. Physicians might pay around 200,000 to 300,000 euro to join a partnership, and this creates barriers to moving on.

> Then comes the problem of goodwill. If you enter a partnership, you must pay for the goodwill to the leaving colleague, which is around an average year's salary. People invested that when they started to work in the partnership, and of course want that money to be returned when they leave. (P6)

Another example of finances limiting possibilities was raised by a physician who works as a manager. He observed that some physicians in his group became trapped because of their financial choices, such as having a large mortgage.

> People should realize that it is important that they can work parttime from an age of around 60 years. This implies that you need to arrange your life in such a way that this is

> financially possible. For some people this is an issue. They want to work parttime, but they cannot because of a large mortgage. I do not understand them. I think, you have earned so much throughout your entire life, so maybe you could have used that money differently. (P23)

Other reasons raised by physicians for not taking up mobility options were related to placing a low desirability on mobility. Changing occupations was, for instance, described as "unattractive" or "a downgrade" (P6, P19) because physicians have invested a lot of time and energy in their education and now earn a substantial salary. For those physicians who work as independently established practitioners in general hospitals, switching to being employed by a hospital is often seen as financially unattractive and unappealing as they do not like the way the work is then organized (P6). Furthermore, physicians were not inclined to change organizations simply because they were satisfied with their current workplace. A physician described the hospital where he worked as the most attractive and best developed in his field and accordingly does not want to switch organizations (P14). Another male physician explained that he was reluctant to change organizations since moving has consequences for his family life.

> I have a family. So why would I travel back and forth to Amsterdam or Almelo while we all have our lives in Utrecht? (P29)

In contrast to the general lack of intention to move organizations, two physicians expressed serious intentions to change organizations. One of them was planning to migrate to continue his career abroad (P5). For the other physician, a lack of employment opportunities in his region might be a reason to move to another hospital. The labor market for the work of his partner, an orthopedic surgeon, is tight, which makes it hard to find work within the region they live. As the system requires physicians to keep working to retain their registration, they might have to move to another city, or even abroad (P34).

Despite the lack of mobility in terms of jobs and organizations, physicians did raise several possibilities for changing tasks. A radiotherapist (P7) mentioned the possibility of changing focus areas within a specialty, which he could address brains, lungs, or breasts. In fact, he deliberately changed his focus area every now and then to create new challenges. Another possibility frequently mentioned by physicians working in academic hospitals was to specialize further, to become a "super specialist" (P14, P35). Another physician noted that the possibility for this depends on your specialism:

> Physicians with a surgical specialty can become an expert in one type of operation and really excel in this, and build their own line of research, (…) but this is harder for physicians with a diagnostic specialty. (P4)

Furthermore, multiple physicians referred to the roles that they can fulfill within their professional associations. One physician for instance mentioned that he has been active in various committees in his professional association (P18). Another one explains that he wishes to fulfill a role in the board in the future, preferably in his professional association (P32):

> My next career step is that I will become a board member, preferably in my professional association. I see the value of fulfilling this role in my professional association. (P32)

Besides changing the content of clinical work, physicians can develop into different areas including education, management, and research, for example, by providing education to medical residents or joining a research project or committee. The possibilities for this type of mobility depend on the hospital, the department, and the professional association. For instance, engaging in research projects is more feasible in academic hospitals than in general hospitals. A physician also mentioned the loss of his role in training medical residents as this requires a department to be accredited to provide this.

> Unfortunately, we have lost the ability to provide education to medical residents as our professional association decided that they can only be educated in leading clinical hospitals. This is a major frustration which hurts me. (P29)

These examples mainly refer to task mobility in terms of horizontal movement. Task mobility in terms of promotion is limited for physicians as they enter the hospital in an already fairly senior position (P10, P22). The number of promotion possibilities depends on the hospital where physicians work and their employment contract. The stronger hierarchy in academic hospitals, relative to general hospitals, results in rigid promotion trajectories to become a professor, head of department, or "super specialist" (P14, P35). However, physicians in general hospitals have fewer promotion possibilities, since there are no trajectories to become a professor for instance. Moreover, for physicians who work in independently established entities, possibilities for promotion are rare due to the absence of a hierarchy. A physician, who works as an independent established practitioner, explained the barely existing hierarchy as follows:

> In our independently established entity, we have a board consisting of a chairman and under him, or I should say alongside him, there are a secretary and a treasurer. (P11)

Despite the limited possibilities for task mobility that physicians have, a physician in the academic hospital described how many physicians are unfamiliar with the necessary career steps to grow into a certain position:

> If you would ask physicians in this hospital, many would not even know the necessary career steps to become a professor. In the US, it is very common that you start, then you become a clinical instructor, then an assistant, associate, and in the end a professor. This is less known among physicians in the Netherlands. (P37)

## Professionals' individual agency and autonomy

The following discussion describes physicians' experiences with making autonomous career decisions and taking individual agency for their careers. Physicians often very consciously chose a specific specialty. One physician for instance explained that she chose her sub-specialization because there was a good labor market with plenty of job opportunities (P19), another one explained that she chose her specialty because she had always wanted to work in that area (P25), and another physician explained that she consciously chose to work in a certain hospital during her time as a physician assistant as she would be given a lot of responsibility (P28). In line with this, physicians also actively develop skills for their clinical work. This is stimulated by the registration system which requires that physicians follow courses and undertake training to stay registered. These activities are mainly medically oriented. Occupational communities play an important role in this clinical development of physicians as they often arrange this kind of activities (P28, P30). A physician explains that occupational communities play an important role in the transfer of clinical knowledge and continuous clinical professional education:

> Our field is constantly in flux. This emphasizes the importance of continuous professional education. As such, there is a very close collaboration between physicians with the same specialty within the Netherlands. This is especially stimulated within professional communities where there is attention for the transfer of knowledge. (P10)

Beyond this, physicians rarely invest in non-clinical career development and tend not to reflect on their careers or make conscious career choices once they have opted for a certain specialty. Rather, career choices are largely influenced by external factors. This is stressed in the language used by physicians to describe their career paths, such as "I have drifted into this position" (P5, P20) and "I got this position [as a manager in the board of an external organization] accidentally" (P24). Furthermore, physicians provided several examples showing that their career path is influenced by others. One physician commented,

> It was not a very conscious choice to do research, that goes without saying. And the part where I became an educator, that came about because others in my group pointed me in this direction. It is quite nice to coach younger people, but it has not been a deliberate choice that I made, thought about, or prepared for. (P14)

Another physician explained that she treats certain cases because her colleague no longer wants to do these.

> An older colleague wanted to get rid of that task because he would soon retire. He said: "Now it is your turn." That is how I moved into this and grew into this position. (P25)

Another reason offered by a physician for carrying out educational tasks was that, if he does not do these, these tasks will not be done as no one else wants to do them (P38).

A typical example which illustrates that physicians do not actively plan their career was provided by an older physician who also works as a manager. In the Netherlands, physicians in academic and general hospitals must do night shifts until at least the age of 60. After that, physicians working in academic hospitals are formally allowed to stop doing these shifts. Physicians who turned 60 years old and work in general hospitals can reduce these shifts with a maximum of 25%, with a maximum of 50% when they turn 63 and completely from the age of 65 onwards. This physician working in an academic hospital, younger than 60 years old, proudly reported that he did not do night shifts anymore.

> Physicians have difficulty doing night shifts in later age. I understand that. I do not do these shifts anymore. If you are getting older, these shifts become harder. (P24)

He explained that he was in the position to make this decision because he is the head of the department. He had no answer to the question what he is planning to do when he stops with his management role and works full time as a physician again, which is something he is planning to do before he turns 60 years old. In response, he laughed and said,

> [Laughing] That is a good question. I need to start making agreements for that. Maybe I will work it out by leaving on a sabbatical for half a year. (P24)

Nevertheless, even if he succeeds in organizing a sabbatical, he will still face some years until he reaches the age where he is formally allowed to stop doing night shifts.

A reason raised by physicians for the lack of individual agency in non-clinical areas is the high workload (e.g., P28). They describe themselves as "working in the moment" (P38) and "busy surviving" (P25). One physician explained,

> You develop ambitions, and, in my experience, you adjust your ambitions because things become overwhelming. This makes you afraid to work on career development because this will further increase your workload. (P31)

The lack of time given over to career reflection is partly linked to the strong focus on output. A physician with managerial tasks explained,

> It has only recently become common to think about career development and to actively put flesh on the bones. This is a secondary task, especially with the constraint that your full workload must be completed. You cannot complain, it just must be finished. (P6)

It appears that strong socialization mechanisms constrain physicians' career choices and limit their willingness to deviate from social norms. Physicians explicitly mentioned several norms: "working from 8 to 6 [rather than 9 to 5] is part of the job" (P25), "[being available at night] is part of my job" (P27, P30), and "it is hard to get away from your work, for instance if you have experienced something emotional, but that is very human and part of the job" (P32). A physician who also works as a manager mentioned that many physicians in his team experience a lack of balance between their work and private lives, with too much focus on work, but saw this as "part of the job" (P33). Other norms that physicians mentioned that affected their careers include the expectation that physicians should "mature" (P32) and develop knowledge and expertise related to their specialty, especially in the first 5 years of their career, before they should take on other tasks. This belief in investing in your profession before taking on other roles is also reflected in formal regulations that limit the career choices of young physicians:

> I would love to be an educator, but I am not allowed to have this role until I have been a physician for five years. (P32)

Furthermore, physicians who work in academic hospitals feel a need to engage in research activities or to work towards a PhD. A physician with managerial tasks explained that he stimulates physicians in his team to start a PhD or to engage in other research activities (P37). Another physician described that some physicians do a PhD against their will (P10). And a third physician explained that you will earn respect if you do relevant research:

> If you publish articles, become a professor and teach PhD students, then you are a king or queen in an academic hospital. (P14)

Although all this suggests that physicians are not used to taking individual agency, there were two notable exceptions. One physician mentioned that he wanted to become an educator and that he was currently supporting the present educator to make himself visible and attractive for the position (P32). The other example was given by a physician who also works as a manager who commented that the physicians in his department take a lot of initiatives. He sometimes has to hold back physicians who want to turn their hands to anything (P34).

## Non-involvement of the organization and managers

Alongside the passive attitude of physicians, physicians experience their organizations and managers as failing to actively support them in their careers. Physicians are expected to take responsibility for their careers themselves since they are seen as very smart and motivated (P38) and receive good financial compensation (P4).

The strong expectations that physicians will use their individual agency are reflected in the language that managers use to describe their role. To account for his passive role in physicians' career management, a physician who works parttime as a manager explained that he did not want to "interfere" (P18). Another physician who works as a manager stated,

> As employers, we do not support this, we do not give information on that. We should not interfere or prescribe how physicians should do this. (P23)

Another example shows that, rather than active support, physicians are granted autonomy:

> At Google, employees can develop themselves, half a day or an entire day a week. Following this example, physicians in our team may spend part of their week on activities that can vary from research to education, or specialization in a clinical area. We refer to this possibility as "non-patient-bound time." (P35)

However, not all physicians shared this view. Some of them perceived there was a lack of time for such activities (e.g., P25). In line with this, physicians mentioned that career support is often not provided and career management is not part of the annual review, unless you arrange this yourself (P31), and

> You have to initiate 99% of all the career management activities. (P10)

This lack of attention to physicians' careers is also visible in the lack of formal training programs to develop non-clinical competences. Physicians experienced zero (e.g., P2) to limited (e.g., P17) attention to developing their non-clinical competences. They for instance commented that the hospital was lagging behind in this, especially in comparison with the private sector (P2). They also mentioned that formal programs providing them with training in IT skills (P6), managerial skills (P2), and how to participate in the appraisal and assessment system (P31) would be highly relevant to them given contemporary challenges. Some physicians explained that training programs for roles such as educator or manager did exist but these were only offered to a selective group of people and only after they had started in a position such as an educator (P14). Although organizations increasingly expect physicians to participate in non-clinical tasks, such as sitting on committees and fulfilling certain roles (such as being an educator or manager), physicians feel unsure about the required competences because of a lack of support on how to fulfill these tasks. One example was given by a physician who used to have the role of manager within his team. He emphasized that he has never been trained for this role and therefore felt "lost every now and then" (P14). A similar example was given by another physician:

> I had nothing, I had no secretary, no education, no training, I did not know anything about finances in the hospital. It was only that my colleagues trusted me with this position. (…) I was totally inexperienced, so I made every mistake possible. (P1)

In summary, most physicians describe their physical mobility as limited. This is especially the case for their occupational mobility. Reasons for this limited mobility given by physicians are limited employment opportunities, financial barriers, specialized nature of their work, and a low desirability to move. Changing tasks, not concerning promotion possibilities, is said to be more common. The results further show that physicians' psychological mobility is slightly higher, as they explain that if a situation requires them to move organizations, most physicians perceive that they can. The results further show that while most physicians actively chose for a specific specialty, many do not manage the non-clinical part of their careers due to a high workload. Many physicians do not feel supported in their careers by their organization and managers. As a result, the course of physicians' careers is largely affected by external influences, coincidence, and social norms.

# DISCUSSION

This study explores the career characteristics of classic professionals and specifically physicians. This was approached by studying two central features of careers, individual agency and mobility, which are often examined in the career literature (Gubler et al., 2014) and mentioned in relation to professionals, albeit in different terms (i.e., autonomy or individual agency) (e.g., Kirkpatrick & Noordegraaf, 2015).

## Career mobility

The literature on professionals describes professionals as being increasingly subject to organizational control and employed by large organizations, thereby reducing their mobility (Noordegraaf, 2020). This contrasts to the view of contemporary career theories which assume that mobility is increasing in today's careers (Gubler et al., 2014). This presumption in career theories is however criticized for its simplicity, the lack of attention to contextual factors that may affect career mobility and for only being applicable to highly educated and autonomous elite groups, such as professionals, who can make decisions about mobility (e.g., Clarke, 2013; Inkson et al., 2012).

In this study, we found that physicians' mobility, especially their physical mobility, is low while their psychological mobility is somewhat higher. This can be understood using the theory advanced by Ng et al. (2007), who distinguish between three categories of factors that may affect mobility: (1) structural factors, (2) decisional factors, and (3) individual differences. Structural factors such as economic conditions, societal characteristics, industry differences, and organizational staffing policies are situated on the institutional level. These factors determine the availability of mobility options. The other two categories are situated on the individual level. Decisional factors, such as subjective norms, the desirability of mobility, and readiness for change, determine the intention to move. Individual differences, such as personality traits, career interests, values, and attachment styles, affect preferences for mobility options. Physicians mainly mentioned structural factors as barriers to physical mobility such as limited employment opportunities. This is especially reducing the mobility of physicians with highly specialized knowledge, who more often work in academic hospitals than in general hospitals. Financial barriers are other structural factors that are raised, such

as high investment costs. For physicians who work in partnerships, having to pay around an average year salary if they leave their partnership further reduces their mobility. They also mentioned the unattractiveness of mobility options as a barrier for their physical mobility, which fits in the category of decisional factor in the model of Ng et al. (2007). Physicians did not mention any factors that are characterized as individual differences by Ng et al. (2007).

Specifically, the findings showed that regardless of the contract type and type of hospital where physicians worked, physicians were unlikely to change occupations (low occupational mobility) but more likely to change organizations. This is in line with mobility patterns found in newer professions (Kipping et al., 2019). The low occupational mobility among physicians can be understood from the strong professional identity that they hold. Physicians, like other professionals, are members of professional communities with strong socialization processes (Noordegraaf, 2016). Professionals who enter a professional field are socialized within these communities and taught the norms, values, and appropriate behavior by senior colleagues. This results in a strong professional identity (Witman et al., 2011), which may discourage professionals from leaving their profession.

## Individual agency and autonomy

Although scholars acknowledge that nowadays professionals have a lower degree of autonomy than in the past (Muzio et al., 2013), autonomous decision making is still regarded as one of the central characteristics of professionals (Kipping et al., 2019).

Given the level of autonomy and control that professionals have in their work, one would expect them to take responsibility for their careers (e.g., Pichault & McKeown, 2019). However, most physicians in our sample, regardless of the hospital where they worked and their contract type, do not invest in non-clinical activities such as career planning or developing non-clinical competences and do not feel supported in this. In line with studies arguing that increasing regulation decreased professionals' autonomy (Lin, 2014), regulation also affects professionals' autonomy in choosing between career development activities. There are, for instance, formal requirements for filling certain roles, such as being an educator, which is only allowed after a certain amount of clinical experience. Moreover, perceived time pressures require them to choose between different development activities. Here, they mainly invest in clinical activities since professional associations strongly emphasize the importance of keeping professional knowledge and expertise up to date (Noordegraaf, 2020). Physicians' strong clinical orientation, at the expense of developing non-clinical expertise, limits the range of development activities that physicians undertake. This does not fit the contemporary expectations of doctors, who are increasingly expected to be competent in more areas than "just" the clinical ones (Smeenk et al., 2016). The lack of attention in training programs on developing competences to fulfill non-clinical tasks results in uncertainty and unpreparedness among professionals (Westerman et al., 2013). Moreover, this is also likely to affect their further career paths as a too narrow focus on clinical competences is likely to handicap physicians in becoming active in other areas such as teaching or management. Overall, this shows that agency in terms of careers is strongly affected by a profession's norms and beliefs that influence what is socially acceptable and what is institutionally stimulated.

## The influence of institutional mechanisms and social structures on career behavior

The aforementioned shows that physicians' career behavior, both in terms of mobility and individual agency, is largely affected by so-called career scripts (Barley, 1989). It appears that institutionally rather than individually determined programs prescribe patterns of legitimate preferences and action (Arthur et al., 1999; Cappellen & Janssens, 2010). For physicians, professional communities play an important role in this process. Professional communities set up educational programs and are responsible for supervision procedures (Noordegraaf, 2016). These programs, together with strong socialization processes, and norms and beliefs, determine what is seen as appropriate career behavior in a professional work environment and in turn affect actual career behavior of physicians.

The considerable involvement of professional associations in the careers of physicians implies that it is important to extend a narrow focus adopted by career scholars on the role of two actors in career management: the organization and the individual career holder (de Vos et al., 2020; Hall, 2002), by including a focus on the role of occupational communities. This suggestion is in line with recent studies which have argued that career studies should examine the role of social structures such as communities and networks that are external to the organization (Crowley-Henry et al., 2019; Currie et al., 2006). These occupational communities have been shown to be able to facilitate career support (Parker et al., 2004) and affect career success and mobility (Crowley-Henry et al., 2019; Currie et al., 2006; Hennekam et al., 2021).

## Limitations

This study has examined one group of classic professionals, namely, physicians, in one country. This limits the generalizability of the empirical findings to professionals other than physicians and to a broader

international context. Instead, the outcomes of the review of the literature take a broader perspective, enhancing the relevance beyond this setting. The theoretical framework explains general ideas of career theories which is part of an international debate on careers and elaborates on general characteristics of classic professionals and developments in professional work environments in a wider sense. As physicians are a typical example of classic professionals (Abbott, 1988), it is quite plausible that similar findings will be found for other classic professions, possibly also in other European settings that must cope with similar developments in professional contexts. Future studies could empirically examine the careers of other classic professionals, such as lawyers and accountants, in various countries to determine whether similar patterns are found in these settings.

The generalizability of the findings in this study is further limited by a non-representative sample caused by the adopted sampling technique which can potentially bias the outcomes (Tongco, 2007). Purposive sampling was used as it allows to capture potential variety in career behaviors and perceptions in the sample (Creswell & Poth, 2007; Eisenhardt, 1989). This fits the explorative character of this study. Future studies could examine whether similar patterns are found if a random sample of professionals would participate in a similar study, to enhance the generalizability of the outcomes. Moreover, these studies could systematically examine the differences in the careers of physicians working in academic hospitals and general hospitals and physicians who are employed by the hospitals or work in partnerships. This study has concluded that their careers vary to a certain extent which is worth further investigation to see for instance what consequences this has for their career behavior and career success.

## Theoretical implications

This study provides contextualized knowledge on the careers of physicians as an example of classic professionals. This is achieved by (1) drawing on the professionalism literature to understand the characteristics of professionals' work environment; (2) showing how two central characteristics of contemporary careers play out in the careers of professionals; and (3) exploring the career experiences of physicians as typical classic professionals. This study contributes to the literature on professionals by offering insights into the career characteristics of classic professionals. Professionals' career experiences help to understand their needs in continuing their careers in a dynamic professional work environment.

In addition, this study contributes to the career literature by showing that characteristics of contemporary careers concerning high career mobility and strong individual agency work differently for the careers of classic professionals. This raises the question whether the careers of classic professionals are exemplars of new organizational careers (Clarke, 2013), instead. The description of new organizational careers is more in line with physicians' career characteristics than assumptions in contemporary career theories. Several characteristics of new organizational careers are employment continuity, adaptability, loyalty to the organization and outside groups, jointly managed careers, and spiral career paths (Clarke, 2013). The element of loyalty to multiple groups can grasp the loyalty that physicians have towards their occupational communities. Moreover, the idea of jointly manageable careers could be studied in professional work environments where there are multiple actors, such as professionals, occupational communities, and organizations, who may all play a role in the careers of professionals. In order to understand the careers of physicians, at least two changes should be made to the perspective of the "new organizational career" as introduced by Clarke (2013). First, this career type should explicitly include the role of occupational communities, besides the role of the individual and organization. And second, the word "organizational" in the "new organizational career" indicates a prominent role of the organization. In order to fit professional careers, this could be substituted for "occupational" resulting in "new occupational careers." Future studies can further examine whether this slightly adjusted typology for the careers of professionals helps to understand the careers of classic professionals.

## Practical implications

The findings of this study are relevant for organizations, (HR) managers, and occupational communities wanting to develop and implement tailored career policies and practices for professionals. Results show that physicians, organizations, managers, and occupational communities do not structurally pay attention to career management. There is especially a lack of attention for developing non-clinical competences. As the findings show that physicians as well as occupational communities are unable to self-arrange non-clinical development programs, career support could focus on developing non-clinical skills and knowledge. Career support could help physicians to prepare for non-clinical tasks or roles, which they are increasingly expected to fulfill alongside their clinical duties (Smeenk et al., 2016). The importance of these non-clinical competencies is stressed in the CanMEDS Physician Competency Framework (Frich et al., 2015), a well-known and frequently used competence profile for physicians. This framework acknowledges that, to be a medical expert, physicians should fulfill various roles: communicator, collaborator, leader, health advocate, scholar, and professional (Frank et al., 2015). Programs to support physicians in developing these non-clinical competences could for instance focus on leadership training, training in the skills needed to become a good

researcher, or updating IT skills. Research has shown that career support is important as it enhances peoples' consciousness and sensemaking of their personal interests, helps in career planning, helps to make tough career decisions, and facilitates career adaptability (Ocampo et al., 2018; Parker et al., 2004; Savickas, 2019). As such, career support can help physicians to make more conscious career choices, especially about the non-clinical part of their careers.

This career support can be offered alongside existing development programs offered by occupational communities focused on clinical development. This non-clinical career support could be facilitated by occupational communities, together with the organizations in which professionals work and (HR) managers (e.g., Parker et al., 2004). Representatives of the three groups could collaborate and reflect on the varying needs and wishes concerning the content of professional development programs and about ways to support professionals in managing their careers.

## CONCLUSIONS

Overall, the aim of this study was to explore two characteristics, mobility and individual agency, in the careers of physicians as classic professionals. This study shows that physicians' physical mobility is limited and that changing occupations is especially rare. Physicians' psychological mobility is slightly higher if a situation requires them to move. Further, physicians do not actively manage their careers, as one might have expected given their high level of autonomy. This situation is the result of a strong focus on clinical development in their occupational communities, with little attention and available time for other developmental activities. This study shows that considering contextual factors helps to understand professionals' career characteristics and career experiences.

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### DATA AVAILABILITY STATEMENT

Raw data are available upon reasonable request. Ethical restrictions related to participant confidentiality prohibit the authors from making the dataset publicly available.

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## APPENDIX A: TOPIC LIST INTERVIEWS

This conversation is about your career experiences and career behavior.

1. Could you elaborate on how your career has unfolded from the moment you finished your medical education until now?
2. What career steps have you taken? (These do not necessarily have to refer to promotion possibilities, but can also include changing roles or tasks).
3. What has affected your career choices?
4. How do you currently manage, and have you managed in the past, the unfolding of your career?
5. What role does the hospital play in your career?
6. (For physicians employed by the hospital) What role does your line manager play in your career?

## APPENDIX B: DESCRIPTION INTERVIEWEES

| Physician | Gender (F = Female, M = Male) | Age range | Organizational tenure range | Additional role(s) besides being a physician (tasks in: E = Education, R = Research, M = Management) |
|---|---|---|---|---|
| 1 | F | 60–69 | 20–29 | - |
| 2 | M | 60–69 | 20–29 | E, R |
| 3 | F | 30–39 | 1–9 | - |
| 4 | M | 30–39 | 1–9 | E, R |
| 5 | M | 40–49 | 10–19 | R, M |
| 6 | F | 50–59 | 30–39 | M |
| 7 | F | 50–59 | * | E, M |
| 8 | M | 50–59 | 20–29 | E, M |
| 9 | F | 30–39 | 1–9 | E, R |
| 10 | M | 40–49 | 10–19 | E, R, M |
| 11 | M | 50–59 | 10–19 | M |
| 12 | F | 40–49 | 10–19 | E |
| 13 | M | 50–59 | 10–19 | M |
| 14 | M | 50–59 | 20–29 | E |
| 15 | F | 50–59 | 30–39 | - |
| 16 | M | 30–39 | 1–9 | R |
| 17 | M | 40–49 | 10–19 | R |
| 18 | M | 60–69 | 20–29 | M |
| 19 | M | 40–49 | 10–19 | - |
| 20 | F | 40–49 | 10–19 | E |
| 21 | M | 30–39 | * | E |
| 22 | M | 50–59 | 10–19 | E, R |
| 23 | M | * | 10–19 | M |
| 24 | M | 50–59 | 10–19 | R, M |
| 25 | F | 40–49 | 10–19 | E |
| 26 | F | 30–39 | 1–9 | E, R |
| 27 | M | 50–59 | * | M |
| 28 | F | 30–39 | 1–9 | E |
| 29 | M | 50–59 | 20–29 | E |
| 30 | M | 60–69 | 20–29 | - |
| 31 | F | 50–59 | 10–19 | E, R, M |
| 32 | M | 30–39 | 1–9 | E, M |
| 33 | F | 40–49 | 10–19 | E, M |
| 34 | M | 50–59 | 1–9 | M |
| 35 | M | 40–49 | * | R, M |
| 36 | M | 40–49 | 1–9 | - |
| 37 | M | 50–59 | 1–9 | M |
| 38 | M | 60–69 | 30–39 | E |

Abbreviations: *, unknown; -, no additional tasks.

## APPENDIX C: CODING SCHEME