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Professional Identity Formation Across the Health Professions

Summary from the *Understanding Medical Professional Identity and Character Development Symposium* held April 30, 2021

PREPARED BY:
Penelope Lusk, MS, & Verna Monson, PhD

MEDICAL COLLEGE OF WISCONSIN
KERN INSTITUTE

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Discussion Leader:

Verna Monson, PhD

Recommended Pre-Reading:

Lewin LO, McManamon A, Stein MTO, Chen DT. Minding the Form That Transforms: Using Kegan's Model of Adult Development to Understand Personal and Professional Identity Formation in Medicine. Acad Med. 2019 Sep;94(9):1299 - 1304. doi: 10.1097/ACM.0000000000 002741. PMID: 31460919.

Paradis E, Whitehead CR. Beyond the Lamppost: A Proposal for a Fourth Wave of Education for Collaboration. Acad Med. 2018 Oct;93(10):1457 - 1463. doi: 10.1097/ACM.0000000000002233. PMID: 29620672; PMCID: PMC6159689.

Primary Discussion Questions:

1. What are the animating and wicked problems in PIF and Character Development in Medical Education?
2. What unique differences between the health professions need to be recognized when doing work in PIF? And what similarities span the professions? How can theories and curricula reflect these similarities and differences?
3. What are the various ways we might work together on these scholarly dialogues? What do we have the capacity and time to do? What would be need to be successful?

Summary/Abstract:

At the 2021 Professional Identity Formation and Character Development Symposium at the Medical College of Wisconsin, six individuals from across the health professions gathered to discuss the nature of inter-professionalism in relation to professional identity formation and character development. The group worked through a set of questions, seeking to understand how we can better apply principles of PIF and character development across the health professions. Topics discussed included the importance of language and framing, the similarities and differences in training and professional understanding across the professions, and tools to develop cross-professional connections. Selected citations to enhance the conversation are provided below the transcript.

Take Home Points:

1. Develop integrated pathways for individuals in any profession to engage in deep

consideration of professional identity formation
2. Language and labeling matters when considering PIF in the professions
3. Constructed controversy is a useful pedagogical tool for developing professional identity formation, and would be ideal for cross-professional relationships
4. Formal approaches are needed to mitigate power differentials between the professions when working together

Transcript:

The group opened with introductions.

[Group Leader]: All right. So, our topic is Professional Identity Formation Across the Health Professions.

Can I ask each of you to say maybe a little bit about this topic, about identity formation across the health professions, and what your particular interest or goals are. That would be helpful to frame our discussion.

[Participant 1]: My particular interest is finding out – it used to be that [professional identity formation] wasn't considered a skill. So, now it's a skill, so we can teach it. I think back when I was in medical school, certainly, there was no discussion anywhere close to this. It was just do your best and move on. So, my particular interest is figuring out at what point we can assess it reliably and validly.

[Participant 2]: My interest is two-fold. One, I've started several little interprofessional program with medical students and masters in social work students where they, together, work on geriatric case studies. And then interview some seniors, people in their upper 90's and talk about some real issues in their lives.

The other is that I do some volunteer work with a group of nursing students on medical missions. And so I get to see how nursing students at a very young age, they're senior nursing students in their early 20's, and how they develop professional identity. And to do a better job as a faculty person on a trip like that. So, that's my interest.

[Participant 3]: We're at the level of we do some things, but yet balancing or getting calendars to align is the biggest problem. And so, the idea of we still are at the level of skills as opposed to – and understanding what the other group experiences with our graduate nurses. We've done a few things with pharmacy students. So, the idea of the big construct of professional identity formation, we're pretty far from that. Although we are trying to align the calendars better. And I think we're gonna do that, so we might have some opportunities.

[Participant 4]: My specific interest is PAs and NPs in early career and professional skills, specifically looking at professional skill, professional growth and development. And what I hear is just some opportunities to enhance those skills that will improve people's individual identity of what it means to be part of their profession. But also understanding a little bit better how it integrates into the team-based care that they're involved in every day.

[Participant 5]: And I'll just say I come from a place of curiosity as to what others are doing in the allied health fields.

[Group Leader]: So, the first question that we have been assigned is, "What are the animating and wicked problems in professional identity formation and character development in medical education?" These are very loaded, juicy questions. What is animating and wicked?

[Participant 1]: I'm not sure if I'm gonna answer this properly, but from my point of view, professionalism and professional identity formation takes a back burner, or is not prioritized. I'm not just saying by the faculty. The faculty actually are – now everyone is talking about it. But by students, it's not on their radar, sometimes when they even start medical school. And then Step 1 becomes the big, bad thing staying over their heads. So, I think making sure that they understand that PIF is as important as anything else in the curriculum is definitely something that I think is a challenge.

[Participant 3]: I would definitely agree with that, the idea that, if anything, the firehose is flowing in greater volume. And so, this idea of while we're trying to integrate professional identity formation, the knowledge that they have to gain is greater and greater.

The other thing that I would say is we don't have a vocabulary. I think the development, and the adult development concepts, we have to build in. We were talking about a couple of students who were challenging a couple of weeks ago within our program. And I realized only later that none of them had moved past Stage 2, kind of this self-authoring. They haven't agreed that the values of medicine trump their values quite yet. And without that language, we were just talking about them kind of as problems.

[Participant 4]: I would just say that I think that both internal – to echo what everybody's been saying, as well – that internally and externally, I think it's easier for the learners to recognize their deficiencies in some of those more tangible clinical skills. And they have a hard time doing the self-assessment portion of their own professional identity. And they're not getting as much feedback on it, as well. So, I think that's what's kind of interesting.

[Participant 2]: I came into this through the patient safety movement and realized how much this professional identity formation, interprofessional training, has to do with patient safety. And when you see how many medical errors and the tragic outcomes that occur because of deficiencies, which is why I think attitude is so central to this. The attitude that there are other people besides doctors that have valuable things to contribute to – maybe that would be part of the vocabulary, that we do this because it's just that much – it's safer and better for our patients.

[Participant 5]: I think any area of the curriculum that is new, meaning that we as faculty educators did not experience ourselves as learners, is difficult to roll out. First, you need the expertise of the faculty and the buy-in. And then for something as broad as professional identity formation, you hope that it gets reinforced in the students' interactions with faculty throughout, but it probably isn't, right?

So, all of us can talk about how do you develop a differential diagnosis, and maybe you wanna think through by organ system. So, we have different schemata that we've used for 30, 40, 50 years. But when we talk about professional identity formation, this is all new. And I think many of my colleagues grapple with the terminology, the stages of professional identity formation, just how to have conversations about it.

[Group Leader]: So, the second question is, "What unique differences between the health professions need to be recognized when doing work in shifts? And what similarities span the professions? How can theories and curricula reflect these similarities and differences?"

[Participant 2]: I can share something. So, we do this thing with the social work students in the community agency setting. And I have people imagine here's the patient, and then go around the room and say, "What do we actually call this person?" And for some, it's a client. For some, it's a partner. For some, it's a customer. And for others, it's a patient. And just hearing that from other people, that we're all talking about the same person, starts part of the dialogue. Getting to the vocabulary that we were talking about.

[Group Leader]: I am struck with how just that simple lesson is probably best illustrated by getting individuals from the different professions together in a realistic clinical setting. And then discussing the issue, because it's fresh in front of them. Rather than hearing about this as an abstract concept. So, there is, I think, a lot of wisdom. And I think there's also a lot of empirical literature that validates the power of those live experiences. Some call it service learning. But there's an extensive literature on how that is helpful in terms of cognitive development and also moral development and identity development. So, thank you for that comment.

[Participant 5]: So, I think what comes first to mind about similarity is that the primacy of the patient or the client, right, they come first. And they have autonomy. And we're here to help them. But I was curious that, [Participant 2], you said that some people used the word 'customer'. Because I wonder if there's anyone in that room that you have where maybe the patient's health and care is not primary.

[Participant 2]: In our setting – certainly someone who's selling products to these persons, or providing some type of financial service. But this is the Aging and Disability Resource Center, which is very strong in our community. And I would think that they have social workers and nurses and other persons. But they choose to call the persons 'customers'. Not that they're paying anything for the services, but that's their model. And then they help them navigate insurance programs and pharmacy benefit programs and things. So, they're looking at it from a more holistic way. But they just use the term 'customer', which is very foreign to me. I was kind of taken aback that that's how my patient was looked at. Of course, they're customers in some respects.

[Participant 3]: When you think of the importance of words and framing, I think that's an interesting exercise of just thinking about how we consider people. And I – this is just coming to me now as I think about the current initiative around character, caring, and competence. In thinking – my conception, at least from the conversations we've had with our graduate nurses, is that caring is much more primary in nursing. Whereas competence is more primary in medicine.

And so, it seems like competency – you admit them with good character, you hope that you picked the right people, and you teach them to be competent. And, oh, by the way, you should be caring. Whereas for nursing, it seems like, okay, we'll admit people of good character. We all assume we're gonna do that. You should be caring. And then competence seems like a smaller C than the other.

And I certainly see medical students talking with nursing and then saying, "You know, they don't know very much." And it's mostly because they're not schooled in the pathophysiology, necessarily. But there's probably something instructive in terms of how we might collaborate and how we might learn something about caring from nurses. And they might learn something about knowledge and figure out the boundaries. But nobody ever taught me what the education of a nurse was and where our areas overlap and where they are different.

[Participant 4]: Yeah. I think it's interesting because where I work is a navigation between Nurse Practitioners and Physician Assistants. One, more, that's a nursing model and one that's a medical model. Different, still, from nurses and

physicians, as well. So, it's interesting to see the approaches. And I think that something that comes to mind to answer [Group Leader]'s question on this topic, it's – I think sometimes it's getting a group together to understand more about their similarities and what their common goals are and what their common approaches are and recognizing the differences.

Because everyone does have quite a bit different training or background perspectives to get to the same cultural environment or the same patient care environment. So, there's a lot of rich knowledge there and a lot of opportunities for sharing.

[Participant 5]: I was gonna say that language is so important. And I wanted to flip it and think a little bit about what we call ourselves and each other. So, a lot of us in medicine feel we've been demoted to provider instead of doctor. But others feel that it's a good way to get rid of hierarchy, which shouldn't be there. And when you call an NP who has a doctorate, etc., etc. So, I think there's a lot that we can uncover with language.

And then it also made me think from the earlier prompt you said, [Group Leader], about similarities and differences. And I don't know if this is always the case, but I think frequently the physician is expected to be the leader of the team. And so that that's a little bit of a difference regarding your – I think – your professional identity. If you're a leader as opposed to one of the other team members.

[Group Leader]: That's interesting. I think in the article it mentioned that the idea that we don't teach about power. And that when we get groups together across professions, it's basically following the idea of the contact hypothesis, going way back to social psychology in the 1950's. That if we can simply get people who from different cultures together, that their prejudice against each other will decrease.The author, was saying that's not sufficient when they come to a group with different power levels and there's no attempt to level out those power levels.

And so, I think we're getting kind of into that territory of there are assumptions about the power levels that we bring in. And so, it's making those assumptions explicit and holding space for, maybe, a different way of using power. And expecting it from not just a physician – I don't mean just a physician, but only the physician – but expecting it from every member of a team at any one point. And so, that would be one assumption, to try to, first of all, unearth in people's thinking. And then, second of all, to construct a new belief, if you will, that power or leadership must come from every single person in the team.

[Participant 1]: I think this conversation prompts me to preface my introduction to teaching clinical skills to a student with your role on the patient care team,

rather than your role as a doctor. And that'll be good. It'll be very interesting. I don't know if I'll see a change or a result, but it certainly, it can only help interprofessional and personal professional identity formation.

[Group Leader]: Absolutely. That's a very good question. And actually, that anticipates the third question that we are assigned of, "What are the various ways we might work together on these scholarly dialogues? What do we have the capacity and time to do? What would be needed to be successful?"

[Participant 2]: Well, we found, for example, when designing the course, the session with the social work students, I had social workers help with nurses and community people. The social workers said, "You know, you'll never get the students to speak up if you just put them in a room with medical students because they'll be inhibited. They're doctors and we're not," was basically the way she put it.

And so, we finally had to find something for them to do that was sort of safe and not just like an ice breaker like your vacation or some other simple things like that. But something that would get them to see that each person had something valuable to contribute. And almost as a way of, then, opening the door to then talk about the medical side of things or the patient care-related sort of things.

So, getting people to appreciate the value of others is really important. And not something that the students are gonna get modeled when they're out in the clinical setting in the community, I think I could fairly say.

[Participant 4]: Just curious, [Participant 2], when you do that, do you do any ground rules or anything that's formalized like that? Or agreed on terms or anything like that?

[Participant 2]: Actually, yeah. This is a project through my institution. We used visual art observation to do that. And so, using visual thinking strategies. Everyone in the room would look at – in this group – would look at a piece of artwork and they would say what do we see? And you would use some very structured questions. What do I see? What does this mean? What am I not seeing here? What's missing?

And so, it's a formal way that's used in other areas of education, but it really helped to lay a ground rule. And then everybody can talk, because everybody can see the piece of art. And the artwork, actually, was part of the teaching in the session as well. So, it brought out some of the teaching points. So, without saying, as well.

So, I think that was one example. There are other ways. Certainly, reading

some piece of literature, some paragraph or poem or something. Some people have used that. But getting people to just show that other people have valuable experiences and perspectives. That's what we thought, at least. And the students, I think, in feedback and when we graded all this or asked for their responses, across the board felt that they had a greater respect for the other people from other groups as a result.

[Group Leader]: I do know of a researcher who was doing some work around professional identity formation and mask-making as an intervention. So there are people who are interested in this topic of using art to stimulate this kind of thinking that removes, in a way, the power distance that is embedded in some of the stereotypes we have about these different professions.

[Participant 5]: So, in medicine, I think we're notoriously bad at sharing. Each school does it their own way and develops their own curriculum and uses their own materials. And it seems silly that we keep reinventing the wheel. And so, I would extend that to other health profession schools, as well, that it makes sense as we move forward to try to share and learn best practices from each other in addition to doing interprofessional work together. Right? If we have some shared language, some shared constructs, then I think that will help when we all get into a room together.

[Participant 1]: I agree. And especially if you don't have the resources to develop things in your own institution. But along those lines, if we are sharing, I think it's also important to share what sort of the numbers of faculty that are needed for this? And what sort of reimbursement? It all seems so much in the cloud if you don't discuss those things. But for small schools – we are not well-funded. It's always tough for us. We're always – we don't have a big support structure around us. It would be so much better if we got all that information, as well.

[Participant 4]: I think in addition to sharing across organizations, even understanding how do you navigate your own organization? What are the resources there? I think it's so valuable to partner with other groups in an organization. We have things like a transformation office that they teach problem-solving skills. And it's great to learn that from an engineer and teach people skills that they would use every day and think about it in a different way than someone else might approach it that is part of their profession.

[Participant 3]: I'm just thinking. I wonder whether there's – what the value is in piloting things with some depth to them, as opposed to what we often try is what can we do for all of our medical students and x-number of nursing students. And you do these three-session things that are over two years or something like that that just are a dose of kind of nothing. And then you evaluate the hell out of it to try to figure out what it's accomplished, even

though you know that it isn't likely to have accomplished much of anything.

Whereas, in one of the other workshops, there are pathways. So, it's for a subset of people. And whether you create some sort of pathway that is a much more meaningful interaction for smaller numbers of people.

[Group Leader]: I think that's a valuable approach. Developing pathways, almost a role, for individuals in any of the professions to take on a more in-depth view of this and in terms of having it integrated within the curriculum over a longer period of time.

And I wanna suggest, and this was alluded to, indirectly, in the article, but idea of team training – it's often talked about as team skills training – as a way of getting at these norms that bring out, with clarity, that when we are working with a client or a patient – I'm not gonna use customer right now – but when we are working with this patient, we are all on that same team to help that individual. And that is our primary goal, and we expect everyone to be active and to play a role in helping that happen. Every voice needs to be brought to the table and needs to be heard.

And so, a pilot group that would make those norms very clear. And I wouldn't say those norms can be guided, but I think it's more powerful to have individuals develop them, to have students actually develop them in their own unique ways. Because it does encourage the self-directedness, which we know is related to identity development. And there's quite a precedent on team training. I'm just wondering, what are your thoughts on that? Are you currently doing any team skills training and development?

[Participant 5]: I know at my institution we did for a few years. I'm not sure we're doing it anymore. And I guess, at a naïve level, I'm trying to wonder what is the problem we are trying to solve now? Do we think that by team training we're going to help the professional identity development of everyone on the team? I think historically interprofessional collaboration was really around breaking down barriers so that the team can function better in the care of the patient.

[Group Leader]: Mm-hmm. What I am getting at is a concept called superordinate identity that is over-arching the identity of individual groups in silos. And I actually sent an article that discussed this at length to [Participant 4]. And I think if you're interested, I can also send it to you. But it would be a way of making explicit that this is a cognitive skill, if you will, of viewing a group of people from diverse professions as having a superordinate identity when it comes to patient or client care.

And in terms of the one-size-fits-all kind of team skills, I used to

coordinate those kind of sessions when I was working as an academic coordinator in a graduate management program. We would randomly assign individuals to base groups for one year. And part of the grade for students was determined by how they were graded by their peers. So, this was the norm in that field.

I don't know what is practical or meaningful for medical schools. I don't know. But I know some of the students that I've coached because of a lapse in professionalism have been very isolated socially, and would benefit from having closer ties with peers. It may have been an artifact of the pandemic and having people isolated. But it's something I wanted to raise as a possibility.

[Participant 4]: I think it's a really interesting concept. And I know this has come up when we look at a PIE assessment and kind of the question I posed with that. Because there is something about being – understanding and having that identity with your own individual profession. And that's invaluable and very important, especially when you're talking about roles.

But when you get down to some of those PIE questions at the bottom, when it's looking at a professional – or someone who you look up to in the profession – I ask the question with that, when it doesn't matter if it's someone of your own individual profession or not if it's something that you see as something valuable, in general, to your role or something to relate to as professional identity formation. Would it matter if it's a nurse, or a respiratory therapist, or a physician, or a PA? I don't know. And I guess that's the question of how it relates to that professional identity formation.

[Group Leader]: I would say from reading thousands of PIEs that medical students will look up to individuals regardless of their status and station. And I've read essays where they admire a nurse's aide or someone who is able to really form a meaningful connection to a patient who is suffering, and that they see how powerful this is. And I hope they don't lose that appreciation of people in those roles, because we know that they are absolutely vital to patient care. So, I would say that no, it shouldn't be bound by the technically labeled profession that you're in.

[Participant 5]: I agree. It certainly shouldn't be bound. But, of course, context matters, right? And so, I think it depends on the particular – this probably goes without saying – but when I gave that anecdote of the medical student subintern who persisted in calling the psychiatry consult to come back multiple times – oh, I'm sorry. This was in a workshop that not all of you were in.

But an example of a student kind of going above and beyond and moving

more to a Stage 4. Obviously, the nurse's aide might have concerns about the patient and feel that they need a consult. But it wouldn't be for the nurse's aide to act on it in the same way as the student or the resident, right? So, obviously, context matters. And I think 99% of the time, people know that and understand that. But I do think about the trainees among us who maybe don't understand that as much, that we might sometimes need to be explicit about that.

[Participant 2]: But couldn't it be that, for the nurse's aide, her responsibility is to say something and then take it to the nursing supervisor or something, if you don't get a response?

[Participant 5]: Absolutely.

[Participant 2]: Some chain of command so that – because my experience from clinical sampling is people just don't speak up. They're afraid to say something at all because of this power thing.

[Participant 4]: Or even boundaries or your own limitations and your skills. Whatever area of the healthcare profession you are in or what your role is in that team, as well. When to ask for help.

[Participant 5]: Right. So, I would say the role modeling is the being persistent and speaking up. And then the specific way of how you do it and the structures that you work within may be different, depending on your role on the team.

[Participant 3]: This is kind of interesting. I'm going in the direction with this. I don't know how it's gonna contribute, but just what you're talking about, [Participant 5], is the sense of the skill would be, on one end of the spectrum is silence. And we don't want people to be silent. At some other point in the spectrum, I'm not even gonna say where it is because I don't know, there's going right to the CEO or something like that. Like going over everybody's head. And then somewhere along the line is talking to the right people.

I hadn't thought about delineating it in that way, such that we've occasionally had students, an attending is saying something to a patient, and they feel compelled, because they don't think it's a hundred percent correct information, to correct the attending right there. That doesn't go over well. But really making those skills explicit.

[Participant 5]: Yeah. More and more so with all the discussions in society about lack of racial equity in medicine. And then society as a whole and the importance of allyship and standing up for others and all of that. I think we have – it's great that we have very activated trainees who do really take this to heart

and do really want to act in the community they're in. And sometimes, David, I think maybe what resonates with me about what you just said is sometimes in their enthusiasm to act, act in ways that don't help the patient, the situation, the community.

And so, right, how can we support our students and our trainees and encourage them? And also learn from them and understand it's okay to push the envelope, right, and maybe we all need to push the envelope. But when does it go too far in that it becomes detrimental instead of helpful?

[Group Leader]: There's a specific pedagogy of group learning called constructive controversy, developed by David Johnson, my co-advisor for my doctoral program. We wrote about how this method likely fosters professional identity formation growth. The empirical basis of the group learning or cooperative learning, and conflict theory is well-grounded with decades of research. I think the reality that group learning has been so pervasive in our education system accounts for why many of our learners today in this age group come into medical school with some assumptions that relate to how they have been taught, and how they should be taught, because of their experiences.

And so it might be helpful to get you thinking about how to make, let's say, a track in interprofessionalism meaningful, and not just a kind of, "Here is a list of the team skills; work together." But, "Here is an ethical dilemma. Here is a real-life problem. We're gonna put you in this team as a future physician, as a NP or a PA, as a nurse, and we're going to have you discuss this problem."

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