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Published in:
Medical Education

DOI:
[10.1111/j.1365-2923.2011.04189.x](https://doi.org/10.1111/j.1365-2923.2011.04189.x)

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2012

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Helmich, E., & Dornan, T. (2012). Do you really want to be a doctor? The highs and lows of identity development. *Medical Education*, 46(2), 132-134. <https://doi.org/10.1111/j.1365-2923.2011.04189.x>

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Do you really want to be a doctor? The highs and lows of identity development

Esther Helmich¹ & Tim Dornan²

The development of professional identity, or truly *becoming* a doctor, is central to medical students' education. How people develop that identity, learn to act in an appropriate way, and demonstrate confidence when doing so, receives less attention. In this issue of *Medical Education*, Bryan Burford addresses this gap by elaborating on social and group processes that contribute to identity formation.¹ His article offers an excellent model of how theory can inform thinking about current challenges in the field of medical education. He clearly outlines the basic principles of social identity theory, of which self-categorisation and group membership are central components, and puts forward some relevant social identity-led research questions regarding professionalism, teamwork, interprofessional communication and assessment.¹

The development of professional identity, or truly becoming a doctor, is central to medical students' education

This commentary sets out to do two things: firstly, to compare Burford's social identity perspective¹ with an alternative theory, highlighting the relative differences and strengths of each, and, secondly, to explore in greater depth some of the issues Burford raises. As well as endorsing the value of theory, we would like to add the caveat that every theory has limitations and that there can be valid alternative perspectives.

Social identity theory is a psychological theory and as such has a more individualistic focus than its main alternative, socio-cultural theory. Self-categorisation is an individual act, based on social comparison, that leads to the identification of 'in-groups' and 'out-groups'. However, from a socio-cultural perspective, health professionals can be viewed as united by practice rather than separated by membership of different groups.²

Self-categorisation as a member of a group seems to represent a quite static concept when contrasted with the continuous negotiation of meaning and identity in interaction with other individuals that takes place in (socio-cultural) communities of practice (CoPs).^{3,4} Social identity theory's focus on people as being 'in-group' or 'out-group' seems more sensitive to boundary issues among groups and the tensions associated with them than to the dynamic nature of groups and their constant renegotiation. We consequently wonder how well social identity theory can cope with the fluidity of today's clinical care teams.

From a socio-cultural perspective, health professionals can be viewed as united by practice rather than separated by membership of different groups

Although the paper¹ extends the concept of groups to interprofessional groupings, the in-group/out-group dichotomy makes the notion of interprofessionalism problematic. It does so by highlighting the distinctiveness of groups rather than the joint enterprise of communities. By contrast, a CoP puts practice at its centre and regards identity as something that emerges not so much from membership as from the negotiation of meaning in an essentially communal situation. The centrality of practice is explicit in a CoP, but is left implicit in social identity theory. The way students from different disciplinary backgrounds within Scandinavian clinical training wards work and learn together when providing real patient care offers a living, and quite successful, example of true interprofessional learning.⁵

Social identity theory stresses two features that are very relevant to medical education: the accessibility and fit of a particular social category. The notion of the accessibility of a social category, we suggest, can be used to explore how different medical learning environments offer different opportunities for participation.⁶ It can help us think about how and to what extent we allow students access to our professional communities. It is within

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doi: 10.1111/j.1365-2923.2011.04189.x

social practice that students learn to fit in by familiarising themselves with the expectations, values and behaviours that prevail in any particular practice.⁷ The important practical implication of this emphasis on accessibility is that medical educators have the power to give or deny students opportunities to participate and learn to fit into their roles.

Within social practice, students learn to fit in by familiarising themselves with the expectations, values and behaviours that prevail

Regarding the notion of fit, Burford proposes that the transition from student to doctor is made difficult by a (perceived) lack of knowledge, skills, clinical experience or confidence.¹ But correct or incorrect perceptions of what doctors actually *are* may also contribute to students' struggle to develop their identities. Some might be reluctant to identify with the needed role characteristics of a doctor, where 'identification' refers to a perception of the self as an occupant of a role, incorporating the meanings and expectations associated with that role.⁸ Cognitive or emotional dissonance may occur when personal values are dissonant with developing professional identities.⁹ Learning to be a doctor includes internalising professional attitudes and behaviours, sometimes at the expense of personal values or at the risk of becoming socially isolated.

Medical educators have the power to give or deny students opportunities to participate and learn to fit into their roles

In one of our own studies on identity development in a first-year nursing attachment,¹⁰ we found

students were very positive about the care-oriented attitude of nurses but struggled to deal with the way some doctors behaved. Regardless of age, gender or other specific factors, a small minority of students drop out of medical school each year after their first clinical experience. Some students discover they would prefer careers as nurses or other health care professionals rather than as doctors because these disciplines have closer contact with patients and the identities they enact are more patient-centred. Other students, after these initial encounters with medical practice, decide they do not fit into medicine at all and no longer aspire to work in patient care. This process was also referred to in Monrouxe's important recent article on identity and identification,¹¹ in which the author described identity dissonance and its possible consequences in terms of: rejection of the professional role; the display of inappropriate professional behaviours as acts of resistance; and the avoidance of or role-playing in professional interactions.

Learning to be a doctor includes internalising professional attitudes and behaviours, sometimes at the expense of personal values

In another recent study, first-year medical students entering medical practice for the very first time reported many joyful, moving and rewarding experiences.¹² They expressed a broad variety of positive and negative emotions, often both arising from the same experience.¹² Frederickson, in her 'broaden-and-build' theory, stated that positive emotions, such as joy, interest and commitment, lead individuals to build physical, intellectual and social skills, and to deepen personal and social resources.¹³ Helping students to be sensitive to their own

positive and negative emotions, and to recognise, accept and value emotions as important clues in the development of professional behaviour and patient-centredness, is largely unaddressed in medical education.¹⁴ Social identity theory also, at least as presented by Burford,¹ seems to be about minimising possible conflicts or tensions more than it is about acknowledging the full range of negative to positive emotions and making them an integral and essential part of identity development. Shapiro¹⁵ recently summarised work required on the emotional dimension of medical education and referred to the needs to pay attention to the emotions of patients, students and role models, to develop relevant theories, and to identify pedagogical tools.

Helping students to be sensitive to their own positive and negative emotions is largely unaddressed in medical education

Burford's illustration of how theory can illuminate research and practice and his exploration of professionalism and teamwork are valuable contributions.¹ Likewise, his illustration of how belonging or not belonging to the in-group and perceiving or not perceiving a fit can have profound emotional and behavioural consequences is valuable in that it shows identification and identity development to be highly emotional processes. Although we support Burford¹ in encouraging educators to question how accessibility and fit are salient in the experiences of medical students and new doctors, we urge them to be sensitive to the emotional highs as well as the lows of identity formation. We suggest that explicitly taking into account the emotional dimension of learning in workplaces will push the field another step forward and perhaps help more young people *really* want to be doctors.

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Shedding new light on tribalism in health care

Jennifer Weller

As a clinician and educator, I am often called to arms in the crusade for improved interprofessional collaboration. The perception that there is a problem is widespread and is highlighted by numerous studies and reports by government bodies and safety institutes linking high rates of medical error with poor communication and teamwork. Reflecting on my own experience as a hospital-based doctor in New Zealand, at times I feel as if I

am working with a number of different tribal groups, often operating in parallel, or collaborating warily and at times engaging in open hostility.

Junior doctors and nurses all identified most strongly with the medical "tribe" or the nursing "tribe" – rather than the tribe of health care professionals

When we asked junior doctors and nurses to describe their experiences of being in a team in their hospital workplace,¹ they all identified most strongly with their own professional group – the medical tribe or the nursing tribe – rather than with the tribe of health care professionals who look

after the patient. Furthermore, they talked about authority gradients between senior and junior doctors and nurses. If we consider that all members of the health care team have important knowledge about the patient, their sharing of this information should result in better patient care decisions. Tribalism and power gradients can impact on information sharing in at least three ways: firstly, input from the junior nurse, who is often the person closest to the patient, may not be valued, and he or she may be left out of decision-making processes; secondly, speaking up against a power gradient or challenging a member of a different tribe requires courage, and without such challenges poor decisions may

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doi: 10.1111/j.1365-2923.2011.04178.x