Who are you and who do you want to be? Key considerations in developing professional identities in medicine

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Who we are, our identities are essential. Identities give our lives meaning, guiding behaviour. Professional identities are of utmost importance in medicine. They are the cornerstone of professionalism, providing us with ethical frameworks within which we work.[1] For example, having a strong professional identity as a doctor enables you to consider your values and how they relate to those prescribed (eg, professionalism codes of conduct), and to patients' and colleagues' values.[2] Furthermore, possessing a strong professional identity can foster confidence (both in yourself, and others in you), cultivate collaborative leadership styles and develop wellbeing.[3] Conversely, having strong professional identities can lead to negative outcomes — including negative workplace behaviour, poor teamwork, challenges to shared decision making with patients, and hierarchical leadership styles — resulting in patient safety threats.[4] For better or worse, professional identities matter: for you, your patients and your colleagues. In this article, we describe what we mean by identities; how different identities play out during interactions; how they are formed, alongside the barriers and threats to development; and the consequences of developing (or not) professional identities. We also discuss how we may support professional identity formation.

The concept of identities has been variously constructed.[1] In essence, our identities are subjective feelings of who we are and who we might be that are played out through language, clothes and everyday behaviour. We have many identities linking to different aspects of ourselves in relation to others (hence, social identities).[5] Indeed, we have different types of social identities, including gendered, familial, professional and national.[1,5] Professional identities have been defined as how we perceive ourselves as professionals based on our attributes, beliefs, values, motives and experiences in relation to our profession. Again, these can be multiple: perhaps you are a clinical teacher, a researcher and a physician? It is all about "fit": the extent to which we take on a professional identity depends on our perception of fit within that particular group.[1,5]

Our personal and professional identities are not separate.[6] Sometimes identities are foregrounded while others are backgrounded.[7] This foregrounding and backgrounding depends on context: at a social gathering outside work, you might identify more with your broader doctor identity; at a medical education conference, you might identify more with your clinical supervisor identity (overlapping with, but extending beyond, your doctor identity). But this foregrounding and backgrounding can be complex. Research suggests that our multiple identities (eg, doctor, gynaecologist) are also influenced by how much our various identities interrelate.[7] These different interrelations can be adopted at different times or with different emotional states, and can have very different consequences for social interaction.[1,7] For example, imagine fictitious Anne. Anne identifies as a female Asian surgical educator. If Anne's identities intersect into a single compound identity, she will identify with all other female Asian surgical educators (her so-called in-group) and differentiate herself from others (out-groups). If her identities are hierarchical, and her surgeon identity dominates, she will identify other surgeons as her in-group (thus broadening her in-group). If Anne's identities are compartmentalised, they become context specific. If, for example, her female identity is activated during sexual harassment situations, she will identify with other women as her in-group. Finally, if her identities merge, she will see females and Asians and surgeons and educators as her in-group (the most inclusive category). The degree of inclusivity of in- and out-groups is important in medical contexts: it can influence aspects such as interprofessional teamwork and doctor–patient relationships.

This brings us to the question: how are professional identities formed? Imagine a world in which you consider the opinions of society, your fellow peers, and patients to be of little consequence. Imagine that regulatory and professional bodies do not exist and qualifications mean nothing; anyone with skills can be a doctor. What impact would this world have on your professional identity? Identities are formed through the process of socialisation.[1] While we are individuals, we are also part of multiple collective worlds. Our ways of thinking and behaving — through which we make sense of ourselves and our experiences — are influenced by the relationships we have and by institutional structures and cultures. Thus, through a process of self-identification, our identities are shaped and reshaped everyday as we contemplate our social worlds. Through this process, we identify with in-groups, and differentiate ourselves from out-groups, looking for role models to either emulate or reject.[1] Our clothes, language, values and behaviour all reflect the identity we wish to project.[8] As we begin to develop an identity, it may initially feel like a new pair of shoes, slightly uncomfortable, with walking an awkward, conscious effort. But eventually, those shoes soften and mould to our feet; we no longer give them a second thought. As with the shoes, our identity becomes part of who we are.[9]

Developing professional identities can feel like a series of (seemingly never-ending) journeys with ever-shifting destinations, challenging twists, turns and, occasionally, dangers ahead. We now consider this journey and the barriers and threats to professional identity formation. Some individuals stand at the brink of their journeys, unable or reluctant to move forward. Their motivation to become a doctor is perhaps externally defined (eg, family expectations). Others begin their journeys enthusiastically, only to become disillusioned later. They may, for example, experience identity dissonance. They struggle to relate their developing professional identities

with existing personal identities — particularly when their personal identities (eg, gender, ethnicity) are under-represented in the medical profession or in their chosen specialties;[10] remember, it is about fit.[1,5] Some individuals struggle to make sense of competing values in medical education; for example, the value of diversity versus the standardisation of medical graduates.[11] Others experience identity dissonance through fractures between personal (eg, being empathic, compassionate humans) and professional (eg, being objective, detached experts) identities.[12] And some become disenchanted when experiencing professionalism dilemmas (eg, witnessing or participating in workplace professionalism lapses), leading them to experience dissonance between their sometimes morally dubious actions and their moral identities.[2] Finally, even if appropriate professional identities are formed, they might be threatened under certain circumstances, including changing doctor–patient relationships (eg, threatening doctors' authority), patient complaint situations, poor media reports, the use of negative stereotypical labels, changing roles and responsibilities (eg, blurring professional boundaries), the removal of dress codes (eg, white coats), regulatory processes (eg, revalidation), and working hours restrictions (threatening traditional rites of passage).[13]

What if professional identities are weakened or fail to develop? A weak social identity has been associated with a poor capacity for coping when under duress: a recent study found that junior doctors' lower levels of self-reported professional identity were significantly related to their higher levels of personal, patient-related and work-related burnout scores (and vice versa).[14] Other implications of a weak professional identity include retention and teamwork problems.[15] Alternatively, the development of a strong positive professional identity can be beneficial to health care practice (eg, ethical decision making), and health care professionals' career choice, wellbeing and life satisfaction.[14] Furthermore, having a strong shared identity (eg, interprofessional identity) with an understanding of the different roles and responsibilities of others can foster trust and facilitate teamwork performance in high intensity situations. However, developing an overly strong and specific professional identity — recall Anne's single compound identity — can lead to a "them and us" mentality resulting in negative attitudes towards out-groups. It can also lead to participation in stereotypical behaviour (eg, within a surgical culture: endurance, authoritativeness, bravery, risk taking, arrogance and masculinity).[13]

How can we facilitate the development of strong, but positive, professional identities? Initial medical professional identities (eg, doctor) are developed sometimes before and also during medical school through formal and informal curricula, as well as through the institutional structures and cultures of the health care workplace (so-called hidden curricula).[2] Formal activities range from anatomy learning, communication skills training, guided reflection and narrative inquiry through to work-based learning (eg, longitudinal integrated clerkships, bedside teaching, case presentations etc) with informal and hidden curricula ever present.[16] Professional identities can be fostered serendipitously for trainees through classroom-based activities, including group coaching and narrative reflective practice.[17] For doctors developing other identities (eg, educator, researcher), collaborative learning, guided reflection, role modelling and mentorship are all important, as is gaining further relevant qualifications.[18] Some have advocated the use of educational milestones to foster the development of professional identity for specific specialties.[19] However, we advocate that curricula explicitly aim to develop professional identities, not by forcing people to go through stages of development, passing (or failing) assessments, but through the promotion of individuals' sense making around who they are and who they want to be. Such professional identity formation is key to the development of professionalism within medicine. While professionalism curricula are now well embedded in undergraduate and postgraduate medical education, curricula rarely explicitly address professional identity development. Therefore, medical students, trainees and trained doctors should regularly engage in conversations about and for their identity development as they progress across important transitions into medical school, clinical training, clinical practice, specialty training and so on. As part of professionalism curricula, individuals should be encouraged to explore how their experiences interplay with their personal and professional identities, discussing any feelings of identity threats or dissonance. They should be encouraged and supported in speaking out when they feel their values are threatened, to uphold their professional identities without fear. We consider that such an identities curricula — interwoven through everyday teaching and learning activities and professionalism curricula — could be the compass aiding navigation through the thorny journey of identity formation.

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