Evolution of professional identity in Clinician-educationalists

Dr Mobeen Iqbal

MBBS, DABIM, DABPD, DABCCM

Shifa International Hospital, H-8/4, Islamabad, Pakistan

Submitted for the Degree of Master's in Health Professions Education: Assessment and Accreditation, Keele University

August, 2018

Supervisor: Dr Viktoria Joynes, Director of studies and Senior Lecturer in Medical education, School of Medicine, University of Liverpool, UK

Declaration

I certify

(a) That the above dissertation/project is my own account, based upon work actually carried out by me, and that all sources of material not resulting from my own experimentation, observation or specimen collecting, including observational data, have been clearly indicated.

(b) That no part of the work incorporated in the above dissertation/project is a quotation from published or unpublished sources, except where this has been clearly acknowledged as such, and that any specific direction or advice received is also properly acknowledged.

(c) That I have read, understood, and abided by the terms of Regulation VII1.5 below:

CONDUCT WITH REGARD TO DISSERTATIONS, PROJECTS, ESSAYS ETC., WHICH FORM PART OF A FINAL EXAMINATION FOR ASSESSMENT PURPOSES

(a) Titles must be approved or specified by the Department concerned in accordance with the provisions in the Calendar.

(b) The dissertation, projects or essays etc. shall be in the student's own words, except for quotations from published and unpublished sources, which shall be clearly indicated as such and be accompanied by full details of the publications concerned. The source of any map, photograph, illustrations, etc. shall be similarly indicated. The student shall indicate clearly the sources, whether published or unpublished, of any material not resulting from his own experimentation, observation or specimen collecting, including observational data. Students will be required to sign a statement to that effect. Failure to comply strictly with these requirements may be construed as cheating.

Signed……  …… Date…21st of August, 2018……

Acknowledgements:

I am thankful to the foundation for advancement in medical education and research (FAIMER) for their generous grant for the Master's from Keele University, without which my efforts for advancing in the field of health professions' education could not have been possible.

The efforts from Professor Janet Grant as the program director, and facilitator of online discussions have been phenomenal. I learned a lot from her comments and thought provoking questions, which made me develop my own point of view in the context of existing theories. For that I would like to thank Prof. Grant.

I am indebted to my mentor, the late dean, Professor Muhammad Amin, who inspired me to become part of educational reforms at Shifa College of Medicine and supported me to develop in education.

I am extremely grateful to Dr Viktoria Joynes, my supervisor, who has been a wonderful guide and mentor throughout this process. Her guidance and thoughtful comments made this journey worth treading especially for someone who had a little experience in social science research.

Lastly, I am indebted to my wife, children, parents, friends and several other well-wishers who helped me bear the pressure of on-going clinical work and all the hard work required for the project.

Table of Contents

1. Abstract:

This enquiry pertains to the professional identity of those clinicians who, during their careers, decided to pursue a formal qualification in education (clinician-educationalists). Using six semi-structured interviews, this research throws light on the evolution of identity formation in the cohort of clinician-educationalist participants, and explores the social, cultural and personal influences of each participant during the journey.

Using a socio-cultural framework, the study provides insight into ways through which identity evolves in clinicians starting from what can be described as legitimate peripheral participation in the medical profession and the journey towards the core of community of medical practice. The analysis reveals interplay of several themes including socializing within medical community, the influence of role-models, exposure to professional development in education, opportunity to participate in educational reforms and influence of the learning environment through which the process of professional identity formation continued. Opportunities to play an active role in curriculum planning, delivery and evaluation, in both under and postgraduate teaching, resulted in individuals developing deeper interest in educational theory and desire to pursue formal qualification in education.

The study recognizes the importance of institutional context in developing interest in education-based career, and has implications for those wishing to develop a career as a clinician-educationalist. The findings also suggest potential efforts for educational reforms, and provide pedagogical strategies to nurture formal educational role as an integral component of medical socialization.

2. List of tables

3. Introduction

Within the literature pertaining to identity and identity formation, it has been argued that professional identity formation is an evolutionary process and entails experiences which are gained in both personal and social life including the process of education (Monrouxe, 2010). It is stressed that professional identity formation is an ultimate goal of any professional education (Irby, Cooke and O'Brien, 2010; Cruess, Cruess and Steinert, 2015). In case of medicine, professional identity develops during the context of undergraduate and postgraduate experiences and then continues to evolve in subsequent career (Roccas and Brewer, 2002; Pratt, Rockmann and Kaufmann, 2006; Rosenblum, Kluijtmans and ten Cate, 2016).

Identity as a clinician has been recognised to be shaped by experiences acquired through socio-cultural interaction, internal values and professional requirements (Gill, 2013; Cruess *et al.*, 2015). It is suggested that as the medical trainees or residents advance in their careers, they go through identity development through interacting with peers, teachers, role models, feedback (formal/informal) and experimenting with available context-specific work-roles which allow identity customization thus constantly shaping professional identity (Pratt, Rockmann and Kaufmann, 2006). Thus identity formation can be seen as a dynamic process, with identity remaining in a state of flux or fluidity.

Most existing identity research has focused on becoming a clinical practitioner (Pratt, Rockmann and Kaufmann, 2006; MacLeod, 2011; Holden *et al.*, 2012). The research

about professional identity is limited when it comes to exploring either the impact or formation of combining various roles within the medical profession. There are limited data on identity formation in those who subsequently evolve as clinician-educationalists. The term educationalist may have several meanings in different cultures but for the sake of this study, I am defining “educationalists” as clinicians who have a formal qualification in education.

How then can we best understand how clinicians are socialised into developing a professional identity? The community of medical practice may serve as the ‘social milieu’ for doctors where various roles (research, education, leadership, professionalism) embedded in the medical society are enacted by medical students depending on the realization through role models and values assigned in a particular context (Goffman, 1975; Ibarra, 1999). The exposure to multiple and diverse role-models may lead to the construction of several ‘provisional selves’, which through self-refection and feedback may subsequently lead to the eventual manifest role in the profession (Ibarra, 1999). Such experiences combined with critical reflection may eventually help to decide the direction, which one may like to take in professional career.

Based on the personal experience, the commonly available careers of a pure clinician, clinician-educator, clinician-scientist and clinician-administrator are some of the examples, which a developing professional may eventually adopt, depending on the institutional/societal values and personal preferences. These career tracks are important for the profession as they provide a focused and specialised work-force for

various areas of the medical profession. It might be possible that identity formation occurs in the wider context of clinical practice and yet these other careers continue to emerge, an area, which needs further research.

The aim of this study is to explore in depth what those clinicians, who had acquired formal qualification in medical education, understand about their professional identity. To do this, the study explores with participants the phases of medical education which they felt led them to become clinicians-educationalists subsequently. It is hoped that the findings from the study will help to understand identity evolution in the subset of interviewed clinicians, which may have implications for the development of clinician educators at individual, institutional and policy levels.

4. Review of literature

The purpose of this literature review was to understand existing literature on professional identity formation in clinicians and the various theoretical frameworks through which identity research in medicine had evolved. In turn, this helped to identify gaps in existing literature, especially in the area of interest to this study, which focused on identity formation in clinician-educationalists. As will be described, the dearth of studies related to clinicians with a formal degree in health professions' education helped to build the case for exploring identity in this category of clinicians (clinician educationalists).

Besides exploring identity in clinician educationalists, the literature review also helped to study and understand the different types of qualitative methodology, employed to explore topics in relation to the development of professional identity in clinicians, to help guide the appropriate study design.

The various combinations of several key words and terms were used to identify relevant literature. The details of key words, terms, and databases (primary, secondary and tertiary) explored are summarized in tables 1 and 2.

Table 1: Key terms and search strategy

Broad categories	Keywords/terms/Mesh	Boolean operators
Professional Identity	• Professional identity • Professional identity formation • Identity formation, • Multiple professional identities • Identity formation • Identity development	These terms were searched in various combinations using AND and OR as the main Boolean operator.
Medical practitioners	• Clinicians • Physicians • Doctors	
Education	• Teachers • Medical teachers • Clinical teachers • Preceptors • Medical education • Health professions education	

	• Educator • Educationalist	
Theory	• Theories • Theoretical framework • Social identity theory • Identity theory • Group processes	

Table 2: Information sources and databases explored

Type of Information sources		Databases
Primary sources	• Journal articles published in peer reviewed publications	PubMed (including Medline, PubMed central and biomed central), Education Resources Information Centre (ERIC), Google scholar and general Google search were used.
Secondary sources	• Review articles • Commentaries • PhD Thesis • Bibliographies	PubMed (including Medline, PubMed central and biomed central), Education Resources Information Centre (ERIC), Google scholar, and general Google search were used
Tertiary sources	• Encyclopaedias • Bibliographies	Wikipedia via Google was searched

4.1 Criteria for inclusion/exclusion of literature:

Various databases were explored as listed in table 2. The literature output was modified by applying limits to retrieve original studies and review articles primarily in the English language. Retrieved literature was split into three broad categories. The first category was of original studies pertinent to the professional identity in medical profession. The second was of review articles, which addressed professional identity in various contexts of medical education. Finally, the third category comprised of review articles, which addressed various frameworks, utilized in analysing professional identity of teachers in non-medical settings.

The full texts of fifty three articles were obtained through Shifa College of Medicine's library, ResearchGate, Google scholar and through personal communication with colleagues. All the relevant articles were imported into a reference manager, Mendeley desktop.

I excluded professional identity articles on Nurses and other allied professionals mainly due to contextual differences in terms of educational, social and economic backgrounds, which were thought to be more marked in the healthcare context of the Pakistan due to the more traditional hierarchy in medical profession. I also excluded some of the articles for which full text versions were unavailable due to logistic reasons.

4.2 Findings from Literature review:

Professional identity formation in health professions is one that is mirrored by the journey through which a novice who enters the medical profession transforms into an

independently practicing professional. It has been argued that professional identity develops in the context of learning the profession (Roccas and Brewer, 2002; Pratt, Rockmann and Kaufmann, 2006; Rosenblum, Kluijtmans and ten Cate, 2016). Professional identity development is said to start when one enters in undergraduate medical education and continues as one becomes an independent practitioner (Monrouxe, 2010; Weaver *et al.*, 2011; Barr, Bull and Rooney, 2015). Identity as a clinical practitioner might be shaped by experiences acquired through socio-cultural interaction, internal values and professional requirements (Gill, 2013). The socio-cultural interaction happens through both planned and hidden curriculum, and involves classroom experiences, observation by students, role modelling, storytelling and healthcare environment (Mizrahi, 1985; Hensel and Rasco, 1992; Cox *et al.*, 2006; Weissmann *et al.*, 2006; Joynes, 2014).

There are several theories about professional identity formation, and these have been developed from a range of psychological, cognitive, social and cultural perspectives (Bandura, 1986; Kroger, 2003; Irby, Cooke and O'Brien, 2010; Mann, 2011; Wilson *et al.*, 2013). The evolution of these theories has been non-linear and overlapping in terms of time line. These theories are influenced by world views of knowledge, reality and inability of a single theory to explain the phenomenon of identity formation. For example, from a psychological perspective, identity emerges as a result of social interactions (especially in adolescence) which results in construction of an individual's identity which may change subsequently (Erikson, 1968).

Another perspective, social identity theory, refers to one's self-concept in relation to the membership of a particular social group (in this case, the medical profession) (Erikson, 1968; Burford, 2012; Hogg, 2016). Such a position provides one way of understanding the within group similarities, biases and differences as they emerge (Tajfel and Turner, 1979; Brewer, 2001). When applied to the medical profession, different identities are available for self-categorization. These may be hierarchical (doctor as subordinate group of healthcare team), more exclusive (specialty groups) and crosscutting in nature (ethnicity, gender, nationality for example). However, using this theoretical stance, it is worth noting that the salient identity at a point in time, which determines the behaviour, is dependent on the context (Burford, 2012).

It is worth noting that context plays an important role in developing professional identity in other theoretical approaches (Lave and Wenger, 1991; Monrouxe, 2010). Personal identity has been understood to develop through socio-cultural interaction and involves relationships, gender, ethnicity and social class (Monrouxe, 2010). From this perspective, an individual has to negotiate and re-negotiate his/her identity whenever new context is entered which may include educational experiences at various levels, working in institutions, constantly evolving socio-cultural values and immersion in varied cultures; all inter-related (Goffman, 1975; Apker and Eggly, 2004). The process of identity formation therefore seems to be complex from both the actual process of formation and our understanding of it.

Medical students learn various professional competencies including professionalism, communication skills, bioethical principles and biomedical knowledge, and skills in a

contextual manner. The context and cultural setting in medical practice is the work place which provides an opportunity to immerse in real life professional practice where patients, colleagues, and other healthcare professionals come together to provide healthcare. The identity develops in this interactional setting through activities (e.g. bedside rounds, morning reports, small group learning) and relationships; all embedded in socially situated learning (Lave and Wenger, 1991; Apker and Eggly, 2004). The socio-cultural interactions with peers, teachers, patients and other healthcare professionals help shape learner's internal values and integrate knowledge and skills in the process of becoming a medical professional. It is suggested that as the medical residents (postgraduate students) advance in their careers, they go through identity learning cycles which through feedback, role models, and work-roles allow identity customization thus constantly shaping professional identity (Pratt, Rockmann and Kaufmann, 2006). Thus developing a professional identity can be seen as an evolving process where one interacts with others within the professional community and patients across cultures and changing context (social, cultural, political and economic).

It is said that when a learner enters the medical profession, the existing identity and self comes into contact with the desired requirements and norms of the medical profession. As the learner matures and delves deep into the profession, (s)he moves more towards the core of profession and community of practice (Swanwick, 2005; Dornan *et al.*, 2007; Mann, 2011). This participation and membership of the medical profession can potentially allow identity construction through various work roles that a professional has to play as their career progresses (Hall, 1995).

There are studies looking at socialization within the “community of practice” which may shape the identity through constant interplay of self and learning about the work requirements through interaction with peers, patients and other healthcare professionals (Weinholtz, 1991; Shulman, Wilkerson and Goldman, 1992; Pratt, Rockmann and Kaufmann, 2006). In order to fully understand this argument, it is important to understand the theory behind how a “community of practice” provides the social context of medical practice (Lave and Wenger, 1991). A novice enters this community formally as a medical student but may tend to see him/herself as part of it even from very early days. As a member of this community, besides acquiring competence, values are build and re-build through social interaction, interprofessional relationships, existing hierarchies, mentoring influences, hidden values, and prevailing norms; all constituting the professional culture (Cruess *et al.*, 2015). This socio-cultural model of identity formation starts with a concept known as ‘legitimate peripheral participation’ and grows as the journey continues towards the core of professional practice (Lave and Wenger, 1991). The experiences gained at various levels of training allow experimentation with various available roles in the community of medical practice. It is argued that this process of socialization helps in becoming a mature professional where the norms of the profession are gradually internalized thus shaping some of the 'provisional selves' into a manifest professional identity (Ibarra, 1999).

It is proposed that observation of role-models can help the learner identify various aspects embedded in the medical profession (research, education, leadership, professionalism) that contribute towards simple to complex professional roles (Ibarra,

1999). It has been argued that the exposure to multiple and diverse role-models may lead to construction of several ‘provisional selves’, which are evaluated through external feedback and internal standards (Ibarra, 1999). As the existing 'self' immerses in this context, conscious and unconscious cognitive factors (reflection, constant negotiation/renegotiation, moral orientation, self-assessment) tend to provide a scaffold for ongoing identity construction and co-construction (Niemi, 1997; Monrouxe, 2010; Frost and Regehr, 2013) based on prior life experiences and multiple (sub) identities like gender, religion, and ethnic groups (Beijaard, Meijer and Verloop, 2004). This process of evaluation can eventually help to decide the direction, which aspires to take in professional life. It is argued that this process of constant re-negotiation continues to shape up both self and professional identity (Goffman, 1975; Burford, 2012) through socio-cultural interaction and participation in community of medical practice (Jarvis-Selinger, Pratt and Regehr, 2012). It is interesting that identity continues to evolve as a need to fit in the desired and ever evolving social roles (Bauman, 2001) which may not be by choice. So professional identity development seems to be an ever evolving complex process, which is much more than mere learning of professional knowledge.

Most identity research is focused on becoming a clinical practitioner (Pratt, Rockmann and Kaufmann, 2006; MacLeod, 2011; Holden *et al.*, 2012). The research about professional identity is limited when it comes to multiple-role identities in medical profession (clinician-scientist, clinician-educator, clinician educationalist and so on). There are limited data on identity formation in those who subsequently grow in two or more disciplines especially clinician-educationalists. It will therefore be interesting to

explore the experiences of this category of professionals. Using the socio-cultural approach outlined here will provide the relevant framework to analyse the participants' experiences as they construct and co-construct identities from undergraduate to postgraduate and independent practice phases of their professional lives. It is hoped that this will enable an understanding of the various factors and influences, which might have shaped up the participants values in trying various available roles and then focusing more in becoming a clinician-educationalist.

It is worth considering the similarities and differences between a clinician and an educationalist when it comes to identity formation. Clinical practice revolves around a set of knowledge skills and experiences integrated to serve the patients in the best possible manner. The focus remains on diagnosing, managing and communicating with the patients and their families (MacLeod, 2011). Senior students help in the learning of juniors, senior residents train junior residents, and senior physicians/faculty are responsible for training their residents and students (Morrison, Shapiro and Harthill, 2005; Helmich *et al.*, 2012). It seems logical to conclude that professional identity as it evolves should have an integrated component of an educator as well. However, within medicine, there remain very few who pursue education as their dominant profession.

4.3 Critical Conclusions:

Based on the literature review, it is clear that professional identity formation is a complex process. The context of medical practice provides a stage where participants of this community of practice interact with peers, role models, community members,

patients; all from diverse backgrounds bringing their unique experiences, biases, and values (Monrouxe, 2010). The resulting socialization provides an opportunity for clinicians to evaluate their beliefs which may modify during a perpetual self-negotiation process thus shaping up identities within the context (Holden *et al.*, 2012).

The process of professional identity formation continues within the socio-cultural context and various available roles are enacted temporarily until certain roles are incorporated within the professional identity. There are studies which talk about junior teachers and clinician educators (Starr *et al.*, 2003; Morrison, Shapiro and Harthill, 2005) but a literature search revealed that the studies looking at identity evolution of clinicians with a formal degree in education are lacking. There are no studies from Pakistan in particular. Based on the available information, it would be interesting to explore the perceptions and evolution of professional identity in clinicians with a formal qualification in medical education.

4.4 Research question and potential implications

Exploring whether holding dual roles of a clinician and an educationalist bring any identity dissonance has not been previously investigated. It is important to explore the attributes, experiences and interactions, which further shape professional identity, especially when such a professional (e.g. clinician-educationalist) has to play a role in supporting and influencing junior learners' identity. One particular question, which remains unanswered, and is the focus of this study, is:

How do clinicians perceive their own identity when they take up specific roles, especially as an educationalist? Subsequent to this, how do these perceptions of identity help us to understand the route, which people take in order to become clinician-educationalist?

This study explores these questions through qualitative methodology focusing on clinician turned educationalists using a socio-cultural identity framework.

The findings from this study have potential implications at individual, institutional and policy levels. At individual level, identifying motivations, personal attributes, unique experiences and thought process can help identify those clinicians who may want to pursue such a career. At institutional level, appropriate enculturation of environment may help promoting clinician-educationalist career track for improving educational programmes and research. At the policy level, it might help local regulatory bodies to re-shape policies promoting clinician-educationalist career track, and implement educational reforms based on evidence and contextual needs.

5. Methods

This exploratory study requires in-depth understanding of the life experiences of clinician-educationalists. The epistemological stance for the study is subjective, which requires a constructivist (interpretivist/naturalistic) paradigm, where participants and the researcher closely interact to construct the meaning from the experiences in the light of social context without any preconceived notions (Hathaway, 1995). A positivist approach, which usually involves objective parameters and hypothesis testing was not feasible for the type of question addressed by this study (Tavakol and Sandars, 2014). This study required a closer interaction with participants to explore their perspective, thus making pure objectivity (that is the researcher being completely removed from the research process) an undesirable attribute (Sherman and Webb, 1988; Hathaway, 1995).

Additionally, this study used phenomenography to explore how identity might have evolved in clinician-educationalists. The study of phenomenon, such as identity formation, required an open ended approach without any preconceived notions. Due to varied experiences and perceptions, the construction of reality was expected to vary in participants. Utilising phenomenography allowed an in depth exploration about identity formation through naturalistic enquiry (Starks and Trinidad, 2007; Stenfors-Hayes, Hult and Dahlgren, 2013)

The question at hand required an in-depth analysis of lived experience of clinician-educationalists. Surveys, questionnaires or any other rating scale were not considered

as research tools due to their inability to capture the true essence of such an experience, which required elaboration and clarifications through dialogue. Thus, the semi-structured interview was used as the main modality for collecting data which helped to stay focused on the research area and also allowed the interviewee to explore the issue at hand in more depth (Edwards and Holland, 2013). The use of semi-structured interview also gave an opportunity to be inductive in analysis thereby linking information gained from interviews to develop broader understanding of identity development (Starks and Trinidad, 2007).

5.1 Sampling:

The critical case variety of purposive sampling was utilized to achieve representativeness and do exploration (Patton, 1990) of the desired phenomenon of interest i.e. professional identity formation in clinician-educationalists. The study sample comprised of clinicians who had spent significant time as practising professionals (more than 10 years of any type of professional medical practice) and then subsequently became educationalists by acquiring a Master's degree in health professions' education while continuing active professional clinical practice, thus serving as critical cases.

I conducted six in depth semi-structured interviews with two male and four female participants, which gave some gender diversity to explore the possibility of gender-related differences in the studied phenomenon. It has been suggested that identity formation may be different in females due to different cultural and early life experiences

(McGowen and Hart, 1990). The gender issue has not been explored in medical education and any differences observed may result in recommendations for institutions and training programs.

5.2 Instrument design and piloting:

As the study revolved around the context of medical education (undergraduate, postgraduate and independent practice), accordingly, the interview schedule was divided in three phases with questions focusing on different stages of professional identity formation both as a clinician and an educationalist. These questions were developed in the light of socio-cultural identity theory, which served as the theoretical framework for this project.

The questions explored identity formation through common work roles during professional practice and medical socialization as the participants advanced through various stages of their education and eventually independent practice (Pratt, Rockmann and Kaufmann, 2006). A list of questions/topics was generated and shared with the supervisor and some of the colleagues for advice. The questions focused on participants' motivations in moving towards education as a career, peer/teacher interactions, challenges, barriers, support systems, influence by role models and balance between clinical and teaching roles; all in the hope of getting the desired information about their evolving professional identity.

The interview schedule had a list of open-ended questions (and follow-up prompts) which allowed exploration of participants' evolving identity by their own priorities and

perceptions (appendix 1). This flexibility allowed a more natural course and dialogue which addressed most of the questions on the interview schedule at some point during the interview, thus providing a richer and fuller depiction of the interviewee's experience as reported before (Castillo-Montoya, 2016).

I piloted my interview schedule by conducting two interviews. I chose a full-time clinician and a basic science educationalist. The clinician's pilot helped in exploring the understanding of a professional in the usual role of providing healthcare with some teaching responsibilities. The interview with the basic science educationalist helped in fine tuning the questions about professional identity in a full-time teacher who had a formal degree in education. The experience helped me in identifying issues with some of the questions and refining prompts, an approach based upon advice of others who have used this method (Castillo-Montoya, 2016). The process of piloting also gave me some hands-on experience with the dynamics of conducting semi-structured interview.

5.3 The interview process

The interviews were allowed to flow naturally and probing questions were asked where necessary. A mutually agreed place was selected which allowed comfort to talk and audio record, by a digital recorder, the proceedings. The sequence of interview schedule was not strictly followed but answers to all the desired questions were ensured. In order to be authentic, semi-structured interviews were allowed to continue for extended periods based on the participants' response. Notes, if required were taken both during and immediately after finishing the interview. This helped in subsequent

analysis and reduced any recall bias. I endeavoured to ensure a balanced conscious approach in addressing the desired topics in interviews to prevent any power or emotion imbalance which might have limited communication or interpretation of data (Edwards and Holland, 2013).

Most of the participants knew me as a clinician-educator. However, I did not see this as a hindrance or limitation in the study as my focus was on the individual's professional identity rather than the professional knowledge. In fact knowing some of the participants facilitated the interview process by promoting a shared understanding of the relevant context.

5.4 Analysis

I preferred not to transcribe interviews, as I wanted to analyse directly while listening and taking notes. This strategy preserved the original conversational tone and meanings, besides being time-preserving. After initial un-interrupted listening of all interviews, I had a second round of listening the interviews to identify categories with reference to specific conversation marked through time counter on digital audio recorder for subsequent (Glaser, 2013) re-listening and modifications in categories if required. The whole process was done manually without the use of software. The analysis was inductive and interpretive in nature. The categories were assigned by constant interaction with the data through repeated listening of interviews. Through constant comparison within the data, relevant categories were identified. The process of delving with the data and comparison helped to be inductive by identifying categories. Once the

categories were assigned, I developed overarching themes based on the conceptual linkage. The interpretive and evaluation process required constant comparison of data with themes, and themes with themes both within and across all the interviews for similarities and differences thus reaching conclusions from the data (Hsieh and Shannon, 2005; Braun and Victoria Clarke, 2006; Starks and Trinidad, 2007).

In order to ensure the robustness of analysis, critical review was sought from two of my colleagues who had prior experience with qualitative analysis. I transcribed one of the interviews and shared some of the excerpts with them. These colleagues were asked to identify categories from the data and also identify any possible overarching themes. The categories and themes were compared with my own analysis, which were mostly in agreement. Some minor variations in themes were resolved when the analysts were provided with the full length interview transcript, which initially resulted in some differences.

Once the analysis was complete, I also shared the quoted quotes under the relevant themes with all the participants. Two of the participants corrected some of the sentences to clarify their actual point of view addressed during the interview process. All the participants responded in agreement both in terms of credibility and representativeness of their quotes within the identified themes, a strategy as described in prior literature (Lacey and Luff, 2007; Starks and Trinidad, 2007). Moreover, intermittent consultation was sought from the supervisor regarding analysis and interpretation of the data.

My own position as a researcher and analyst was constructivist in nature (Bunniss and Kelly, 2010) as I tried to construct the meaning of their experiences by going over the interview data, identifying and avoiding personal understanding and prior assumptions effecting data interpretation.

The study was not set to produce generalizable data. It was ensured that there was detailed description of participants, their experiences and context; in case someone would like to gauge the usefulness of the findings to their own context.

Research rigour was also maintained by being honest throughout the process of recording, analysing and reporting the real account of the participants' experiences with a conscious understanding of the possible impact of my personal experiences on interpretation of the data.

5.5 Ethical Concerns:

The study was approved by the institutional review board and ethics committee of Shifa International hospital and Shifa Tameer-e-Millat University, Islamabad (appendix 2). The informed consent (appendix 3) was obtained from all the participants. Each participant was assigned a pseudonym to ensure confidentiality while mentioning individual quotes.

6. Results

All six (four females and two males) participants were clinicians from various specialties and subspecialties. Four participants were from Internal Medicine and its sub specialties (general internal medicine, Neurology, Oncology, Pulmonology) and two were from surgical sub-specialties (Ophthalmology and Obstetrics/Gynaecology). Three participants were full professors (two males and one female) and three were associate professors (all females). Out of six, three participants were serving heads of their departments (two females and one male). All participants had more than 10 years of experience of independent practice (range from 12 to 35 years).

The data from six semi-structured interviews conducted is presented here. All the names used in quotes are pseudonyms to ensure confidentiality. The interviews lasted between forty-five minutes and one and a half hours. Four participants were interviewed at the researcher's hospital office and two were interviewed at their workplace.

In order to organise the results in a chronological fashion, the results are presented based upon the phases of medical education which comprise; undergraduate medical education, postgraduate education and independent practice. The major themes identified at each phase are listed in table 3.

Table 3: Identified themes at three stages of exploration

Phases of experience	Themes identified
Undergraduate Medical experiences	1- Personal values 2- Learning environment 3- Role-modelling and workplace socialization 4- Strategic peer-group socialization 5- Support systems.
Postgraduate medical experiences	1- Learning environment 2- Professionalism 3- Transformation through reflection and role-models 4- Formal exposure to teaching. 5- Gender-based biases
Independent practice and professional identity	1- Peer influence 2- Influence by mentors 3- Opportunity to participate in educational reforms 4- Self-realization 5- Exposure to educational professional development 6- Education as value/identity.

6.1 Undergraduate Educational Experiences:

This section explores the experiences described by the participants as a result of interacting with peers, teachers, patients, and socio-cultural scenarios. This resulted in themes that emerged around personal values, learning environment, role-modelling and work-place socialization, strategic peer group socialization and support systems.

Personal values

All participants were well aware of their existing personal values, which influenced their identity and later became an integral component of their professional values as the professional journey continued. These values included passion for the profession, commitment, hard work, honesty, truthfulness, readiness to learn, self-reliance, resilience, punctuality, self-accountability and being respectful to others.

These values played role in their professional development as both a clinician and educationalist:

> *...umm I am caring…I am honest and a hard worker. One has to be honest with oneself and with profession. Once you are honest with your work and self then everything else becomes secondary* (*Sara)*

> *I am a caring person as I used to feel for patients and in modern day language you can call it empathy…In my opinion what you say and what you practice need to be the same in profession. There should be no conflict between the two*. *(Amen)*

Learning environment

Participants reflected that, as a new entrant to medical school, the learning environment was thought to be very important to understand the context of learning. Interaction with peers, teachers, patients and prevalent ethos was seen as having helped in shaping motivation and strategies to learn. Participants reported developing the politics of learning, informal ways employed for learning, and strategies to meet the expectations of different teachers.

> *I decided to open the book and start reading….the concept of adult learning and active learning which looks so difficult as an educator, we all were doing it from the beginning….this was the way I fitted in the system…I found seniors who guided me about teachers, do this and do that…(Ahmed)*

All of the participants mentioned keen observation of their environment, which included understanding of the learning context, teachers' preferences, likes and dislikes, and tricks, which may help them, progress in a smooth fashion.

Due to limited guidance available, self-learning was realized to be an important feature of early professional development, with participants discussing that this was done through the formation of informal learning groups and peer mentors. The learning was seen as a self-directed activity with a lot of guidance from peers. As lecturing was the major teaching modality for all participants (and would have involved more than 250

students), it could be suggested that lack of close interaction with teachers promoted active self-learning especially in early years of basic science teaching.

Participants also noted that diverse patient exposure helped in understanding various cultural differences (language, gender related cultural differences) in communicating with patients and varied epidemiology of diseases.

> *A special thing about my city is that it is a multilingual society…. One could find patient from all these diverse linguistic groups. Understanding and communicating with patients was an issue…the students also used to speak several languages and the learning groups were formed in such a fashion to ensure better patient communication…patients used to come from across the border which were very good source of learning. (Bashir)*

Role-modelling and work-place socialization

As the journey continued towards clinical years, participants described how their professional values started to emerge in the context of observing care providers, role models, interacting with patients and constantly self-evaluating their personal values. Communicating with patients and observing professional behaviours, (respect for patients, caring through listening and demonstrating empathy) were recognized and reconciled with what participants described as their own innate characteristics:

I first saw two patients with leucodystrophy in paediatrics. I still remember whenever they used to come for follow-up they would shout my name the moment they used to spot me …If you are honest to you and your work, everything falls in place…I remain the same as a person when I enter in my professional role. (Sara)

When I go to hospital or I go to see the patient, I enjoy and like rounding and interacting with patients...I do not see myself any different when at work…There are no two personalities. *(Amen)*

This resulted in identification of both positive and negative role models, which helped in discarding unwanted behaviours such as poor communication, lack of up-to-date knowledge, promoting favouritism, being disrespectful to juniors and lack of accountability as a professional. This ties in with existing literature on this topic, which also suggests that negative role-models can be helpful in inspiring feared professional roles which need to be avoided (Jordan *et al.*, 2015). Easy accessibility, openness to questions, respectfulness to students, commitment to the profession, good communication skills, demonstration of empathy with patients, making learning easy, good bedside manners and command on subject were identified as desired attributes for good teachers and role-models.

I learned from Z how to lay down things and develop patterns. I learned hard work from A and motivated by B to become a teacher due to her style and command on the subject. (Mehwish)

Our rheumatologist impressed me. She knew medicine and the way she used to teach and interact with patients was appealing. She was involved with patients. Unlike other clinicians, she was punctual, would see all patients...Some of the clinicians were not very impressive…one of our surgeons had bad outcomes mostly after surgery... This aspect of doing surgeries without discussing with patients was very bothersome….making favourite postgraduates was another aspect which I disliked. (Amen)

The participants observed various role models closely where the professional values were distinguished, desired professional behaviours were appreciated and unethical practices were identified. More role models were identified during clinical years due to closer interaction, smaller group size and work-place based learning.

The first teacher who inspired me to be a doctor was Dr S. He was an internist and used to bring his own computer with all multimedia. The first lecture he took was in auditorium where he played the song sung by Fine Young Cannibals 'she drives me crazy'. I was really amazed that he is a medical teacher who is saying that there is life beyond medicine…Dr S was very close to students easily available and was very accessible…..he was very punctual and for him 8 am meant 8 am. (Ahmed)

One of our professors was very impressive. He would start observing the patient the moment patient used to enter his room. I liked the way he handled the patients,

his thorough examination, ethics, mannerism, compassion and professionalism irrespective of social class of the patients… (Rida)

Strategic peer-group socialization

Interestingly, the peer interaction was based on the needs of the new entrants to the medical community, which included both enjoyment and studying. The desire to meet the strategic needs induced relevant friendship groups.

The interaction with peers was compartmentalized. I knew the peers who were good when we had to go outside for enjoyment. I had identified seniors and my peers who would help me in studying. Obviously at that time there was no formal peer assisted learning so what we used to do was to have free time where junior can come and ask for any help. (Ahmed)

Our seniors taught us. We did the same during the breaks in daily schedule. I have taught my peers and juniors. Our group was very active in self- study and teaching others. These self- made groups were the mainstay of learning in those days. (Amen)

In this process, participants noted that certain groups developed where partying, having fun, and sharing common interests were the main focus. Most of these groups had members of single gender mainly due to a strong cultural influence.

Support systems

Self-identification of support system (peers, family members, and friends) was also an important aspect of education. These support mechanisms helped in providing guidance about learning, understanding prevailing politics of institution, and finding protection in case of adversity. All of the identified support systems were thought to be helpful in developing resilience and self-reliance in subsequent professional life.

6.2 Postgraduate Educational Experiences:

The postgraduate phase of education revolved around clinical training and started from a year-long phase termed in our local system as “house job” and continued until becoming an independent practitioner. The interaction with patients and clinical teachers was closer at this stage, with increased responsibility in terms of clinical care and decision making. The identified themes revolved around learning environment, professionalism, transformation through reflection and role models, formal exposure to teaching and gender based biases.

Learning environment

The participants saw their postgraduate training as hands-on phase where their direct involvement in clinical care made it the most relevant to their learning. They started to feel part of clinical care teams with contribution towards clinical decision making.

However, participants still felt that hierarchy was strongly maintained and questioning seniors' practices was not welcomed.

> *During internship, we used to value those clinicians more who used to communicate effectively with patients…..I felt comfortable in terms of knowledge about medicine in postgraduate training in the USA but struggled in terms of its clinical application. I realized later that the learning kept seeping in as we rotated. It was obvious that I gained expertise but I realized it later during my independent practice. (Amen)*

> *The style was different in Lahore and Karachi as compared to my city. I focused more during training. The training was formal and sophisticated. The responsibility was more in terms of independent work. The rounds used to be detailed, hands-on, and I learned clinical problem solving. I learned a lot practically in Karachi with the availability of sophisticated management and investigations. We learned a lot from several foreign trained physicians. (Bashir)*

> *Working with one of my teachers, I learned the concept of explaining diagnosis and management to the patient, a practice not routinely performed by most of clinicians. I also observed him asking the patient 'do you have any questions?' at the end of a consultation. (Ahmed)*

One participant could identify the components of patient-related safety addressed informally in their hospital when clean linen was regularly provided along with hygienic

good quality food. Negative aspects like professional rivalry and jealousy were apparent in some anecdotes. One participant in particular was severely tarnished by her female supervisors who constantly rebuked due to appearance, apparel and a particular family background.

> *They were vindictive…I was pushed aside…those women were powerful. They made everybody's life miserable including mine. I did not have the guts to stand up to them and I ran away after 2 months. (Mehwish)*

Professionalism

Ideas about professionalism started to mature further in the postgraduate training phase especially in relation to matters of informed consent and the need for formal counselling about disease and management strategies. The importance of patient's role in clinical decision was observably absent as mentioned by some participants. Some of the practices such as lack of informed consent and poor/inadequate communication with the patients were apparent in almost all the interviews.

> *I was impressed by clinicians in USA, mainly due to their patient interaction and command on subject matter…I think their discussions with patients were more formal and consent was routinely obtained for procedures…we had students in our teams as well and we used to guide them about management and we were evaluated by them as well…there is more accountability at all levels including medical students, interns and senior residents. (Amen)*

Working with one of my teachers, I learned the concept of explaining diagnosis and management to the patient, a practice not routinely performed by most of clinicians. I also observed him asking the patient 'do you have any questions?' at the end of a consultation. (Ahmed)

Transformation through reflection and role models

During postgraduate training, the increasing responsibility towards independent practice along with critical reflection resulted in transformation towards a more complete professional and a holistic human being. In one case, religion was re-discovered as a means for becoming a better human being and professional.

I am very fond of reading and in medical college I started reading about Quranic transliteration. This changed me and I started to feel softening in my inner self. In fact I believe now that one can be a better human being if you are related to any eternal concepts, or any religion….I felt that any concept of God in any form changes you and it makes you a better person….I care for my patients, as I feel answerable to them… (Rida)

In other cases, it was ability to identify one's strengths and potential through role-models and self-reflection that triggered self-awareness.

I was motivated by a close friend who inspired me to re-join my postgraduate training. My interest in clinical research further motivated me. During postgraduate

training, I was exposed to some of the faculty members working in medical education. This interaction made me very much interested in theory behind education and on-going reforms in our medical school. (Mehwish)

I am driven by my internal motivation. I always observe keenly and believe in both positive and negative role modelling. When I was attending my mother in law in hospital, I observed nurses taking care of her. One of the nurses will grab the hand gently while administering intravenous medication and used to rub it to make her feel relaxed… (Rida)

In another case, role-modelling helped in incorporating experience from non-medical domains of life (politics, religion, personal anecdotes) to enrich bedside teaching.

Formal exposure to teaching

At this stage, almost all of the participants enjoyed a more formal teaching exposure. The personal experiences at undergraduate level helped the participants tailor their approach towards teaching. Teaching was seen as a diverse activity with close interaction with learners through open communication and feedback. New methods of teaching were tried to make learning easy and enjoyable.

As I was from a small city, I concentrated more on students teaching during my postgraduate days. I learned from my experience in Lahore and then applied to student teaching. They liked me and my style as they thought it was more natural and close to real life….I used to apply my undergraduate experience of learning where the interaction with teachers was very friendly….(Bashir)

We were told to teach our juniors in our second year of training…we had a structured teaching for juniors…. There was no formal evaluation of our teaching… It gave me freedom to do what I wanted to do. It was there I realized that I am a good teacher, tooting my own horn…I was trying to simplify things to the learners…..most of the problems arise due to language barrier in learning…I tried to contextualize. I used my undergraduate experience of simplifying things. (*Ahmed)*

Gender-based biases

Most of the female participants thought that gender caused them difficulties to be treated as a professional. They mentioned how the life was different at various stages of their development due to cultural differences. The female participants felt that they had to perform more than their male counterparts to win acclaim, and make impact in both teaching and clinical practice.

As a woman you have to give 110% to prove that you are better…..males are insecure….due to being female, I had to struggle hard and felt more confident as a result. (Sara)

Men have edge at all stages of professional development. Due to societal norms, there is a barrier when it comes to females interacting with males. (Amen)

In fact, a male participant also recognized the difficulties faced by female colleagues during professional life.

Females are undervalued and not heard. (Ahmed)

6.3 Independent Practice and Professional Identity:

This phase mainly revolved around clinical practice and subsequent teaching experiences of the participating clinician-educationalists. The broad themes included peer influence, influence by mentors, opportunity to participate in educational reforms, self-realization, exposure to educational professional development, and education as a value.

Peer influence

During professional practice, most of the participants were exposed to passionate teachers who employed innovative ways in their routine teaching. As a ripple effect, they developed interest in the theoretical aspects of teaching/learning. This led to incremental interest in various aspects of education (curriculum, pedagogy, assessment, feedback, and evaluation)

Influence of mentors

The presence of mentors, with rich philosophical underpinnings, also helped some of the participants to pursue formal degree in health professions' education. The mentorship helped some to recognize their own hidden potential as well.

> *I enjoy teaching as it makes me think for myself as how I can simplify things for my students. It invigorates me as students respond to me about questions which they might not have thought before…it all comes back to an email sent to me by a mentor…He wrote that your teaching is a gift from Allah and you are wasting it and you should be doing something about it… that e-mail was my motivation to do something about my teaching. (Ahmed)*

...I presented an initial study on use of evidence in morning report at AMEE… Our dean was one of the several mentors around me. He used to have logic, depth, and reasoning behind all his targets….these influences gradually drove me in acquiring formal qualification in medical education. (Amen)

I was motivated by a mentor in the deanery who said good words about my potential as a researcher after publication of an important well cited article…I realized that that there is so much more in education when compared to clinical work…my personality test as part of my fellowship in medical education helped me in realizing my true self… (Mehwish)

Opportunity to participate in educational reforms

The surrounding environment motivated several participants where they could experiment with teaching and learning of undergraduate medical students as part of broader institutional reforms. The resulting experience further motivated their participation and led to strengthening of their teacher identity.

Self-realization

During the process of interaction with peers and mentors working for educational reforms, some of the participants rediscovered their passion as teachers and wanted to

develop as educationalists. The positive feedback from students also helped them realize their potential as teachers.

Exposure to educational professional development

Professional development in education also triggered interest through listening and participating in faculty development workshops by experts in the field. The ability to apply various skills learned in the respective undergraduate and postgraduate domains further stimulated interest to pursue formal qualification in education.

Education as a value/Identity

When asked about their professional identity, the opinion was split. The participants realized education as their core value. Most of the participants had not thought explicitly about their professional identity. Some required clarification about the concept of professional identity. Some of them considered themselves educationalists much more than a clinician. However, some thought that they were clinicians from the core, but realized that the role of an educationalist is an integral component of a clinician and cannot be separated. One of the participants thought that once in an environment with strong stress on the educationalist role, he realized that he in fact was more of an educationalist than a clinician. Another clinician thought that the two roles are completely separate and try to compete with each other in terms of time and practice.

Interestingly, most of the literature revolves around identity in clinicians with education as one of the available role in the medical community of practice. This study highlights the importance of context (Cruess *et al.*, 2015) where some participants got interested in educational theory through exposure to professional development programs and opportunity to participate in on-going educational reforms at their institutions. Institutional ethos played important role in pursuing formal degree in education by most of the participants.

7. Discussion:

The original research question aimed to explore how clinician-educationalists perceive their professional identities as they progressed through various phases of medical education to independent clinical practice. The purpose was to explore their unique experiences to create meaning especially towards becoming educationalists and to understand the tensions and conflicts identified at various levels and their contribution in shaping them as a professional.

All the participants were clinicians (from different specialties) and educationalists who passed through similar steps of training in medical education but with unique set of experiences. The interviews generated understanding of different participants' context and experiences which shaped their identity development. The journey of becoming a clinician and educationalist sheds light on some of the factors which might have played pivotal role. Using the lens of Socio-cultural theoretical framework (a variant of social identity theory) to understand the narratives of the participants about identity formation, I have tried to explain the relationships of themes to create meaning from the data.

The socio-cultural theory of identity formation revolves around constant shaping of 'self' through interaction with peers, personal experiences, prevailing norms, personal values and professional requirements; all dependent on the context (Bandura, 1986; Vågan, 2011) and getting involved in reflective practice (Imel, 1992). For example, the entry into medical school can be seen as formal entry into the community of medical practice (legitimate peripheral participation) and subsequent experiences at postgraduate and

independent practice seen as the journey towards the core of this community of practice (Lave and Wenger, 1991; Cruess *et al.*, 2015; Wald, 2015). This gradual and constantly evolving process of socialization into medical world has been argued to continually shape professional identity.

In this study, role models were identified by all participants at every stage of their learning. They were clinicians, teachers, friends, and from other healthcare professionals. In most cases, the roles which were positively modelled by them were related to profession (desired knowledge, skills and attitudes). Role-modeling has been identified as an important way of learning in the context of medical practice (Cohen *et al.*, 2009) . It is mostly, informal and opportunistic as compared to mentoring which is more formal and includes role-modeling as its component (Kenny, Mann and Macleod, 2003), and the more formal apprenticeship (planned workplace experiences in formal curriculum) which is an extension of role-modeling where cognitive re-structuring occurs as part of close interaction in the defined context (Kenny, Mann and Macleod, 2003). As the participants were exposed to various stages of education and practice, they identified practicing role-models in their learning environment who helped them learn and imbibe professional roles, at times, as part of hidden curriculum.

Most of the participants had some teaching experience at all levels of education. The participants described that their experience always was enjoyable and was related to their learning experiences during their undergraduate and postgraduate days. They were able to build on some of the deficiencies identified through their own experience which included lack of close contact with teachers, lack of empathy at times, poor

displays of professionalism (punctuality, respect for patients, informed decision making) and lack of opportunity to provide feedback as a learner.

Socialization into the medical profession is a broad concept and an important theme that emerged from the data. Socio-cultural theory provides a nice framework for understanding the impact of socialization on identity formation (Mann, 2011; Vågan, 2011). It involves how a learner identifies learning context and interact with peers, teachers, patients and other healthcare professionals. The work-based interaction provides the ground for adopting professional roles (clinician and educationalist in this case) in the learning environment which mature as the experience accumulates (Trede, 2012). All participants mentioned being influenced by peers, role-models, mentors, teachers, and patients. The ability to identify and reflect on the practices which were valued by the profesional community and society was important in shaping the evolving identity from an existing ‘self’ to a potential future ‘self’, thus making identity development a fluid phenomenon in nature (Bauman, 2001; Wong and Trollope-Kumar, 2014). The data from the study supported the notion when participants described their life experiences at various stages of their development.

The participants in this study identified 'learning' as a self-directed process as they progressed through the different phases in their medical education. The learning context encouraged them to study and align themselves with study-oriented peers in order to attain the desired goals (strategic socialization). The finding suggested once again the value placed on certain way of learning and interacting with colleagues to develop strategic friendships to achieve the desired goal (Wong and Trollope-Kumar, 2014;

Cruess *et al.*, 2015). Due to large class size and lack of close interaction with teachers, self-identified groups become a major pedagogy for learning. Participants perceived that the guidance continued to flow from seniors and at times with more accessible formal teachers. The clinical phase of education was centered around available patients and formal small clinical groups though informal self-study groups continue to provide after-hours learning supported by more willing and accessible junior level teachers (postgraduate trainees) and freely available patients in a public sector environment. Participants described that these interactions helped them in identifying aspects of inadequate clinical practices, issues with clinical teaching, ethical dilemmas, teachers' biases and poor standards of care through self-reflection. This study reinforces the importance of hidden curriculum (observing role models, patient encounters, peer interaction), albeit in a different context, as reported before which serves as a powerful influencer during the process of identity evolution (Karnieli-Miller *et al.*, 2010; Monrouxe, Rees and Hu, 2011; Wong and Trollope-Kumar, 2014)

Almost all participants acknowledged that their personal values and desired professional values were congruent which made them realize the value of honesty, hard work, integrity, empathy, desire to help patients and respect for patients. The conflicts between desired professional values and observed practices were identified through observation and reflection on the clinical environment' which comprised of context, preceptors, patients, nurses and peer interaction. These conflicts helped them in identifying the gaps between professional standards and the actual practice of medicine in their respective contexts. Such critical observations of the mismatch between the

expectations and reality can be very helpful in learning and shaping the professional identities of developing physicians especially the ones who will be playing a formal role as educationalists subsequently (Bartle and Thistlethwaite, 2014).

Opportunity and chance were important factors in developing interest in education, a finding which has been reported before as well where people instead of actively seeking educational paths, fell into them, at least initially, by chance (Joynes, 2014). During their career, most of the participants got an opportunity to participate in educational development programs and ongoing educational reforms in their respective medical schools. The participation was mostly voluntary but provided an opportunity to interact with students and members of another 'community of practice' (mostly educationalists) (Mann, 2011). The immersion in this new learning environment stimulated the desire of explore the nuances of educational theory. As a result of this opportunistic socialization (Cruess *et al.*, 2015), past experiences were re-shaped and the momentum of change continued to develop interest which culminated in a formal career in education subsequently.

Participants described that once they had entered independent practice, they were attracted by mentors, influenced by peers, exposed to opportunities in education and self-identified natural passion for teaching. This resulted in desire to improve teaching, understand nuances of education, fill gaps in teaching, and contribute towards institutional priorities towards medical education reforms. This lead to a new form of socialization which was nurtured by formal exposure to theories of education through ongoing education-related professional development programs in their institutions, a

finding which is relatively unique to this study. This helped them relate their teaching experience with the underpinning theories of education. Most of the participants had sought to further validate their skills acquired through institutional professional development programs by entering in Master's degree programs. Masters provided them an opportunity to focus on the reasons behind teaching and learning methodology thus filling the gap between practice and theory.

During the process of 'becoming', parallel experiences are important. These experiences can be of personal nature or in the realm of professional practice. For example, religious inspiration can impact the 'self' through reflection and can lead to evolution towards a new 'self' which may encroach various aspects of life including profession (Ibarra, 1999). The literature on identity formation in Jesuit tradition sheds light on the use of religious lens of reflection through which professional encounters are evaluated. The phenomena of suffering, professional wisdom and relationships are seen with a different mindset which is more appreciative and positive (Holden *et al.*, 2012).

Similar transformation can be expected through role-models who manifest behaviours which attract people in the environment and lead to moulding of their identities. These socio-cultural influences constantly shape and re-shape professional and work-related identities.

Personal life experiences outside the professional domain also influenced some of the participants. The support from parents in terms of promoting values was identified by

most of the participants. The influence of friends in motivating in testing times, and interaction with their growing children helped in understanding the context of teaching and learning. The individual (personal attribute and preferences), relational (family, mentors, peers, friends) and collective (as part of community of medical practice or other social groups) identities can, and in the case of the participants, were, merged. The process of integrating personal and professional ‘selves’ through experiences and reflection to develop a congruent professional ‘whole’ continues thus making identity a constantly evolving process as suggested before (Bauman, 2001, 2005).

In terms of identity, most of the participants considered themselves as clinicians but some have a very clear preference for teaching, policy making in education and capacity building as their priority. Participants identified however that there is always tension between the clinician and educationalists role with both consuming each other's time. Some of the participants saw the role of an educationalist as a grounded function of an academic and in fact a necessary extension for being an educator. Others felt that the tension remains when it comes to play both roles simultaneously and in equal proportions where one can become a competitor of the other. It was apparent that the will to be the both an educator and a clinician can create a constant struggle to strive balance. Interestingly the context specificity is also highlighted in this study where one role is valued more than the other just impacting the manifest identity. This is an interesting finding and Slotnick mentioned in his article how the experiences, context, expectations and valued roles influence identity development, and determines dominant role display (Slotnick, 2001).

Gender-based biases directed towards female clinician-educationalist were identified as an important factor for professional growth. The female participants were disadvantaged in promotions and acquiring leadership positions. The cultural norms were seen as barrier to communication with strategically important academic and clinical leaders, a finding reported before as well (Horn, 2014). The literature on identity formation in females is limited when it comes to clinician-educationalists. The female participants descibed issues in relation to socialization at all levels of education and independent practice, a finding reported in female faculty members before as well (Pololi and Jones, 2010). The literature about gender-based biases did shed some light on issues with professional identity in females which had its differences rooted in early life experiences and different professional socialization process (McGowen and Hart, 1990). It was interesting to note that identity dissonance was more common in females due to different early experiences (Eubank, 2006). The female participants in this study described being more likely to have problems when integrating professional identity into their existing personal identity which at times could be very traumatizing due to discordant views and values, and different emotional orientation.

8. Strengths and limitations of ths study:

The present study is very context specific with a very small sample size and the findings cannot be generalized to any other context. However, as explored throughout the discussion, the identified themes are in accordance with other studies about professional identity of clinicians. This study is the first in its kind which expands the existing literature involving clinicians who have formal degree in health professions'

education. The identity development in this cohort throws light on the roles of a clinician and educationalists and the tensions related to them. Interestingly, most of the participants evolved as clinicians till their postgraduate education and subsequent independent practice, educational ‘self’ though was identified early but manifested in the presence of an education-laden socio-cultural enviroment.

9. Implications:

More studies will be required to further broaden the knowledge of clinician-educationalists’ identity development in different contexts. This exploratory study is an important contribution in the present context of Pakistan, where ongoing movement of educational reforms is gaining momentum at the policy level inspired by initial experiences from some of the private medical schools in the country.

It will be important to have practicing clincians with deeper knowledge about theory of educational practices to be the fore-runners in implementing such reforms. It is interesting to note that opportunity played an important part in the careers of our small cohort. Exposure to educational development programs, practicing role-models and conducive socio-cultural environment are important factors which can actively promote this breed of clinicians thus creating new career line. Table 4 summarises some of the recommendations to encourage clinicians into becoming educationalists.

Table 4: Recommendations for promoting clinician-educationalists as career

For individuals

1- Develop a formal understanding of professional identity formation through active observation and self-reflection at all levels of medical education
2- Constantly reflect on socialization at workplace to identify interest in education and actively seek mentors and role models

For institutions

1- Exposure of faculty members to professional development programs in education
2- Encourage and nurture role models who are clinicians-educationalists
3- Encourage broader faculty participation in on-going educational reforms through discussions, capacity building and providing institutional support for further education

For policy makers

1- Identify gender-based differences at all levels of education and provide necessary support to ensure female academic development
2- Curriculum modification at undergraduate and postgraduate levels to introduce formal exposure to teaching pedagogy linked with underpinning educational theory

10. Conclusion:

The present study is the first of its kind from Pakistan which throws light on the professional identity formation of clinicians who evolved as educationalsts. It reiterates the importance of context, socialization (role-modeling, learning expriences, interactions), available opportunities and personal life experiences in the process of becoming clinician-educationalists.

Looking back at the experiences of participants, it is interesting that most of the learning at undergraduate and postgraduate levels was opportunistic and not well organized. The entry into the community of medical practice and legitimate peripheral participation sounds very logical but it requires a planned approach in the form of a well laid-down curriculum and related processes which go hand in hand towards promoting learning of students. Role modeling stands out as the most influential factor for identity development but it is left to the students to identify role models and develop mental faculties to self-define medical professionalism without guided space in the curriculum to discuss and express their own observations, and perceptions of learning.

Interestingly the socialization in postgraduate education continues in the same manner thus internalizing identity roles which my be acceptable to professional norms and society but may not be acceptable by professional standards. As practicing clinicians and educators, the values are set in the manner that education takes the back seat and professional knowledge is applied in a de-sensitized context.

The stories from the participants reveal late appearance of educationalist role-models and mentors in their careers and some of them happen to be at a common institution with common mentors at different points in time. The dearth of mentors and role-models with strong passion in education, severly compromises the socio-cultural context which promotes unwanted professional behaviours.

The findings from the study can be utilized both at the institutional and policy levels to provide the required ingredients during various phases of professional education which may promote this professional track for clinicians. Pakistan medical and dental council should focus on professional development of teachers and especially clinician-educationalists to provide the necessary socialization at the work-place so that graduating physicians are well aware of the professional demands consonant with their own personal identities.

11. References

Apker, J. and Eggly, S. (2004) ‘Communicating professional identity in medical socialization: considering the ideological discourse of morning report.’, *Qualitative Health Research*, 14(3), pp. 411–429. doi: 10.1177/1049732303260577.

Bandura, A. (1986) *Social foundation of thought and action: A social cognitive theory*, *Englewood Cliffs*.

Barr, J., Bull, R. and Rooney, K. (2015) ‘Developing a patient focussed professional identity: an exploratory investigation of medical students’ encounters with patient partnership in learning’, *Advances in health sciences education : theory and practice*, 20(2), pp. 325–338. doi: 10.1007/s10459-014-9530-8.

Bartle, E. and Thistlethwaite, J. (2014) ‘Becoming a medical educator: motivation, socialisation and navigation’, *BMC Medical Education*, 14(1), p. 110. doi: 10.1186/1472-6920-14-110.

Bauman, Z. (2001) ‘Identity in the globalising world’, *Social Anthropology*, 9(02). doi: 10.1017/S096402820100009X.

Bauman, Z. (2005) ‘Education in Liquid Modernity’, *Review of Education, Pedagogy, and Cultural Studies*. doi: 10.1080/10714410500338873.

Beijaard, D., Meijer, P. C. and Verloop, N. (2004) ‘Reconsidering research on teachers’ professional identity’, *Teaching and Teacher Education*, 20(2), pp. 107–128. doi: 10.1016/j.tate.2003.07.001.

Braun, V. and Victoria Clarke (2006) ‘Using thematic analysis in psychology’, *Qualitative Research in Psychology*, 3 (November 2014), pp. 77–101. doi: 10.1191/1478088706qp063oa

Brewer, M. B. (2001) ‘The many faces of social identity: Implications for political psychology’, *Political Psychology*, 22(1), pp. 115–125. doi: 10.1111/0162-895X.00229.

Bunniss, S. and Kelly, D. R. (2010) ‘Research paradigms in medical education research’, *Medical Education*, 44(4), pp. 358–366. doi: 10.1111/j.1365-2923.2009.03611.x.

Burford, B. (2012) ‘Group processes in medical education: learning from social identity theory’, *Medical Education*, 46(2), pp. 143–52. doi: 10.1111/j.1365-2923.2011.04099.x.

Castillo-Montoya, M. (2016) ‘Preparing for Interview Research : The Interview Protocol Refinement Framework’, *The Qualitative Report*, 21(5), pp. 811–831. doi: Retrieved from: http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=2337&context=tqr.

Cohen, M. J. M. *et al.* (2009) ‘Identity transformation in medical students’, *American Journal of Psychoanalysis*, 69(1), pp. 43–52. doi: 10.1057/ajp.2008.38.

Cox, M. *et al.* (2006) ‘The Developing Physician — Becoming a Professional’, *New England Journal of Medicine*, 355(17), pp. 1794–1799. doi: 10.1056/NEJMra054783.

Cruess, R. L. *et al.* (2015) ‘A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators’, *Acad Med*, 90(6), pp. 718–725. doi: 10.1097/ACM.0000000000000700.

Cruess, R. L., Cruess, S. R. and Steinert, Y. (2015) 'Amending Miller's Pyramid to Include Professional Identity Formation', *Academic Medicine*, 91(X), pp. 180–185. doi: 10.1097/ACM.0000000000000913.

Dornan, T. *et al.* (2007) 'Experience-based learning: A model linking the processes and outcomes of medical students' workplace learning', *Medical Education*, 41(1), pp. 84–91. doi: 10.1111/j.1365-2929.2006.02652.x.

Edwards, R. and Holland, J. (2013) *What is Qualitative Interviewing?*, *'What is?' Research Methods Series*. doi: 10.5040/9781472545244.

Erikson, E. H. (1968) 'Erikson ' s Theory of Psychosocial Development', *Identity: Youth and Crisis.* doi: 10.1016/B978-0-08-097086-8.23200-5.

Eubank, R. K. . (2006) 'Professional identity crisis: race, class, gender, and success at professional schools.', *Choice: Current Reviews for Academic Libraries*. doi: 10.1353/rhe.2007.0016.

Frost, H. D. and Regehr, G. (2013) '"I AM a doctor": negotiating the discourses of standardization and diversity in professional identity construction.', *Academic medicine : journal of the Association of American Medical Colleges*, 88(10), pp. 1570–1577. doi: 10.1097/ACM.0b013e3182a34b05.

Gill, D. (2013) 'Becoming Doctors : the formation of professional identity in newly qualified doctors', (April).

Glaser, B. (2013) 'Grounded theory methodology', *Introducing Qualitative Research in*

Psychology. doi: 10.1191/1478088706qp063oa.

Goffman, E. (1975) ‘The presentation of self in everyday life’, *Life as theater*, p. 173. doi: 10.2307/258197.

Hall, D. T. (1995) ‘Unplanned executive transitions and the dance of the subidentities’, *Human Resource Management*, 34(1), pp. 71–92. doi: 10.1002/hrm.3930340106.

Hathaway, R. S. (1995) ‘Assumptions underlying quantitative and qualitative research: Implications for institutional research’, *Research in Higher Education*, 36(5), pp. 535–562. doi: 10.1007/BF02208830.

Helmich, E. *et al.* (2012) ‘Entering medical practice for the very first time: Emotional talk, meaning and identity development’, *Medical Education*, 46(11), pp. 1074–1086. doi: 10.1111/medu.12019.

Hensel, W. and Rasco, T. (1992) ‘Storytelling as a method for teaching values and attitudes’, *Academic Medicine*. doi: 10.1097/00001888-199208000-00003.

Hogg, M. A. (2016) ‘Social Identity Theory’, *Understanding Peace and Conflict Through Social Identity Theory: Contemporary Global Perspectives*, (August), pp. 3–17. doi: 10.1007/978-3-319-29869-6_1.

Holden, M. *et al.* (2012) ‘Professional identity formation in medical education: The convergence of multiple domains’, *HEC Forum*, 24(4), pp. 245–255. doi: 10.1007/s10730-012-9197-6.

Horn, K. V. (2014) ‘Gender bias in Academic medicine’, *Donald School Journal of*

Ultrasound in Obstetrics and Gynecology, pp. 97–99. doi: 10.5005/jp-journals-10009-1342.

Hsieh, H.-F. and Shannon, S. E. (2005) 'Three approaches to qualitative content analysis', *Qualitative Health Research*, 15(9), pp. 1277–1288. doi: 10.1177/1049732305276687.

Ibarra, H. (1999) 'Provisional selves: Experimenting with image and identity in professional adaptation', *Administrative Science Quarterly*, 44(4), pp. 764–791. doi: 10.2307/2667055.

Imel, S. (1992) 'Reflective practice in adult education', *Eric digests*, (122), pp. 1–7.

Irby, D. M., Cooke, M. and O'Brien, B. C. (2010) 'Calls for Reform of Medical Education by the Carnegie Foundation for the Advancement of Teaching: 1910 and 2010', *Academic Medicine*, 85(2), pp. 220–227. doi: 10.1097/ACM.0b013e3181c88449.

Jarvis-Selinger, S., Pratt, D. D. and Regehr, G. (2012) 'Competency is not enough: integrating identity formation into the medical education discourse', *Acad Med*, 87(9), pp. 1185–1190. doi: 10.1097/ACM.0b013e3182604968.

Jordan, C. *et al.* (2015) 'Motivation by Positive or Negative Role Models : Regulatory Focus Determines Who Will Best Inspire Us Motivation by Positive or Negative Role Models : Regulatory Focus Determines Who Will Best Inspire Us', (October). doi: 10.1037//0022-3514.83.4.854.

Joynes, V. C. T. (2014) 'Exploring the professional identity of health and social care

staff via experiences of interprofessional education and collaborative practice'. Viktoria Cheryl Taz Joynes Submitted in accordance with the requirements for the degree of Doctor of Philosophy T', *White Rose UK*, (September).

Karnieli-Miller, O. *et al.* (2010) 'Medical students' professionalism narratives: A window on the informal and hidden curriculum', *Academic Medicine*. doi: 10.1097/ACM.0b013e3181c42896.

Kenny, N. P., Mann, K. V and Macleod, H. (2003) 'Role Modeling in Physicians' Professional Formation: Reconsidering an Essential but Untapped Educational Strategy', pp. 1203–1210.

Kroger, J. (2003) 'Identity development during adolescence', *Blackwell handbook of adolescence*, pp. 205–226. doi: 10.1002/9780470756607.ch10.

Lacey, A. and Luff, D. (2007) 'Qualitative data analysis', *Trowbridge, Wiltshire: The Cromwell …*, pp. 1–46. doi: 10.7903/cmr.14043.

Lave, J. and Wenger, E. (1991) 'Situated learning: Legitimate peripheral participation', *Learning in doing*, 95, p. 138. doi: 10.2307/2804509.

MacLeod, A. (2011) 'Caring, competence and professional identities in medical education', *Advances in Health Sciences Education*, 16(3), pp. 375–394. doi: 10.1007/s10459-010-9269-9.

Mann, K. V. (2011) 'Theoretical perspectives in medical education: Past experience and future possibilities', *Medical Education*, 45(1), pp. 60–68. doi: 10.1111/j.1365-

2923.2010.03757.x.

McGowen, K. R. and Hart, L. E. (1990) ‘Still different after all these years: Gender differences in professional identity formation.’, *Professional Psychology: Research and Practice*, 21(2), pp. 118–123. doi: 10.1037/0735-7028.21.2.118.

Mizrahi, T. (1985) ‘Getting rid of patients: contradictions in the socialisation of internists to the doctor-patient relationship’, *Sociology of Health & Illness*. doi: 10.1111/1467-9566.ep10949079.

Monrouxe, L. V. (2010) ‘Identity, identification and medical education: Why should we care?’, *Medical Education*, 44(1), pp. 40–49. doi: 10.1111/j.1365-2923.2009.03440.x.

Monrouxe, L. V., Rees, C. E. and Hu, W. (2011) ‘Differences in medical students’ explicit discourses of professionalism: Acting, representing, becoming’, *Medical Education*. doi: 10.1111/j.1365-2923.2010.03878.x.

Morrison, E. H., Shapiro, J. F. and Harthill, M. (2005) ‘Resident doctors’ understanding of their roles as clinical teachers’, *Medical Education*, 39(2), pp. 137–144. doi: 10.1111/j.1365-2929.2004.02063.x.

Niemi, P. M. (1997) ‘Medical students’ professional identity: self-reflection during the preclinical years.’, *Medical education*, 31(6), pp. 408–415. doi: 10.1046/j.1365-2923.1997.00697.x.

Patton, M. (1990) ‘Qualitative Evaluation and Research Methods’, *Qualitative Evaluation and Research Methods*. doi: 10.1002/nur.4770140111.

Pololi, L. H. and Jones, S. J. (2010) ‘Women faculty: An analysis of their experiences in academic medicine and their coping strategies’, *Gender Medicine*, 7(5), pp. 438–450. doi: 10.1016/j.genm.2010.09.006.

Pratt, M. G., Rockmann, K. W. and Kaufmann, J. B. (2006) ‘Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents’, *Academy of Management Journal*, pp. 235–262. doi: 10.5465/AMJ.2006.20786060.

Roccas, S. and Brewer, M. B. (2002) ‘Social identity complexity’, *Personality and Social Psychology Review*, 6(2), pp. 88–106. doi: 10.1207/s15327957pspr0602_01.

Rosenblum, N. D., Kluijtmans, M. and ten Cate, O. (2016) ‘Professional Identity Formation and the Clinician–Scientist’, *Academic Medicine*, XX(X), p. 1. doi: 10.1097/ACM.0000000000001252.

Sherman, R. R. and Webb, R. B. (1988) *Qualitative research in education: Focus and methods*, *Explorations in Ethnography*.

Shulman, R., Wilkerson, L. and Goldman, D. A. (1992) ‘Multiple realities. Teaching rounds in an inpatient pediatric service.’, *American journal of diseases of children (1911)*, 146(1), pp. 55–60. doi: 10.1001/archpedi.1992.02160130057021.

Slotnick, H. B. (2001) ‘How doctors learn: Education and learning across the medical-school-to-practice trajectory’, *Academic Medicine*. doi: 10.1097/00001888-200110000-00008.

Starks, H. and Trinidad, S. B. (2007) ‘Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory.’, *Qualitative health research*, 17(10), pp. 1372–1380. doi: 10.1177/1049732307307031.

Starr, S. *et al.* (2003) ‘Community Preceptors’ Views of Their Identities as Teachers’, *Academic Medicine*, 78(8), pp. 820–825. doi: 10.1097/00001888-200308000-00017.

Stenfors-Hayes, T., Hult, H. and Dahlgren, M. A. (2013) ‘A phenomenographic approach to research in medical education’, *Med Educ*, 47(3), pp. 261–270. doi: 10.1111/medu.12101.

Swanwick, T. (2005) ‘Informal learning in postgraduate medical education: From cognitivism to “culturism”’, *Medical Education*, pp. 859–865. doi: 10.1111/j.1365-2929.2005.02224.x.

Tajfel, H. and Turner, J. (1979) ‘An integrative theory of intergroup conflict’, in *The Social Psychology of Intergroup Relations*, pp. 33–47. doi: 10.1016/S0065-2601(05)37005-5.

Tavakol, M. and Sandars, J. (2014) ‘Quantitative and qualitative methods in medical education research: AMEE Guide No 90: Part i’, *Medical Teacher*, 36(9), pp. 746–756. doi: 10.3109/0142159X.2014.915298.

Trede, F. (2012) ‘Role of work-integrated learning in developing professionalism and professional identity’, *Asia-Pacific Journal of Cooperative Education*, 13(3), pp. 159–167.

Vågan, A. (2011) ‘Towards a Sociocultural Perspective on Identity Formation in Education’, *Mind, Culture, and Activity*, 18(1), pp. 43–57. doi: 10.1080/10749031003605839.

Wald, H. S. (2015) ‘Professional Identity (Trans)Formation in Medical Education’, *Academic Medicine*, 90(June), pp. 701–706. doi: 10.1097/ACM.0000000000000731.

Weaver, R. *et al.* (2011) ‘“Part of the team”: Professional identity and social exclusivity in medical students’, *Medical Education*, 45(12), pp. 1220–1229. doi: 10.1111/j.1365-2923.2011.04046.x.

Weinholtz, D. (1991) ‘The Socialization of Physicians during Attending Rounds: A Study of Team Learning among Medical Students’, *Qualitative Health Research*, 1(2), pp. 152–177. doi: 10.1177/104973239100100202.

Weissmann, P. F. *et al.* (2006) ‘Role modeling humanistic behavior: Learning bedside manner from the experts’, *Academic Medicine*. doi: 10.1097/01.ACM.0000232423.81299.fe.

Wilson, I. *et al.* (2013) ‘Professional identity in medical students: pedagogical challenges to medical education.’, *Teaching and learning in medicine*, 25(4), pp. 369–73. doi: 10.1080/10401334.2013.827968.

Wong, A. and Trollope-Kumar, K. (2014) ‘Reflections: An inquiry into medical students’ professional identity formation’, *Medical Education*, 48(5), pp. 489–501. doi: 10.1111/medu.12382.

Appendix 1: **Interview schedule**

Evolution of professional identity in Clinician-educationalists

Each participant to be given an information sheet and asked to sign a consent form to show that they are willing to take part in the research, and that they are willing to have their responses recorded and transcribed.

Questions:

1- Ask the interviewee to explain their professional background and current role.
2- I would like to ask how your experience was when you were going through undergraduate education.
    a. Did you get any opportunities to interact with students of junior years?
    b. Tell me about your learning experiences at various stages of your medical school. (classroom, laboratory, bedside, informal)
    c. What inspired you during your undergraduate education? (Teachers, mentors, colleagues, senior students, patients, environment)

3- Can you share with me your experiences of postgraduate training?
    a. What opportunities did you have to interact with medical students and residents during this stage of your training?
    b. Tell me about your learning experiences at various stages of your training. (Bedside, conferences, informal)
    c. How did you see teaching and providing clinical care at the same time?
    d. How did you see the role of your preceptors, attending physicians and senior residents in your learning?
    e. What inspired you during your this phase of your education?

4- Let us switch to professional identity.
    a. What do you understand by professional identity?
    b. How do you see your own professional identity?
    c. What factors do you think were influential in your professional identity formation? (give examples, any narratives, influences, incidents)
    d. Do you think gender play any role in shaping your identity as a professional?
    e. Do you think professional identity stays the same as you advance in your professional life?
    f. How do you relate your own personality with professional identity? (Interrelated, integrated as a continuum, role switching...)
    g. How do you see your professional identity as an educationalist? (Continuum of a clinician vs. any drift vs. evolution vs. primary professional identity)

Appendix 2: ethical approval

شفا انٹرنیشنل ہسپتال اسلام اباد

Shifa International Hospitals Ltd.
Sector : H-8/4, Islamabad - Pakistan
Tel : 051-8463000, 8463075
Fax : 051-4863182
Email: irbshifa@shifa.com.pk
web: www.int.shifa.com.pk/irb

INSTITUTIONAL REVIEW BOARD & ETHICS COMMITTEE
(IRB & EC)
Shifa International Hospitals Ltd. (SIH)
Shifa Tameer-e-Millat University (STMU)

Dr.Mobeen Iqbal

Shifa International Hospital

Islamabad

Ref: 934-209-2017

Dear Dr. Mobeen Iqbal,

We would like to inform that your study entitled as "***Evolution of Professional Identity in Clinical-Educationalists".*** has been approved.

The IRB/EC is in accordance with the ICH and GCP guidelines. Any chances in the protocol should be notified to the committee for prior approval. ***All the informed consents should be retained for future reference (if applicable).A proper report should be submitted quarterly and final report after completion of the study to the IRB/ ethics committee.***

Sincerely

Dr.EJAZ KHAN

Chairman IRB and EC

Appendix 3: **Participant Consent form**

I, _____, agree to participate in a research study titled "Evolution of professional identity in clinician educationalists" conducted by Mobeen Iqbal from the division of pulmonary and critical care Medicine, Shifa International Hospital, under the direction of Dr. Viktoria Joynes, University of Liverpool. I understand that my participation is voluntary. I can refuse to participate or stop taking part at anytime without giving any reason, and without penalty or loss of benefits to which I am otherwise entitled. I can ask to have all of the information about me returned to me, removed from the research records, or destroyed.

The purpose of this research study is to understand how do clinicians perceive their identity through different phases of their education and eventually during independent practice. The study will also explore various factors which may have enabled these practitioners to pursue formal degree in health professions' education. The study will explore how do clinician-educationalists view themselves and their profession, professional identity, as represented through their lived experience.

If I volunteer to take part in this study, I will be asked to do the following things:

1. Participate in an interview regarding my personal and professional identity. The interview will be audio taped and last about one hour, at a convenient location to both the interviewer and interviewee.

2. Participate in a follow-up interview if required for any further questions or elaborations which may surface during the course of study.

Though, I will not benefit directly from this research but the study may shed light on phenomenon which may have implications for institutions desiring to promote clinician-educationalist career track. No discomforts, stress, or risks are expected.

No individually identifiable information about me, or provided by me during the research, will be shared with others without my written permission unless it is required by law. My identity will be disguised by a coded name during the research process and in all final research products including publications. I also understand that digitial audio files will be destroyed once the study is completed and published with in three years after completion of the project.

The researcher will answer any further questions about the research, now or during the course of the project, and can be reached by telephone at 0321 529 6880.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____ _____ _____

Mobeen Iqbal Signature Date

Cell:03215296880 iqmob@yahoo.com

_____ _____ _____

Name of Participant Signature Date

Please sign both copies, keep one and return one to the researcher. Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Ethics Committee, Shifa International Hospitals, H 8/4, Islamabad. Telephone (051)846-3000.