

Reframing Medical Education to Support Professional Identity Formation

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Abstract

Teaching medical professionalism is a fundamental component of medical education. The objective is to ensure that students understand the nature of professionalism and its obligations and internalize the value system of the medical profession. The recent emergence of interest in the medical literature on professional identity formation gives reason to reexamine this objective. The unstated aim of teaching professionalism has been to ensure the development of practitioners who possess a professional identity. The teaching of medical professionalism therefore represents a means to an end.

The principles of identity formation that have been articulated in educational psychology and other fields have recently been used to examine the process through which physicians acquire their professional identities. Socialization—with its complex networks of social interaction, role models and mentors, experiential learning, and explicit and tacit knowledge acquisition—influences each learner, causing them to gradually “think, act, and feel like a physician.”

The authors propose that a principal goal of medical education be the devel-

opment of a professional identity and that educational strategies be developed to support this new objective. The explicit teaching of professionalism and emphasis on professional behaviors will remain important. However, expanding knowledge of identity formation in medicine and of socialization in the medical environment should lend greater logic and clarity to the educational activities devoted to ensuring that the medical practitioners of the future will possess and demonstrate the qualities of the “good physician.”

The implicit objective of teaching medical professionalism has been to assist learners as they develop their professional identities. Thus it has represented a means to an end. We propose that the current objectives of medical education be altered from teaching and assessing professionalism to what is actually the desired end, the development of a professional identity.

In 1997, two of us (R.L.C., S.L.C.) published articles in which we proposed that professionalism should be taught actively. “Teaching medicine as a profession in the service of healing”¹ and “Professionalism must be taught”² represented early responses to concerns about the performance of individual physicians and the medical profession in increasingly complex health care systems. Both articles suggested that professionalism, a subject of fundamental importance to medicine

and to society, should be taught explicitly throughout the continuum of medical education. Subsequently, all of us have been actively involved in establishing and implementing structured undergraduate and postgraduate programs of teaching and assessing professionalism,^{3–5} supported by a program of faculty development.⁶ The teaching and learning of professionalism has constituted an important objective at McGill University. On the basis of our experience and the evolution of our understanding of identity formation, we now believe that this educational objective is too narrow and should be expanded and reformulated around the concept of professional identity formation.

Others have addressed this issue. The Carnegie Foundation report recommended that identity formation constitute a “pillar” of medical education.⁷ Jarvis-Selinger and her colleagues⁸ suggested that medical education should be designed not only to ensure that “medical students and residents perform competently but to also consider how professional identities as physicians are evolving.” We would go further. The aim of this article is to propose that supporting the development of a professional identity in each medical student and resident should be a primary objective of medical

education and that educational strategies should be reoriented to support this goal.

Fifteen years ago it seemed appropriate to stress the active teaching of professionalism as an important component of the medical curriculum; the two early articles became a part of a concerted global effort to ensure that professionalism would be addressed directly. Accreditation requirements for undergraduate and postgraduate education were modified to ensure that professionalism would be taught and assessed.^{9–11} Principles for establishing teaching programs were developed,^{12,13} along with a theoretical base for instruction.¹⁴ In addition, systems for teaching and learning professionalism were instituted and described,³ and the difficult issue of how best to assess the professionalism of students, residents, and faculty was addressed.^{15–17} The commonly stated educational objectives were to ensure that learners at all levels understood the cognitive base of professionalism, internalized the value system of the medical profession, and consistently demonstrated the behaviors expected of a professional. While the phrase “professional identity” was occasionally used, assisting students to develop a professional identity was not a stated goal of most educational programs

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because identity formation had received little attention by medical educators. This is no longer true. There is a growing literature on identity formation in sources readily available to the medical education community.^{8,18–28}

The Historical Context Behind the Concept of Professional Identity Formation

Physicians and those in other occupations have acquired and demonstrated professional identities since at least the time of Hippocrates. Thus, identity formation as a concept is not new to medicine. The first comprehensive study of the sociology of medical education gave prominence to professional identity formation. Merton^{29(p5)} in 1957 stated that the task of medical education is to “shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that *he comes to think, act, and feel like a physician*” (italics ours). Subsequent literature reinforced the concept,^{30,31} but only recently have there been efforts to analyze the nature of this identity, to link the development of a professional identity to the literature in developmental psychology, and to identify the factors that influence the development of the professional identity of physicians.^{7,8,18–28}

The current emphasis on identity formation is not creating a new educational phenomenon, and it does not negate previous efforts to teach professionalism and emphasize professional behavior. It is attempting to analyze the process by which members of the lay public are transformed, or transform themselves, into skilled physicians who possess and demonstrate a professional identity.³² Furthermore, it is important to realize that the development of a professional identity takes place within the context of individual identity formation, a process that begins at birth and results in a complex mix of identities (gender, nationality, race, religion, class, etc.) that represents how each individual is perceived and perceives herself or himself. The pioneers of developmental psychology provided a foundation for subsequent work on identity formation. Piaget and Inhelder³³ established that cognitive development proceeds in stages until early adult life, and Kohlberg³⁴

examined the related process of moral development. Erikson³⁵ and later Kegan³⁶ extended the concept to identity formation and proposed a series of stages through which individuals pass from birth through old age. Excellent summaries of Kegan’s framework are available in the medical literature.^{8,18} Essentially, individuals construct and situate themselves in “progressively more complex systems for making sense of the world.”^{318(p64)}

While understanding the broad principles of identity development is important, the details of the developmental stages are not essential to understanding professional identity formation. However, knowledge of three aspects is helpful. First, as physicians in training approach transitional phases of their life (entry into medical school, entry into residency training, and entry into practice), they do so with the personal identities they have developed during their life.²³ These identities are the foundation on which a professional identity is constructed, and significant aspects of these original identities will still be present in the practitioner of the future.^{24,26}

Second, in spite of the physical and cultural isolation of medical students and residents, their friends and family, gender, culture, and a host of internal and external factors do not disappear—they continue to have an impact on the ongoing development of an individual’s identities.^{8,23} In fact, these factors would have influenced the construction of a meaningful sense of self, even if another career had been chosen.

Finally, it is clear that for all but a few older students the identities of incoming medical students and residents are, according to developmental theory, still in a formative state and thus may be more susceptible to the influences of the culture and the learning environment which learners choose to enter. Bebeau¹⁸ and Jarvis-Selinger and her colleagues⁸ have situated professional identity formation in medicine within the “constructive developmental theory” proposed by Kegan.³⁶ They point out that one would not expect a fully developed professional identity to be present until Kegan’s last stage, which occupies the early to mid-30s. At that point a physician should possess a “fully integrated

moral self (one whose personal and professional values are fully integrated and consistently applied).”^{21(p65)}

Professionalism, Professional Identity, and Professional Identity Formation

Words and definitions are important. Professionalism and professional identity are not synonymous. Professional identity formation is a process. If professional identity and its formation are to be addressed and analyzed as educational objectives, it is important that they be defined and understood and that their relationship to professionalism be made explicit.

Professionalism

There are many definitions of professionalism, most of which stress the demonstration of the behaviors expected of a professional. The Royal College of Physicians of London definition, “a set of values, behaviors and relationships that underpins the trust the public has in doctors,”³⁷ emphasizes the demonstration of professional behaviors: doing. Because of the difficulty of assessing characteristics, values, and beliefs, this approach has been reinforced by assessment systems heavily oriented towards tools that measure observable behaviors.^{15–17} The difficulty does not rest in defining professionalism but in operationalizing the definition.³ As pointed out almost a decade ago, professionalism often does not deal with absolutes; rather, professional behavior results from a series of personal negotiations between competing aspects of professionalism specific to the context of each situation.³⁸

Professional identity

The Oxford English Dictionary definition of identity is “a set of characteristics or a description that distinguishes a person or thing from others.”³⁹ In attempting to provide a definition more specific to physicians, we propose the following: “A physician’s identity is a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician.”

When the educational goal becomes the formation of a professional identity, the nature of that identity should be clearly

delineated. Daniels,⁴⁰ using a conceptual framework shared with others,^{41,42} has suggested that there is a socially negotiated ideal of the “good physician” and that at any given point in time a physician’s behavior is both guided and constrained by this ideal. While there is some latitude in the expectations of both physicians and society due to individual, national, and cultural differences and specialty choices, certain core values are universally accepted.¹⁷ In joining the profession, an individual must accept these values and is not at liberty to pick and choose among the obligations resulting from them. The concept is not immutable and is being constantly renegotiated as “conditions inside and outside medicine change.”⁴⁰ Outlining the nature of the good or ideal physician often involves creating a list of attributes or characteristics,^{43,44} an approach that we ourselves have taken.^{4,5} While this may detract from the holistic aura of professional identity, it is probably a necessary guide to assist those who are attempting to “integrate their various statuses and roles, as well as their diverse experiences, into a coherent image of self.”⁸

Identity formation

Jarvis-Selinger et al^{8(p1185)} have provided a clear definition of the process of identity formation: “an adaptive developmental process that happens simultaneously at two levels: (1) at the level of the individual, which involves the psychological development of the person and (2) at the collective level, which involves the socialization of the person into appropriate roles and forms of participation in the community’s work.”

The desired educational goal is the development of a value system and a unique perception of self, including personal attributes and roles, that culminate in expressions of specific behaviors or pursuits within a social community. Specific actions and/or statements of norms and aspirational goals serve to guide and reinforce emerging behavior patterns, indicating that an individual’s perceptions of her or his actions, motives, and feelings are congruent with those of Daniels’ “good physician.”

Socialization

Socialization, “the process by which a person learns to function within a

particular society or group by internalizing its values and norms,”³⁹ is the principal process through which identities are developed.^{20,25} Socialization is different from training. Hafferty^{20(p60)} has put it well: “while any occupational training involves learning new knowledge and skills, it is the melding of knowledge and skills with an altered sense of self that differentiates socialization from training.” If educational programs are to assist individuals on their journey from layperson to professional, the process of socialization must be understood and made as supportive and effective as possible.

Socialization consists of a complex network of personal experiences, reflection on these experiences, and social interactions that take place in a learning environment.^{20,25,27} The impact of the multiple locations, each of which constitutes a mini-learning environment in which learning takes place, has a profound impact on the process of socialization.²⁰ The learning environments that affect identity formation are vast in number and include classrooms, inpatient and outpatient facilities, informal areas where social interactions take place, and the health care system itself. The sum of their often-conflicting influences can support individuals as they attempt to achieve the status of a physician—or can actually inhibit the process.^{25,27}

Professional socialization involves individuals with already-established complex identities and is therefore secondary socialization.²⁰ Of necessity, it requires some degree of what Erikson³⁵ called “identity repression” of portions of existing identities. Incoming medical students are socialized first to develop the identity of a medical student; they then proceed to residency training where they perceive themselves and are perceived as residents, and finally emerge to enter practice where their multiple identities include the many aspects of their original “self” and a mix of the identity of a generic physician and one that is more discipline- and/or role-specific.⁸ Along this journey, which may be seen as a transition from legitimate peripheral participation to full participation in a community or communities of practice,⁴⁵ they are impacted by positive and negative experiences with mentors and role models^{20,23}; their clinical

experiences^{8,21,24,26}; the curriculum including its formal, informal, and hidden elements²⁵; distancing from their previous environment^{25,26}; and how they are treated by patients, peers, health care professionals, the general public, and their family and friends.^{8,23} Students and residents respond at both the conscious and unconscious levels, with much of their learning being tacit.²⁰ They must learn to play the role of physician, acquire the language of medicine, understand the hierarchy of the profession and its power structures, and learn how to live with ambiguity.^{21,23} Socialization involves negotiation with self and compromise,^{20,27} activities that can result in “identity dissonance” as elements of the preexisting identity conflict with those required by the profession.²³ Anxiety and stress are a frequent result as individuals either accept or reject the changes.^{20,27} The process is not linear, with major changes taking place following seminal events such as the first contact with a cadaver or death.²⁴ With increasing competence, the process becomes cyclical and self-reinforcing as competence generally leads to greater confidence. As the student, resident, or practitioner repeatedly plays a role, the role becomes internalized and a part of the self. The individual moves from “doing” to “being.”

Educational Implications and Future Directions

If educational activities devoted to the teaching of professionalism are reoriented so that their objective is to assist individuals as they develop their professional identities, it follows that there are implications for educational institutions and for accrediting, certifying, and licensing bodies.

Modifying the goal of medical education to focus on professional identity formation

It is probable that the implicit goal of teaching professionalism has always been the development of a professional identity in learners. It has thus represented a means to achieve an end. This situation changes when professional identity formation becomes the designated outcome. It should be stressed that the efforts devoted to teaching professionalism have not been wasted. The lessons learned by those who have developed programs focused on

teaching and assessing professionalism remain relevant. Knowledge of the nature of professionalism, the reasons for its existence, and its relationship to medicine's social contract with society⁴⁶ will remain important, as will the necessity for the demonstration of professional behaviors.¹⁷ Redefined goals and educational objectives are required, and new and more appropriate learning opportunities should be devised around the new objectives.^{23,26} For example, Frost and Regehr²⁸ have suggested, amongst other things, that students engage in explicit conversations about identity formation facilitated by mentors in order to assist them as they attempt to reconcile the competing discourses to which they are exposed. There is a need to "infuse these newer understandings into a series of learning environments that are intentionally designed to reinforce and promote the types of physicians as professionals we wish to produce."^{20(p65)}

Reexamining underlying theoretical frameworks

The theoretical underpinnings of the teaching of professionalism and the strategies used should be reexamined. The efforts thus far devoted to teaching professionalism have stressed authenticity,⁴⁷ situated learning,^{14,48} and experiential learning and reflection,⁴⁹ all of which seem equally applicable to professional identity formation. In addition, there will be a continuing need to impart knowledge of the nature of professionalism.^{3,4} Nevertheless, informing medical education theory with evidence derived from the wider identity formation literature may lead to new insights.^{23,26} As an example, the United States Army has used Kegan's framework as a theoretical basis for following the development of the professional identity of their officer corps,⁵⁰ an experience that may have lessons for medical education.¹⁸

Making identity formation explicit

Experience gained in teaching professionalism can serve as a guide. Most programs teach professionalism explicitly to ensure that physicians understand the nature of professionalism and of their professional obligations. It would also appear desirable to be explicit about the nature of professional identity formation, making students aware of the concept of professional identity, its links to professionalism, the role of

socialization, and the characteristics of the good physician.^{8,18} The goals are to engage learners as active participants in the process of identity formation and to encourage them to trace their own progress through the journey.

Expanding our understanding of identity formation and socialization

Our knowledge of professional identity formation has emerged thanks to the pioneering work of a few individuals.¹⁸⁻²⁷ However, it is clear that much remains to be done in understanding identity formation in medicine. By altering the emphasis to assisting learners as they transform their own identity to that of a physician, it should be possible to reexamine the linked issues of professionalism and professional identity through a different lens. This will require further research into the basic processes involved, as the current state of our knowledge is not yet sufficient to recommend with certainty ways of involving individuals in the determination of the nature of their future professional selves.

The essential components of socialization in medicine also must be better understood if we are to actively intervene to develop educational programs to support professional identity formation. As an example, medical school and residency training are stressful experiences.^{20,23,24} We understand the source of some of the stress, and some stress is undoubtedly necessary as individuals alter their preexisting identities to conform to professional norms.²⁰ Both the role of stress in identity formation and its management require further study.

In addition, there is a need to better understand how socialization acts to induce individuals to merge their previous identities into a new professional identity, one obvious source of identity dissonance.²³ By better understanding the many factors influencing socialization, it should be possible to ensure a smoother and less stressful transition to the new desired identity.

Redesigning admissions procedures

If the objective of medical education is to provide society with individuals who have internalized the values and norms

of medicine, the process can certainly be facilitated if those selected already possess many of these attributes.⁵¹ Again, the attributes of the "good physician" can be invoked and selection processes implemented whose objective is to choose individuals who already possess many of these characteristics: caring, compassion, the ability to listen, communication skills, and so forth. The recently developed multiple mini-interviews⁵² seem to be remarkably fit for purpose in this regard, and by adapting the process to attempt to select individuals already possessing these characteristics,⁴ it should be possible to diminish identity dissonance.

Reorienting assessment and remediation

The assessment of the professionalism of medical students, residents, and faculty remains a major issue for both the educational establishment and for the profession.¹⁵⁻¹⁷ Professionalism is acquired gradually throughout the educational process, and stage-appropriate means of assessing the professionalism of individuals are necessary.^{17,18} Altering the approach to one whose objective is the assessment of the progress of an individual's professional identity offers an opportunity to rethink the issue. The emphasis should be on trying continuously and longitudinally to help students to find out who they are, who they are becoming, and who they wish to become. The experience gained by the military in following the development of a professional identity can be helpful.^{18,50} Researchers have noted variability in the progress of individuals through the stages of identity formation and that not all reached the higher stages of development.

Some things will not change—unprofessional conduct and professional lapses will remain as issues even if the educational goals change.

The same advantages can be invoked in addressing remediation for professional lapses. This is particularly appropriate at the undergraduate and resident levels as the professional identity of most learners has not yet stabilized.^{33,34} Tailoring programs of remediation to assist individuals in understanding the nature of a professional identity, the process of identity formation, and the obligations inherent in being a physician could

change not only what they do but also who they are.

Prioritizing faculty development

Experience with introducing professionalism into the medical curriculum has indicated that faculty development is essential to ensuring that faculty understand the cognitive base of professionalism and the methods of teaching and assessment most appropriate for their own setting. It can also serve as a powerful instrument to effect change.^{6,53} As we wrote this essay in 2014, few faculty members have knowledge of the process of identity formation, a situation that will inhibit attempts to establish it as an educational objective. Thus, faculty development should serve as an important foundational basis for the introduction of educational programs aimed at understanding the factors involved in the process of socialization and in the promotion of identity formation.

Envisioning the professional identity of the future

An important issue requiring recognition and action is that, although there are clearly core elements that are foundational and seem to be timeless, some aspects of the traditional professional identity must change. As medicine and society evolve, the details of the social contract change^{46,54} and the nature of the good physician is continuously renegotiated.⁴⁰ This becomes obvious if one examines the changing nature of professionalism and professional identity through the years. The early history of modern professionalism in the Anglo-American world reveals that it was more exclusionary than inclusive, with women, nonwhites, and ethnic minorities having difficulty in finding a place.^{1,54} While progress has been made, these issues have not disappeared, and “classism” is still found.¹⁹ There is ongoing tension between the conflicting educational objectives of standardization of norms and the necessity to accommodate diversity in a world in which medical students come from different cultural and ethnic backgrounds and may have differing interpretations of professionalism.^{17,28} Other examples of necessary change include the current emphasis on team health care that will

require an alteration in the professional identity of physicians.⁵⁵ The educational strategies supporting the development of professional identities appropriate for the future practice of medicine must not be grounded in a concept that reflects what has been termed the “nostalgic professionalism”⁵⁶ of the past that emphasizes the role of the individual physician. The professional identity of the future must be more open to the expertise of others in order to be appropriate to the more inclusive and globalized world.^{28,55}

Summing Up

We recommend that, as Merton²⁹ postulated many years ago, the principal objectives of medical education should be to ensure that each practitioner has acquired both the knowledge and skills necessary for the practice of medicine and a professional identity so that he or she comes to think, act, and feel like a physician. Within this conceptual framework, teaching professionalism becomes not an end in itself but a means to an end. We believe that the end has always been the development of a professional identity and that the substance of that identity should be the “good physician.” In reframing the educational goal to support and assist learners as they develop their professional identities, the emphasis shifts to an interpretation of professionalism based on “being” rather than “doing.”^{8,20,27}

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