Exploring the challenges of professional identity formation in clinical education environment: A qualitative study

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Abstract

Introduction: This study aimed to explore the challenges of professional identity formation at clinical education environments from the faculty members' viewpoints.

Methods: This is a qualitative study. The population consisted of clinical faculty members of Tehran University of Medical Sciences. In this study, 39 faculty members participated in an in-depth semi-structured interview. To analyze the data, conventional content analysis approach was used. Open coding was extracted from the participants' statements that represented their experiences. Then, based on their similarities, the codes were classified. Subcategories were emerged and after arranging, they were classified into categories based on their relationships.

Results: Instability of professional commitment, patient-centeredness as the missing loop care and treatment, and inappropriate conductive context were explored as the challenges of professional identity in clinical educational environment.

Conclusion: According to the results of the study, the formation of professional identity among the providers is not an easy task because many factors affect the formation of professional identity. Therefore, a comprehensive shift towards forming the professional identity at individual and organizational level should be planned.

Keywords: Professionalism; Qualitative research; Education; Environment

Introduction

Professionalism introduced as a set of values, beliefs, manners and interactions emphasizes the creation and sustainment of trust among the healthcare providers, service recipients, and society (1, 2). The most important element of professionalism is "prioritizing the patient's interest over provider's interest" (3). Recently, the commitments to professionalism principles have been determined as the requirements of the healthcare providers beside the specialized knowledge and skills (4-8). In this regard, "professionalism" has been considered as one of

the most important competencies of providers which are taught and worked in the healthcare educational system (4, 8). It expects the providers to be able to prove the professionalism capabilities and show their commitment towards recipients, profession and society by ethical performance and compliance with professional rules (6). The goal of educational systems is to ensure that learners understand and are committed the value of medical profession (9). The implicit aim of teaching medical professionalism is described when learners develop their professional identities.

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Recently, the exchange of the objectives of educational system from training and evaluating the professionalism toward developing a professional identity which is the desired outcome has been highlighted (9). In this regard, the professional identity formation introduced a process for transformation of the layperson to the physician (10, 11). Cruess et al. defined a physician's identity as "the representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in the individual thinking, acting, and feeling like a physician" (9).

The professionalism competency improvement and the professional identity formation have occurred through observation, role model, and critical reflection and small group activities, mindfulness, suitable constructive feedback, and establishing collaborative learning environments, specifically in clinical environments (9, 12, 13). However, the teaching of professionalism is not an easy work. The challenges such a negative role models, a hidden curriculum and the weakness in giving feedback have been defined in teaching the concept and forming professional identity in the medical sciences system (14). This matter is important in educational hospitals where learners play crucial therapeutic and educational roles as a part of health care provider such as residents, internship students different professions (15). To form the professional identity, one should consider the individual and social levels (9). Therefore, it is essential to recognize its features based on cross-cultural context, and organizational and social culture of the society, besides the personal feature (16). Professionalism and identity formation issues in clinical environments are considered as a barrier of patient-centered care implementation (17). Exploring the formation of professional identity challenges helps the educational planners to focus on the real needs of the learners and empower them in clinical environments, so that the quality of services is improve and patient-centered services are achieved.

Professionalism and professional identity are neonatal concepts in educational and healthcare systems of Iran. Therefore, understanding the existing challenges is very important in planning for development of professionalism commitment and formation of professional identity in Iranian healthcare system. Limited quantitative studies have been conducted in Iran regarding professionalism and professional identity. Thus, they cannot explain the challenges of professional identity formation properly. This study aimed to explore the challenges of professional identity formation in different professions (medicine, nursing, midwifery) at the clinical education environments where learners of different professions learn and work as a member of healthcare teams from the faculty members' viewpoints.

Methods

This is a qualitative study. Qualitative content analysis is an appropriate method to obtain valid results from contextual data to produce knowledge and new idea, present facts, and develop practical guidelines for performance (18).

Inclusion criteria were being a clinical faculty member with a work experience of at least two years in clinical practice and professionalism training. Clinical faculties (n=39) including 19 specialist physicians, 15 nurses, five midwives were enrolled in the present study through purposeful sampling. Sampling was continued until data saturation, when no new data were achieved in the interviews. Participants were interviewed in a quiet place at their convenient time by the author (F.K).

In the current study, data were gathered through in-depth and semi-structured interviews. The purpose of research, interview method, and the right to participate or withdraw from the study were explained to the participants. The interviews were recorded, and the participants were assured about the confidentiality; also, informed consent was obtained from them. Semi-structured interviews started using questions such as "Can you please explain a work day, which showed your professional commitment to your profession?" and "What obstacles did you encounter in your workplace in your professional commitment?" "Have you ever felt that your dignity in this field has been questioned?" "Can you please describe it?", and related probing questions.

Each interview lasted between 60 to 110 minutes and a total of 44 hours. Based on the informed consent of the participants, all interviews were recorded and typed verbatim.

To analyze the data, we used conventional content analysis method. This method is used for subjective interpretation of the textual content of data. This method can be determined through a process of systematic classification, codes, subcategories and categories. Conventional content analysis is used when we need to extract objective content more than what exists in the textual data. Using this method, covert and overt categories and patterns of content data of the participants could be determined (19). To achieve immersion in the data and get a general sense of

the data, researchers (F.K, F.B) listened to the recorded interviews and reviewed the typed-text several times. The initial codes were extracted from the participants' statements that represented their experiences; then, the codes were classified based on their similarities. Subcategories were emerged and classified into categories based on their relationships.

Four criteria of trustworthiness in qualitative research includecredibility, confirmability, dependability, and transferability (20, 21). We used various techniques to increase trustworthiness in the current study. Peer checking by the researchers and member checking by the participants for validation of the findings were performed. Moreover, the encoding process and forming of the categories were checked by the faculty members (external checks). In order to achieve confirmability, the participants were enrolled from different professions according to maximum variation sampling. In the present study, data gathering meetings were conducted twice, if necessary. We consulted with some experts (three faculty members of nursing and midwifery and social sciences schools) about the accuracy of interpretations and coding process (expert checking). We precisely recorded all steps of the interview and analysis process. The initial codes were merged by constant comparison of data and we explored the subcategories and categories about the participant's experiences of the phenomena.

Ethical Considerations

In this study, the principles of protecting the confidentiality of the participants, giving informed consent and the right to withdraw from any phase of the study, recording conversation were observed. Presenting the findings to the participants to obtain their approval was among the ethical considerations observed in this study.

Results

Participants in this study were clinical faculties of internal medicine, general surgery, anesthesia, pediatrics, medical ethics, emergency medicine, sports medicine, palliative medicine and gynecologist, ICU, CCU and Dialysis departments. 20 of them were male and 19 were female. The faculty members included assistant professor (n=18), associate professor (n=11) and full professor (n=5) and preceptors (n=5). The mean educational experience of the participants as a faculty member was 15±3 years. All faculty members had participated in professionalism workshops and 17 of them had experience in the professionalism filed as researcher or teacher.

The findings of analysis process resulted in 405 opening codes and three categories including instability of professional commitment, patient-centeredness as missing loop of care, and inappropriate conductive context (Table1).

Instability of professional commitment

The commitment to the value of the society, professions and health care teams has been defined as a requirement of professional identity. The result of the present study showed that weakness in awareness and compliance with the professionalism principles were determined as a basic reason of destabilization of professional identity. These reasons resulted in irresponsibility and uncommitted behaviors over their professionals. The participants in this study believed that providers did not consider professionalism principles as a professional obligation. In addition, professional behavior, which was the result of interaction between interpersonal and work environment, develops by accepting the group's rules and norms that guide the individuals towards sociability and transition phase. Inefficiency in preserving professional norms was the main category in which challenges such as the lack of respect in interpersonal and inter-professional, and non-compliance with professional norms are discussed. Inefficiency in respecting the norms and values in inter-personal and inter-professional relationships was one of the main challenges of learners in clinical wards. In this category, the challenges of conception failure and application of professionalism in the providers' professional life are discussed which include five subcategories;

Ignorance towards individual/systemic excellence: Participant No. 3 stated, *"In a classroom presentation or journal club, a student showed us a couple of slides and just rushed to close his speech. It was clear that he didn't know the subject properly, or if he did, he didn't want to transfer it"*.

Weakness of accountability: In the lack of accountability category, weakness in aspects of treatment and education responsibilities and the lack of commitment toward inter-professional cooperation were discussed. Participant No. 5 stated, *"Some of the residents who perform stealthy surgery in order to learn, even hide their knowledge from junior residents, so they can't learn from them."*

Lack of integrity, disrespectful inter-personal and inter-professional relationships: Participant No. 20 said, *Residents always say, "Leave it there" and, "it is not my business", I have recently heard that one of them said, "I don't get paid enough, so I don't waste my time".* The lack of professional

Table 1: The challenges of professional identity formation in clinical education environment

Categories	Subcategories	Meaning unit
Instability of professional commitment	Ignorance towards individual/systemic excellence	o Participant No. 15: They only think of finishing the course not learning and becoming a capable person practically and scientifically, so that they can help others to develop. o Participant No. 30: They do really not believe honesty and excellence are part of the medicine.
	Weakness of accountability	o Participant No. 12: Residents talk unclearly, so they can change their story at any time. A resident wanted to operate on a patient, so he said to the patient," don't worry, the risk of complication is not vast", I said why did you give wrong information to the patient, he said;" I told him the risk is 50%". o Participant No. 19: A resident, when he/she is doing a work therapy, should see him/herself as a doctor not just coming to work with any clothing he/she likes.
	Lack of integrity	o Participant No. 8: We had a resident who took the patient's x-ray or ordered a sonographer, so he could take the photo for his research.
	Disrespectful inter-personal and inter-professional relationships	o Participant No. 3: They are happy to receive a young patient, but when an old women (80 year old for instance) comes in, the resident starts to ignore and tries to pass her to someone else.
Patient-centeredness as missing loop care	Inappropriate relation with patient	o Participant No. 11: They believe there should be a gap between their position and that of patients. o Participant No. 8: We have seen inappropriate relationships. A complaint was made as a resident wanted to have an inappropriate relationship with a patient.
	Ignorance of patient's right	o Participant No. 14: Many times, I have witnessed that a resident has come to my office with red face (angry) and said, the patient does not let me examine him. Who does he think he is? He must let me examine him. o Participant No. 8: I had a resident who said his take of diagnosis to patient at midnight. Poor patient had psychological reaction, which made his recovery harder even though the resident's diagnosis was wrong. (Ignorance patient mental state) o Participant No. 19: I remember a resident who, without considering the patient's financial status, prescribed an expensive medication for him. Upon his return, the patient said: "doctor I spent all my money for the medication." (Ignorance of patient's financial state) o Participant No. 15: I had a patient who washed his vacuum drain as he thought it must be clean. Nobody had told him anything about what he should do. (Ignorance of patient's education) o Participant No. 4: What we do not know is what happens to our patient after discharge, especially those who come from far away towns. (Ignorance of patient's life condition) o Participant No. 6: They view the patient as a tool or object; whether they want to learn a procedure or want to use his/her information for a research, they view patients as a tool for their success. (viewing patient as an object)
Inappropriate conductive context	Weakness in the system's infrastructure	o Participant No. 7: We do not have an education system based on meritocracy because our criteria are scores. Everything is score-centered.
	Lack of different role models on principles of professional behavior	o Participant No. 19: Think about a doctor who, during a lecture, says one of the professional responsibilities is to be punctual; if you are going to be late, let people know and so on, but the problem is you never see the same doctor to be on time.

integrity was another category.

Non-compliance of Dress Code: Participant No. 16 stated, *"We do not obey a dress code, so learners wear different uniforms".*

Patient-centeredness as missing loop care and treatment

Patient-centeredness as the missing loop care was the second category in which, *"inappropriate*

relationship with the patient" and "*ignorance of patient's right*" were important challenges of the learners in clinical practice.

Inappropriate relationship with the patient: Establishing inappropriate relationship with patients, inadequate patients' education, lack of participation of patients in the treatment process, ignoring the patients' financial and psychological status during treatment, and considering the patients as educational tools were examples of the patient-centeredness as the missing loop care and treatment mentioned by the participants. Participant No. 14 said, *"I saw a resident who told the patient to be quite and not speak when he was writing prescription"*.

Ignorance of the patient's rights: Participant No. 39 stated, *"I remember a resident, who without considering the patient's financial status prescribed an expensive medication for him. Upon his return, the patient said doctor: I spent all my money for the medication."*

Inappropriate conductive context

The third category included two subcategories; "*weakness in the system's infrastructure*" and "*lack of different role models on principals of professional behavior*".

Weakness in the system's infrastructure: Lack of education system support in promoting professionalism and forming professional identity was one of this study's main challenges which included the lack of role models in regard to principles of professional behavior and the system's weak infrastructure. In this regard, a participant stated, *"There is a need for an appropriate system that can identify these violations. If we could have a disciplinary system, we could easily evaluate and provide feedback. But the problem is that we still do not know what to evaluate; we do not even have support for implementation of professional commitment"* (Participant No. 20).

Lack of different role models of the principles of professional behavior: Other weaknesses in the education system support included the lack of proper patterns of behavior, the conflicts of interest in the behavior of faculty members, and unprofessional behaviors of teachers. For example, participant No. 7 said, *"Our teachers are not good role models for the learners in teaching hospitals; on contrary, learners are frequently faced with unprofessional behaviors which create resistance towards professional commitment"*. Participant No. 7 said, *"Our learners are not exposed to correct role models and professional behavior, so I think this is a serious challenge in the educational system"*.

Discussion

The results of the current study showed the challenges of professional identity formation in medical sciences students such as medicine, nurses and midwifery at clinical educational environment were categorized in the individual and organizational level including instability of professional commitment, patient-centeredness as the missing loop care, and inappropriate conductive context. The explored challenges considered the identity formation process as an adaptive developmental process that takes place concurrently at the individual and the collective level. In the individual level, the emphasis is on the growth of psychological aspect of the learners and the collective level addresses the socialization process to prepare the learners to play their roles and to participate in the community (9).

"Instability of professional commitment" category addresses the challenges of health care providers about the non-compliance of professionalism principles such as accountability, excellent, dignity and communication that restricted the formation of professional identity. Accountability to professional responsibilities is among the most important duties of the healthcare team (22, 23). Recognition of professional responsibility and respect for patients' rights are considered as the most important accountability codes (22). In the present study, prioritizing one's own interest over the patient's interest, inefficacy in fulfilling therapeutic and educational duties, defect of commitment towards inter-professional cooperation, and the lack of punctuality have been considered as the accountability challenges. These challenges could result from the weakness in recognizing and implementing of responsibilities to patients, healthcare team, professions and society. In this regard, Drybye illustrated lack of understanding about professional responsibilities was the most important reason for the doctors' failure as the main decision makers of the healthcare team (24). They stated that dissatisfaction or the lack of interest towards their profession prevents them from understanding their professional responsibilities. The lack of recognizing professional responsibility as a member of the healthcare team, bedside individual factors such as the lack of motivation and enthusiasm of providers towards their profession have led to challenges in the professional behavior and commitment of providers in healthcare system and delivery of services by them (24-26). Moreover, the participants have not considered the excellence as a part of their profession duties. Then, they do not have motivation for

participating in the developmental courses and seeking feedback in order for the professional and personal development. The lack of willingness to use feedback for development and the lack of motivation for excellence of the individual/system was found in the present study. Similar to the findings of the current study, the result of Salinas' study showed that factors such as the lack of motivation, lack of time to seek feedbacks, and lack of awareness about professional responsibilities within a team were explored as the personal challenges for the profession obligation and the professional identity formation (25).

Compliance with the norms of the profession is one of the most fundamental factors in maintaining the dignity of professional behaviors (27). The professionalism challenges are creating an imbalance between the interests of patients, and maintaining finance-oriented performance of healthcare personnel which mostly has a negative effect on their honest behavior (28). Bernat's study addressed the commercialization of medicine, declined the doctors' sense of charity and humanitarianism and conflicts of interest as the main challenges of neurologists (29). Conflict of interests is one of the challenges in the integrity domain, which has been mentioned in several studies (25, 29, 30). The results of Kanat's study showed abuse of power, arrogance, greed, misrepresentation, lack of conscience, conflict of interest and acceptance of gifts were major professional challenges among neurosurgeons (31). Preferring personal interests, unfair treatment, concealment, financial conflict and incorrect reports were categorized as the professionalism challenges in the current study, which can be made due to the imperfection of professional identity and commitment between health care providers.

Communication skill and respect are two aspects of professional behavior, which are important in the formation of relationships and building trust between people. It should be noted that the concept of respect is more than just being polite or honest with patients (32, 33). In the current study, the participants stated that disrespect in interpersonal relationship with people (tutors, colleagues, patients and their families) was one of the professionalism challenges in clinical practice. The challenges found could be concluded by the hierarchical relationship among providers and interprofessional discrimination. Regarding the result of the present study, 'respect' among colleagues and respect between patients and providers recognized as a major challenge in the results of Nagler's study. They believed that providing guidelines for professionalism

regarding the patients' respect was insufficient (32). Therefore, in order to create professional commitment, planning and implementing comprehensive programs are necessary in the educational system.

Patient's preferences and respect for their values and preferences, education of the patient/family, and proper communication with them are important components of the patient's rights and patient-centered approach (34, 35). Patients as the main customer of the health care services should take part in all stages of the care process with dignity and respect (36, 37). The challenges of inappropriate communication with patients, t lack of patient education and participation in the care process, and disregard for financial and psychological status of the patient in the process of diagnosis and treatment were discussed in the current study. The result of the present study showed there were challenges in different stages of relationships with patients, which resulted from the dominance of doctor-centered relationship in the clinical environments and lack of patients' familiarity about "patient's right". Similar to the Bernat's study, disregarding the needs and interests of patients in treatment is the a challenge of professionalism that damages the doctor-patient relationship (29). Poor relationship of healthcare providers increases the risk of patients' non-compliance and weakness of cooperative relationships with other healthcare team members (38, 39).

The challenges of education system's infrastructure and the lack of role model in the education process were explored in the current study as inappropriate conductive context. Salinas-Miranda study considered the negative and inappropriate role model, the lack of rewarding system, increased workload without training, long working hours and managerial barriers as the challenges of the system in developing professional identity and professionalism commitment (25). The incompetence of faculty members and lack of interest of team members were the most important professionalism challenges of family physician in Canada (26). Concerning the weak rules and regulation to support professional commitment, the lack of organization's support and limited education about professionalism were the challenges of the educational system which have also been mentioned in different studies (29, 30). Similar to the results of several studies, the lack of appropriate role model, lack of proper use of opportunities to organized education for professionalism in clinical settings and managerial challenges were the issues of professionalism competency

development and professional identity formation mentioned in the present study. A formal and informal education has been emphasized as the most important factors affecting the adherence to professional obligations and the professional identity formation. They believed education, either explicitly or implicitly, play a vital role in developing commitment of health providers at the classroom or hospital (40, 41). Since the most part of the professional identity of health care providers have been formed in the clinical environments, it is necessary to provide a proper situation to develop the professional identity of providers. Developing the education about professionalism, the patient's bill of rights, respect for professional dignity and values of medicine among healthcare systems is recommended. In addition, development of professional identity depends on resolving weaknesses of healthcare and financial systems, developing informal curriculum and administrative support to achieve the educational goals.

Although this is the study to explain the challenges of the professional identity formation of clinical practice in one of the main medical education centers in Iranian context generalizability in qualitative study is a vague concept, and the current study is not an exception. Therefore, it is recommended that further studies should be conducted in other environments to become the basis for the formulation of guidance in this area.

Conclusion

The formation of professional identity among providers is not an easy task because many factors affect formation of professional identity. The results of the current study showed the challenges of professional identity formation among healthcare providers at clinical educational environment were categorized into individual and organizational levels; thus, developing infrastructure such as an appropriate educational intervention and faculty development program through pedagogic strategies and supporting of socialization process is recommended.

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