

Professional Identity (Trans)Formation in Medical Education: Reflection, Relationship, Resilience

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Abstract

A fundamental goal of medical education is the active, constructive, transformative process of professional identity formation (PIF). Medical educators are thus charged with designing standardized and personalized curricula for guiding, supporting, and challenging learners on the developmental professional identity pathway, including the process of socialization. The author of this Commentary provides an overview of foundational principles and key drivers of PIF supporting the being, relating, and doing the work of a compassionate and competent physician. Key elements

of PIF including guided reflection, use of personal narratives, integral role of relationships and role modeling, and community of practice are viewed through various lenses of PIF theory and pedagogy. Questions informing the PIF discourse are raised, including interprofessional identity considerations. Central emergent themes of reflective practice, relationships, and resilience are described as supporting and reciprocally enhancing PIF. Overarching lessons include attending to learners' and faculty's PIF within a developmental trajectory of the professional life cycle; process and content

within PIF curricula as well as learners' individual and collective voices; curricular/extracurricular factors contributing to socialization, self-awareness, development of core values, and moral leadership; integrating PIF domains within pedagogy; faculty development for skilled mentoring and reflective coaching; and implementing resilience-promoting skill sets as "protective" within PIF. Outcomes assessment including the impact of curricula on learners and on patient-centered care can be challenging, and potential next steps toward this goal are discussed.

The becoming of a physician inspires wonder at and wonder about¹ the transformation of a lay person into a health care professional through the acquisition of requisite knowledge, skills, attitudes, values, and attributes. "Education in its broadest sense," Goldie² reminds us, "is about the transformation of the self into new ways of thinking and relating." Within identity transformation, described as the "highest purpose of medical education,"³ and the increasing call for reframing approaches to medical education away from an exclusive focus on "doing the work of a physician" toward a broader focus that includes "being a physician,"⁴ we now ask: What are the key drivers of professional identity formation (PIF)? What foundational principles of PIF can guide our education

and practice? As responsible educators, how do we best design standardized and personalized curricula to accompany, guide, support, and challenge our learners on the developmental professional identity (PI) pathway, one with active construction, deconstruction, and reinterpretation⁵ processes for healthy PIF consolidation along the way? How might we assess outcomes? And, more broadly, in a rapidly changing health care environment, how can we foster a collaborative interprofessional identity⁶ within emerging PIs without homogenizing the distinctiveness of health care professional team members?

My interest in PIF was sparked within my teaching at a medical school as I read students' reflective narratives about and observed small-group grappling with formative experiences within emerging professional persona. I worked with various authors in this issue to coordinate a collection of articles on PIF, and as that collection grew into an entire issue about PI, I had a "view from the balcony and was on the dance floor"⁷ (like the reflective process itself) as I considered the gestalt of where we are and where we might go. This Commentary serves as a guide to the many PI perspectives represented in this issue (interprofessional faculty and

clinicians, students, administrators)—a "GPS" of sorts—helping the reader with background and thematic "signposts" (see Supplemental Digital Table 1 at <http://links.lww.com/ACADMED/A276>) to navigate this rich and varied collection on topics of theory and practice for the lifelong, integrative process of PIF. Overall, this Commentary may offer a road map of change for the formation of a humanistic, ethically vigilant, reflective, socially responsive and responsible, resilient health care professional.

An Overview

PIF is an active, developmental process which is dynamic and constructive and is an essential complement to competency-based education.⁸ PIF encompasses development of professional values, moral principles, actions, aspirations, and ongoing self-reflection on the identity of the individual^{9,10} and is described ultimately as a complex structure that an individual uses to link motivations and competencies to a chosen career role.¹⁰ The PIF process involves "deepening of one's commitment to the values and dispositions of the profession into habits of mind and heart"¹¹ and is fundamentally ethical¹² (including an ethic of caring)¹³ with development of a set of internal standards or an "internal

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compass” regulating professionals’ work.¹⁴ Holden and colleagues⁸ provide a PIF definition as foundational to their framework of domains, subdomains, and developmental stages:

[PIF] is the transformative journey through which one integrates the knowledge, skills, values, and behaviors of a competent, humanistic physician with one’s own unique identity and core values. This continuous process fosters personal and professional growth through mentorship, self-reflection, and experiences that affirm the best practices, traditions, and ethics of the medical profession. The education of all medical students is founded on PIF.

Cruess and colleagues¹⁵ enhance our understanding of PIF as socially constructed and as an integration of personal identity and professional self with their schematic representations of the linked processes of PIF and socialization. Such schematics, incorporating features of social learning theory, communities of practice, and situated learning,¹⁶ they propose, can ideally guide educational interventions supporting PIF as medical students and residents come to “think, act, and feel like a physician.”¹⁵ They contextualize such PIF formulations within broader identity formation theory of individual, relational, and collective identity. Within Kegan’s longitudinal framework of sequential-stage development of self into a moral and meaning-making entity,¹⁷ they note, identities stabilize in early adulthood, yet transformation continues throughout life. In line with this, the identity of a practicing physician continues to evolve throughout practice with potential contributors including a “connectivist” approach to teaching professional development skills,¹⁸ strengthening PIF with intramural grant-supported academic growth,¹⁹ affirming and enhancing PIF through mind–body medicine facilitation,²⁰ and ultimately, cultivating coping strategies to minimize identity threat within retirement considerations.²¹ At the other end of the spectrum, we are invited to consider coordinating premedical and medical school phases of physician education to “facilitate the initiation of the physician’s PI”²² with a longitudinal framework (TIME: the Transformation in Medical Education Initiative)⁸ and other means of beginning “proto-professional development as college undergraduates.”²²

According to Rabow and colleagues,²³ “The goal of professional formation is to anchor students to foundational principles while helping them navigate the inevitable moral conflicts in medical practice.” Easier said than done. Educators are challenged to create and implement effective pedagogy to support transforming theory into an “internalized identity facilitating learners’ development into the roles and responsibilities central to the medical profession”²⁴ given that PI is “not a unitary construct which can be categorized into a neat set of competencies.”²⁶ Additional challenges include, for example, (1) distinguishing “outward” professionalism (behaviors)²⁵ from the quality of a professional’s inner life,^{25,26} and (2) encountering tension between standardization and diversity discourses within PI construction when students’ PIs do not always align with their expectations or professional standards.²⁷ Educators are encouraged to acknowledge and take advantage of such “creative tension”²⁸ and “negotiation”¹⁵ within pedagogy. Such efforts can address, for example, yet another challenge of ameliorating discrepancy between PI that students develop during nursing school and the reality of professional practice, cited as a possible cause for student and nursing attrition.⁶

Key drivers of PIF include experiential and reflective processes, guided reflection, formative feedback, use of personal narratives, integral role of relationships and role models, and candid discussion within a safe community of learners (an “authentic community”).^{9,23} These drivers also resonate with formation in clergy training, which prepares individuals for “spiritual calling.”²⁹ Student voices³⁰ and first-person reflective narratives about clinical care and training experiences^{31,32} inform the discourse with valuable insights, raising pertinent questions, and illuminating how the PIF process can indeed be both “adventure–wonder and adventure–ordeal.”³³

Among a multitude of relevant concepts, overarching themes of reflection, relationship, and resilience emerged from this collection.

Reflection

There is process and content in “the becoming” of a physician. A foundation of reflective habits of mind, heart, and

practice³⁴ with processes of metacognitive thinking about thinking and meta-affective feeling about feeling³⁵ can foster “practical wisdom”³⁶ for engaging in messy complexities of practice³⁷ and potentially influencing choices of how to act in difficult or morally ambiguous circumstances.³⁸ Critical reflection on being and action (i.e., self-assessment of values, attitudes, beliefs, reactions to experiences, and learning needs in conjunction with deepened experiential learning) is integral to PIF.³⁹ Guided reflection, both as an individual and in a group,⁴⁰ supports students engaging as active participants in development of their PI,^{6,8,15,41} helping to cultivate a meaningful combination of qualities of expertise and values.²³ Without reflection, it has been asserted, personal identity transformation cannot occur.⁴²

Reflection to support PIF is not necessarily intuitive; thus, curricula aim to enhance critical reflective process with a skillful mix of support and challenge. Curricula described in this issue aiming to promote and sustain reflective “SOS” awareness⁴⁰ (i.e., awareness of self, other, situation/society) to support PIF include narrative reflective approaches of “interactive” guided reflective writing,⁴⁰ a mentored portfolio within graduate medical education,⁴⁰ “personal retirement speeches” for “reflecting forward,”²⁴ and fostering ethical mindfulness within narrative ethics teaching that incorporates emotions given the legitimate role of awareness, understanding, and appropriate management of emotions in PIF.⁴³ Pedagogic innovations also include a mindfulness curriculum fostering self-awareness,⁴⁰ using synergy of words and images to cultivate empathy and awareness of myriad forces shaping understanding of what it means to be a doctor,⁴⁴ and a Holocaust and Medicine curriculum for ethical vigilance.⁴⁵ In regard to the latter, “there is a growing recognition that essential lessons for students and doctors derive from studying history even as medicine remains committed to pushing the frontier of knowledge.”⁴⁶ Ethics, literature, art, and history foster reflection,⁴¹ and exposure to the humanities has the potential to broaden students’ perspectives, raise awareness, and promote empathy within development of social identity complexity.² Such a background can enable the physician to

reflect on subtleties of the physician–patient relationship and to be prepared for ethical dilemmas in medical practice.²²

Figure 1 illustrates how “roots” of guided reflection (with proper “fertilizer”) support the “trunk” of PIF, including “nonconventional” competencies⁴⁷ (such as attentiveness, presence, critical curiosity, tolerating uncertainty, stress tolerance,⁴⁸ and adaptive flexibility within practical wisdom),^{21,49} bearing “leaves and fruit” of core professional competencies. Reflection for noticing and meaning-making scaffolds appreciation and

understanding of “identity enriching experiences,”⁵⁰ thus helping learners develop a coherent physician story (of self-transformation) to live by¹³ and continue creating throughout one’s career.¹¹

Relationship

Relationships influence adoption of professional values within PIF.⁵¹ Students actively construct PIs through interactions with patients, mentors, and colleagues within complex learning environments,⁵² with early contact and discourse between patient and student highlighted as a key driver of identity

construction.^{6,53} Shochet and colleagues’ learning environment scale emphasizes learning in a social context given that students’ perceptions of the learning environment influence how they develop behaviors and form identities as future physicians.⁵⁴ Curricula bridging theory to practice within this issue^{24,40,43–45} exemplify a relationship-centered education approach⁵⁵ within positive learning environments and demonstrate that skilled mentorship as well as positive role modeling are key.^{42,56,57} The connection between student and teacher has been described as similar to the connection between clinician and patient.⁵⁸



Figure 1 Reflection supporting professional identity formation. Image © Embe2006 | Dreamstime.com—Tree Roots Logo Photo. Reproduced in accordance with specified terms of use.

Small-group processing (which can include reflective writing as a catalyst for reflection) with teaching and collaborative reflection within a relationship (teacher–learner, teacher–teacher if cofacilitation, learner–learner, learner–self with internalized feedback) can be particularly effective within social construction of PIF. Reciprocally, positive PIF outcomes for faculty can be realized with inclusion of relationship-centered educational offerings within their academic experiences.²⁰ Benefits of a “connectivist” approach are also described within an online, global medical community¹⁸; a peer mentoring program for “interconnectedness” and changes in knowledge, skills, confidence, and satisfaction⁵⁹; and new nurse practitioner residency programs supporting transition to practice and improving retention.⁶⁰

As health care professionals and protoprofessionals engage with team members in collaborative health care environments, can identities be better defined or reconfigured as less bounded?⁶ Effectiveness of educational approaches for promoting interprofessional identity, including how to implement interprofessional education modules within an appropriate developmental timeline (given simultaneous emerging PI) is worthy of consideration.⁶ As we review PIF domains for undergraduate medical education,⁸ what differentiates us from other health care professions? What unites us? Redesigning postgraduate nursing and medical education training for development of both PIs and a group identity through a process of meaning-making and group negotiation has been proposed,⁶⁰ though data on the potential impact of such a redesign on patient care are needed to support this shift.⁶¹

Resilience

Development of PI relates to well-being⁶² (with a strong sense of shared social identity, for example, as a factor in stress buffering), and well-being relates to PIF.⁶³ Burnout in medical students, associated with excessive detachment from patient and self and impairments in self-care and sense of self, can impede development of a mature, well-integrated PI.⁶³ Later in the professional life span, teaching experiences supporting healthy personal and professional formation may attenuate burnout²⁰ and personal reflection on

inattention to self-care, while attempting to accomplish professional goals is encouraged within a “journey to resilience.”⁶⁴

Resilience is defined as responding to stress in a healthy way with “bouncing back” after challenges and growing stronger.⁶⁵ It is termed an “emotional competency,”⁶⁶ linked to “sustainable practice” within the Professional CANMEDS competency,⁶⁷ and is conceptualized as a vital component of PIF within resiliency and mindful clinical practice curricula.^{40,64} Such curricula focus on learning, acquiring, and improving skills and habits of mind that promote insight and resilience within a culture prioritizing learner well-being.⁶⁸ Supportive learning environments for PIF would ideally mitigate or prevent negative influences contributing to erosion of core values, thus reducing risk of depersonalization, physician burnout, loss of empathy, and potential risk to patient safety.²⁹ From an appreciative inquiry approach, what is working? What can work in fostering emotional, moral,¹² and social resiliency as part of PIF? For the latter (“social resilience”), Langendyk and colleagues⁶ propose that individuals who are able to work cooperatively on the basis of mutual trust and respect form resilient teams better able to navigate the complexities of work in health care organizations. Quality leadership (as a PI component) has a role here, and the PI attribute of empathy is conducive to relationship building—an important feature of effective leadership.⁶⁹ Furthermore, these authors suggest, teaching for mindfulness and resilience within interprofessional education may effect a more flexible interprofessional identity.⁶ Evidence is emerging for methodologies including synergistic “protective” mind–body medicine skills and reflective writing (fostering awareness, meaning-making, and attitudes associated with patient-centered care within PI) as potentially boosting resiliency throughout the professional life cycle.^{70,71}

Reflection, Relationship, Resilience—Connecting It All With Reciprocity

Reciprocal feedback loops amongst the themes of reflection, relationship, and resiliency support PIF (Figure 2). Reflective skills enhance both relationship-centered education and resilience for healthy PIF, including the ability to constructively process emotions and cognitions (such as appreciating multiple perspectives) used for empathy, which is potentially protective against stress and burnout.^{43,72} Growth within relationship-centered education and resilience can then feed back and deepen reflection on being, relating, and doing to foster awareness and meaning-making within learning. Enhanced relationship-centered education can boost resilience (medical education is a fundamentally social process, and sense of connection with one’s peers and colleagues impacts well-being),⁶² which then can feed back for more effective use of such relationships for constructing and consolidating PI.^{20,64}

Where Do We Go From Here?

In the business world, a “developmentally deliberate organization” is a high potential culture explicitly designed to advance mutual flourishing of the organization and its people, weaving support for people’s development into the daily fabric of working life.⁷³ This concept resonates for me within the context of considering best practices in PIF curricula and faculty development and fostering a reflective culture supporting PIF.³⁶ The authors in this issue have shed light on fashioning the “developmental space” learners need to be able to develop their PI⁷⁴ at a time of transition to a team-based health care delivery model. Some overarching lessons from their work include remaining attuned to the PIF of learners and faculty within a developmental trajectory of the professional life cycle (i.e., premedical years to retirement); attending to process⁷⁵ and content within PIF

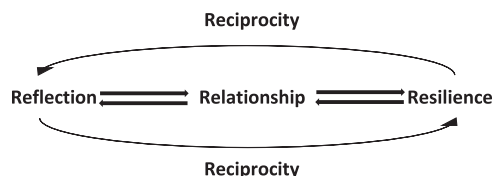


Figure 2 Reciprocity—reflection, relationships, and resilience within professional identity formation.

curricula; hearing individual and collective voices of our learners³⁰; considering curricular/cocurricular/extracurricular factors contributing to socialization; cultivating self-awareness and development of core values and moral leadership^{15,76–78}; designing educational activities that promote integration across multiple PIF domains and subdomains^{8,15,79}; providing faculty development for skilled mentoring and reflective coaching⁴⁰; and implementing resilience-promoting skill sets as “protective” within PIF.^{42,70,71}

Outcomes assessment can be challenging.^{8,22} Descriptive, formative assessment using mixed methods to provide feedback, evaluate curricular programs, and guide theoretical development is recommended by the TIME task force.⁸ They note Cooke and colleagues³ recommendations of three general strategies for PIF assessment: observations as part of clinical assessments, developmental benchmarks, and assessment of learning environments as well as considering “aspirational” elements outside the arena of competencies. Next steps include studying how certain outcomes impact patient-centered care.

Upon “beginning the journey” as editor-in-chief, David Sklar reflected on current challenges in the health care environment and suggested ways in which *Academic Medicine* could help “protect and nurture professional identity.”⁵⁸ It is my hope that this special issue (as a “GPS” on that journey) offers tangible insights and sparks fresh dialogues and creativity as we join with our learners (and connect with ourselves as lifelong learners) to actualize positive transformative learning environments and help crystallize and integrate affect-laden threshold moments³³ of challenge and triumph supporting healthy PIF.

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