How do professional identities impact upon how postgraduate students of education within healthcare ‘make sense’ of learning to become teachers?

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Abstract

This study sought the espoused social identities of health professionals entering a UK university's part-time postgraduate programme in health professions education (HPE) in 2019. It identifies the presence of changes consequent to attendance, and their influences on the initial ten participants (finally reducing to six), using data from three phases of semi-structured telephone interviews conducted over three years. These were analysed within a thematic method and applying the lens of Social Identity Theory (Tajfel 1974).

This research found that these healthcare professionals' social identities were entrenched within healthcare from adolescence. Concepts of *the teacher within healthcare* were often unclear initially, but the participants later demonstrated a sense-making and clarity arising from exposure to educational practice and theory within their programme of study, alongside subsequent reflection. The application of Social Identity Theory uncovered their espoused *in-groups* within healthcare, whilst shifting motivations for achieving teaching qualifications were unveiled. This appeared in addition to interviewees' suggestions that *formalised* teaching roles would only be considered once seniority within explicitly healthcare roles were obtained. The work concludes that a greater understanding of the intended and consequent use of HPE qualifications by healthcare practitioners will both inform similar programmes' curricula and delivery, whilst increasing their ability to attract greater numbers of much needed educators within healthcare.

List of Abbreviations

CTF - Clinical Teaching Fellow

F1 - First year foundation-level doctor

F2 - Second year foundation-level doctor

GP - General Practitioner

HEI - Higher Education Institution

HPE - Health Professions Education

MHPE - Master’s in Health Professions Education

NP - Nurse Practitioner

RQ - Research Question

SIT - Social Identity Theory

TA - Thematic Analysis

Chapter One - Introduction

This chapter introduces the thesis and a longitudinal study that centres on a series of one-to-one interviews conducted with part-time post-graduate students, who are already healthcare professionals. The students studied Health Professions Education (HPE) during the period September 2019 to August 2020, with final interviews completing in January 2023. The enquiry commences with 10 students, reducing to six over the three years of research. The data collection begins with their arrival at the programme of study to become educators within healthcare and concludes 29 months *after* the completion of their one-year postgraduate certificate course.

This introduction chapter provides a basis from which the thesis as a whole may be understood. It begins by presenting the contemporary landscape within which both the interviewees and their studied HPE programme reside. There is demonstration of the historic growth of health professions learning, whilst highlighting the challenges such post-graduate programmes and their students now face. Then continuing with a detailed outline of the Master's in Health Professions Education (MHPE) programme these interviewees attended, charting its setting, entrants, content, delivery and processes. This is followed by a rationale of both the motivation and aims of the research and concludes by offering the structure of the thesis.

1.1 The Wider Context of this Study

This study is about those who seek the skills and knowledge to support education within healthcare, by pursuing a one-year part-time certificate component of a MHPE. Upon completion, these educators within healthcare may choose to seek *formal* educationally focussed roles, albeit these are notably diverse in nature and often poorly defined (Bartle and Thistlethwaite 2014; Bligh and Brice 2009). Those attempts that do seek to characterise their educator roles suggest a breadth of responsibilities encompassing everything from professional expert to curriculum developer to postgraduate trainer (Nickendei et al 2015; Harden and Crosby 2000). This appears reflective of the wide gamut of healthcare specialties that separately and differently inform the notions of *an educator in healthcare* (Mount et al 2022; Cantillon et al 2016; Chuenjitwongsa et al 2018).

The educational landscape that these educators enter is changing. Ten Cate (2021, p.518) proposes that ‘medical education’ has evolved into *Health Professions Education* (HPE), seeking to more clearly encompass *all* healthcare disciplines, and contends it now firmly resides as a ‘mature scholastic discipline’. The growth in demand for HPE historically appears driven from an equally rapid increase in Medical Schools – the number has risen globally from circa 500 in the mid-1950s to nearly 3,000 just before the onset of the Covid-19 pandemic (Risman et al 2018). Indeed, since the pandemic there appears increased interest in not only how education within health professions has developed, but also what knowledge it chooses to offer (Jacobs and Van Schalwyk 2022) and what form it delivers this within (Tekian et al 2024). This has fed those with claims that these educators’ roles are to shape the identities of entrant and junior practitioners (Kerrins et al 2022;

Vivekananda-Schmidt et al 2015; Creuss et al 2015; Jarvis-Selinger et al 2012). Yet educational programmes such as those within this research remain underexplored (Tekian et al 2024). This appears surprising, when combining expectations of a more sophisticated learning environment within healthcare, with increasing demands for the formal accreditation of its teachers (Tekian et al 2024).

The challenges that face those entrusted with developing both new and existing healthcare practitioners appear more recently complicated by a stark reduction of entrants for its largest vocational entry courses. Nursing training applicants fell in the UK in 2023 by nearly 20%, significantly accelerating a decline already apparent since 2020 (Hill 2023). A similar picture emerges in medicine, with a year-on-year reduction in 2024 undergraduate applications by 12% (UCAS 2024). This despite pledges by the Conservative government in 2022 to double available medical school places by 2031 (NHS 2024), a challenge which will accordingly be accompanied by significantly increased demand for their health professions educators.

As these changes emerge over time, it is concerning that there appears only limited *longitudinal* research on health professions education programmes (Sethi et al 2018), and those that offer temporal consideration often focus on experiences for the duration of their students' study, rather than seeking reflections post-qualification (Archer et al 2022). This concern extends with O'Callaghan et al (2024) highlighting that not only does there exist a paucity of investigation over time, but that their use of often small sample sizes can reduce transferability as, unlike in this research, theoretical frameworks are often not applied.

These challenges to the body of research appear during a complex intersection of contemporary factors in healthcare. For medicine, an ageing UK population with

increasing and broadening demands for care provision and high levels of vacancies within the NHS, place greater demands upon its infrastructure (Bodey 2024). The scarcity of resources is demonstrated in 40,000 specifically healthcare NHS vacancies alongside a halving of its available beds compared to 30 years earlier (Kings Fund 2024). Similar difficulties appear more broadly within other healthcare domains. Plessas et al (2022) demonstrate the extensive support for notions of systemic causation in dental practitioners' reporting of high levels of mental distress through poor working environments, threats of litigation and dealing with the complexities of the NHS as a *de facto* employer. Nurses and hygienists within oral healthcare similarly report high levels of anxiety (Hallet et al 2023). There also appear concerns that the pandemic's limiting effects upon the dental students of this time, will remain long lasting and apparent within their practice (Maragha et al 2023). Amongst veterinary professionals, Spendelow et al (2024) note evidence of higher levels of psychological distress than the general population, this appearing acutely within its students and newest practitioners. Notably, veterinarians similarly appear in many countries with higher levels of anxiety and even suicide rates above the population norms within which they practice. Often this is attributed to their role's 'performing euthanasia, and easy access to lethal means of suicide' (da Silva et al 2023 p.1266).

One example of a situational context for these practitioners, is how the contemporary NHS workforce manifests. Over 13% of the UK's total workforce are employed within the health and care sector (Anderson et al 2021). Yet, Woolf et al (2023) identify the UK as having the lowest density of healthcare practitioners (per head of population) within Western Europe. Further noting, that nearly a quarter of those employed within it are from ethnic minorities, and this rising to over 40% amongst doctors. However,

they suggest significant difficulties are found in supporting diversity already present in this workforce, one totalling over 1.7 million people in NHS England alone (Kings Fund 2024). It has been argued that developing equality of opportunities can clearly be linked to enhanced patient care and satisfaction (Hemmings et al 2021). Equally, building a diverse workforce is considered to be fundamental in resolving the NHS' challenge of recruitment (Woolf et al 2023). Although some suggest that healthcare professions' resistance, government immigration policies and poor demand forecasting, reduce the opportunities to engage with practitioners from overseas at a greater scale (Morgan 2022). It remains however, that over 1 in 6 of healthcare workers in NHS England are from overseas (Kmietowicz 2023).

Anderson et al (2021b), suggest education provision may form much of what is needed in the *post-pandemic healthcare system* that the NHS needs to become. They suggest greater funding be found to support education in explicitly improving the range of skills present in the current workforce, alongside ensuring improved retention of staff for the longer term. The consequences of dis-enfranchisement since the pandemic have resulted in strike actions by clinicians. Due to their unique societal position, these saw higher levels of public support than found toward other public sector workers' actions (Hansen and Pickering 2024). These disputes were considered by many of their participants as beyond simple pay demands, but rather as expressions of distress with the undervaluation of health provision and a consequent lack of recognition and investment in its practitioners (Ramsey 2025).

Such a setting prompts consideration of the MHPE programmes that seek to feed educators into its landscape. The rapid growth of specifically master's-level teaching programmes within healthcare emerges from just seven globally in 1999 (Tekian and Harris 2012), subsequently rising to over 150 programmes in 2018 (Artino et al 2018)

(the year before this research began) and reaching 158 in 2024 (Tekian et al 2024). However, Schermerhorn et al (2023) note not only a distinct lack of homogeneity of these many programmes' published curricula, but also a disproportionately greater growth within the already dominant (in terms of numbers) regions of Americas and Europe compared to Africa and Asia over that period.

When combined with these faculties' often limited understanding of how completion of such programmes support future career paths for their students (Chen et al 2017), this becomes fertile ground for exploration.

1.2 The Setting for the Study

The specific programme of HPE study these interviewees attend emerged in current form in the early 2000s, offering a range of master's-level qualifications including certificate, diploma and master's for those practitioners that seek the role or ability of an educator within healthcare. It is set within one of the UK's Russell Group universities and connected, albeit indirectly, to the Medical School of that institution.

Whilst entrants are drawn from all professions within healthcare, including nursing, dentistry, veterinary and paramedic disciplines, the majority of its circa 120 certificate-component students enter each September from medicine. Often, these students are provided with the postgraduate certificate element of study (that all the interviewees undertook) funded as part of fixed-term clinical roles where some component involves the structured teaching of medical students within a hospital setting. At the time of this study, no records of students' original healthcare professions for each academic year intake were maintained by the university.

The certificate programme at the initiation of this research comprised seven solely face-to-face study days, with no option for remote or asynchronous study (these were later introduced during Covid-19 restrictions and remain as options at time of writing). These in-person study days were interspersed over one or two years and supported the delivery of three 20-credit level 7 units covering the theory and practice of teaching and learning, the use of assessment and evaluation to promote learning and the application of learning techniques within clinical settings. Each unit being studied in cohorts of circa 12 students, with these groups comprising the same students only for each two or three-day taught element component of the total seven in-person study days. However, as a result of the Covid-19 restrictions from March 2020, the final/third certificate unit for these interviewees was delivered remotely, using a combination of synchronous and asynchronous methods.

The academic faculty delivering the programme represent a full and part-time mixture of clinical specialists holding a minimum of Fellow of Higher Education Academy (FHEA) recognition, alongside non-clinical practitioners in education, holding postgraduate qualifications or doctorates in education-related subjects.

1.3 The Rationale for the Study

I am a lecturer within this MHPE programme. I spent the two years after completing my postgraduate certificate in education (PGCE) looking for opportunities to teach adults and stay immersed in education. In 2017, I was appointed to a *junior* lecturer role in the Health Professions Education department within a large and (what I felt to be) prestigious university. As someone already married to a GP for a number of years, the context and conversations of healthcare appeared familiar. My own role's

focus on education and the academic debates within it seeming therefore suitable for a *non-clinician* within this landscape.

During the subsequent two years between my appointment as an MHPE lecturer and the first interviews of the study being undertaken, questions arose for me as a result of my teaching experiences with these healthcare practitioners whilst they sought their qualifications. I had initially considered their 600 hours of notional study-time (that also incorporated their seven taught study days), as demonstrative of a significant commitment from busy professionals to the development of teaching within their professions. However, over time and through a series of informal conversations with students, only a small number suggested plans that would afterwards place education visibly within their future. As my role developed, I gained responsibility for developing educational content and then more broadly the programme's curricula. This presented a challenge in identifying the purposes of our students' learning with which these choices would align. I sought to clarify how and why this programme would address their needs, explicitly looking beyond that which may might be perceived as a form of consumer research or product evaluation.

As already outlined (see 1.1), the prior two decades' rapid expansion of master's-level programmes in HPE had produced limited standardisation, with consequent difficulty for both potential students and employers, in determining what such a qualification would entail.

Further, as will also be seen in Chapter Two's literature review, there is much consideration of student identities as they enter healthcare, often shaping them into a form that addresses the perceived needs of their specialty's practice. However, there is also much *less* focus on the identities of those who study to be educators within

healthcare and even less that further addresses how their perspectives may develop over time.

In considering all of the above, this study's research questions seek to engage with the broader topic of education within healthcare, but more explicitly add to the currently limited consideration of the motivations of master's-level students in HPE. The small sample size and the interruption of a global pandemic during the period of research present anomalies that may of course be difficult to replicate. However, the application of the theoretical framework of Social Identity Theory, allows greater clarity in connecting to other similar contexts that may be found within alike MHPE settings. The goal is not generalisability *per se*, but instead a prompt for other MHPE programmes to consider the questions raised and contribute to a discussion that it appears few currently engage with. The outcomes of such debate offer the opportunity for enhanced clarity on the conversations to be had with potential MHPE students, alongside tailoring such programmes' content and delivery in a way that addresses the real needs of future cohorts and their educational context.

This research's aims therefore are to develop further the understanding of how these varied healthcare professionals entering HPE, perceive teachers already within it. Consequently, to identify if the experience of studying to become HPE teachers reshapes those perspectives, alongside how and why this may be the case. The lens of identities and in particular Social Identity Theory therefore supports their consideration of self in the relational contexts of healthcare and teaching within healthcare.

In summary, the overarching thesis' title is *How do professional identities impact upon how postgraduate students of education within healthcare 'make sense' of learning to become teachers?*

The research's questions are:

1. What are the perceptions of teaching identities amongst healthcare professionals on an award-bearing course in teacher education in healthcare?
2. In exploring the considerations of change:
    a. *What happens to these healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare?*
    b. *What are the influences that contribute to the subsequent identities presented?*

1.4 The Structure of the Thesis

The thesis continues over the following five chapters. Chapter Two presents a review of the literature focused on the topics of identities, professions, identities within the vocations of healthcare that attend the studied programme, and finally Social Identity Theory within HPE.

It begins with a consideration of the developed notions of identities, their 'packaging' in the presentations of self to others and offers contrast and balance between Social Identity Theory (Tajfel 1974) and Identity Theory (Stryker 1968). It considers the origin, purpose and formation amongst concepts of professions, before drawing out similarity and difference within those of the varied health professions with which this research seeks to engage. There is exploration of the concepts of the educator

within healthcare and finally coverage of Social Identity Theory's application to the healthcare professional's context.

Chapter Three addresses the methodology employed, incorporating my underpinning research approach, and the justification of research design chosen, with particular reference to the value and risks of its longitudinal application. These are followed by the choices and consideration of access to research subjects who may be influenced by my position as a lecturer. There is exploration of the value of semi-structured interviews as a data collection process, the implementation of ethical considerations and practice, finally presenting the opportunities and boundaries of a Thematic Analysis approach (Braun and Clark 2022) to the data.

Chapter Four offers the first discussion of the data and seeks to connect Social Identity Theory (Tajfel 1974) frameworks when primarily applying to RQ1 and perceptions of identities. It draws together interviewees' considerations in their identification processes with in-groups, their concepts of the teacher and specifically *teaching within healthcare*, alongside the notable influences of their healthcare origins upon these. There is also exploration of interviewees' initially-espoused motivations to teach and their emerging connections to notions of esteem and self-protection. It considers the foundations for those notions that these participants display upon arrival.

Chapter Five similarly offers a discussion of data, but in the context of primarily the two components of RQ2 and noting explicitly the observation of *change* over time. The path taken offers expansion on the use of *teaching as distinctiveness* amongst in-group members and considers the interviewees' development of their concepts of the teacher within healthcare crystalising over time, numerously presenting

positionality and esteem as determining factors. Healthcare identities develop that incorporate teaching capability, these appearing alongside the emerging concepts of practitioner role-modelling *as teaching*. Finally, the considerations of both the challenges and expectations for teaching within healthcare become more expressive. These underpin decisions around the 'identity packages' (Deaux 1993 p.6) interviewees wish to present outwardly, both immediately and in their future.

The Conclusion appears within Chapter Six, approaching the aims of the research and how the research questions have supported their consideration. This consequently informs implications unveiled for HPE generally and MHPE programmes explicitly. There is reflection on the evolution of the research design applied, and the limitations that result from this. Finally, in addressing these limitations, there is a consideration for future research that may consequently move further still toward addressing the 'tailoring [of] such programmes' content and delivery in a way that addresses the real needs of future cohorts and their educational context', that I identified in the rationale for this study in 1.3.

Chapter Two - Literature Review

2.1 Introduction

This chapter seeks to identify and connect relevant literature with the two research questions of the study. In addressing the first research question, *what are the perceptions of teaching identities of healthcare professionals on an award-bearing course in teacher education within healthcare?*, it begins with consideration of the notions of identities. In 2.2, there is introduction to the purpose and use of *identity packages* in the presentation of self to others, alongside the application of identities in determining expected or normative behaviours within social groups. It is here that I also offer the two differing frameworks of Social Identity Theory and Identity Theory through which to construe identities. I subsequently provide justification for the one chosen being applied to this research.

In order to develop understanding of how the studied healthcare professionals will make comparative judgements, in 2.3 there is exploration of the concepts of *a profession*. This begins by unpacking its historic emergence as a refuge for the offspring of the privileged, to more contemporary perspectives in offering a social good or where seen as a demonstration of learning through capability and performance.

In support of this first research question and the first component of the second, *what happens to healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare?*, Section 2.4 unpacks how identities within professions are formed. It examines where such processes may be influenced by accident of circumstance, but also where the professions or other entities seek to manipulate candidates' identities to consequently determine their

behaviours in professional practice. Section 2.5 considers diversity amongst the identities of those two health professions that both attend the studied teaching programme and comprised the cohort of interviewees . It notes their differing vocational training curricula that seek to address unique *profession-specific* needs through identities.

Section 2.6 moves toward addressing the final component of research question two, *what are the influences that contribute to the subsequent identities displayed?* It seeks to define the educator in healthcare and offers differing perspectives on the value of this role, alongside how it is perceived within the varied healthcare professions from which the research subjects are drawn. Finally, this section looks toward the use of Social Identity Theory in healthcare and specifically education within it. This endeavours to explicitly justify my application in the context of this research.

2.2 Considering Identities

The perspectives on identities and their formation are numerous and suggested to have been overworked, consequently generating ambiguous meanings unsuited for the practical application needed in social analysis (Brubaker and Cooper 2000). Contrastingly, this is seen by some as reflective of not too much but rather the wrong type of theory, showing a lack of applicability for the ‘analytical load required’ (Bendle 2002 p.2). In applying to this research however, the concepts of identities allow for consideration of the research participants’ perspectives on an identified group and subsequently how they position themselves in relation to it.

Identities are often considered outcomes of the world around us. Indeed, early work on identity shows agreement that the presence of others is important to the formation of identities (Erikson 1959; Goffman 1959; Mead 1967). Evidence for this can be found in frameworks such as Erikson's Eight Stages (1959). This presents that our relationships with others are a continually developing process, formed from early childhood. Similarly, Mead (1967) presents three stages of development, but extends this by suggesting that in the latter stages the individual develops clear concerns around how they are seen by others. This therefore becomes their own perceptions of how others might see them, which supports the formation of an identity. Goffman (1959) sets out a similar process, yet arguably in an effort to make these ideas more widely accessible, locates it in the context of a stage production, one within which the individual as actor, projects a considered identity to the audience around them.

In setting aside arguments around too much or just simply unworkable theory, this section considers the bifurcation of notions around identity and its formation through Social Identity Theory where one's *social identity* is 'derived primarily from group memberships' (Brown 2000 p.743) or alternatively via Identity Theory where 'identities are meanings a person attributes to the self' (Burke 1980 p.18). In relating to this study's interviewees, these considerations are both appropriate for an application within the workplace (Liljegren 2012) and specifically in a multi-professional environment such as healthcare, which draws in a variety of distinct roles and throughout which prominent role-based hierarchies clearly still exist (Braithwaite et al, 2016; Brown and Jones 2004).

There appears longstanding agreement that Social Identity Theory connects the formation of identities with the context of identified social groups (Roccas and Brewer 2002; Tajfel 1978), appearing as an understanding of who we are alike and often

more pointedly, are *not alike*. This approach is often seen as supporting the human need for meaning and reduction of uncertainty, a view that is seen to be enhancing self-esteem through efforts to 'achieve or maintain a positive social identity' (Brown 2000 p.747). It is through this lens that the notion of identity can been seen as membership of those social categories or groups displaying characteristics which are held as most important or *salient* to the individual (Fearon 1999), a membership developed from a process of selection by the individual that generates both similarity and difference judgements, one that clearly supports a reliance on the social nature of identities. The choices around social categories are informed by social interactions and the resulting perceptions that emerge (Jenkins 2004).

The latter has been described as forming a tension between 'the fundamental need for validation and similarity to others (on the one hand) and a countervailing need for uniqueness and individuation (on the other)' (Brewer 1991 p.477). It appears grounded, in some part, by early notions of the presentation of self within the writings of both Mead (1967) and Goffman (1959). For this reason, Tajfel (1974 p.68) might seem supportive in offering that whilst making such determinations, 'an individual strives to achieve a satisfactory concept or image of himself'[1]. What determines this satisfactory image of the self can also now be seen to be influenced by those many social groups within which the individual is already a member (Brewer 1991; Deaux 1993; Fearon 1999; Brown 2000). This is a realisation that Tajfel (1974) suggests Social Identity Theory is capable of addressing. It offers a flexibility as a broadly

[1] In considering Tajfel's 1974 use of 'himself',a reference can be made to Ng (2007 p.116) who notes that John Kirby established the prescription of male generics in 1746 on the basis that the male gender was 'more comprehensive' than the female one, yet offers that this has subsequently been viewed in the context of society's male dominance. However, the controversy regarding Tajfel's own behaviour in relation to female colleagues and students alongside a suggested indifference to researching issues of gender suggest a lack of concern in how such ideas appear (Young and Hegarty 2019).

applicable lens for a variety of investigation (Brown 2020). Haslam et al (2013) suggest this can encourage the creativity of the researcher in its use.

Such considerations lead toward a view that individuals construct their own ‘identity packages’, which are guided by their choices of membership categories and the importance they attach to them (Deaux 1993 p.6). Questions have arisen around whether awareness of the range of choices available is dependent on social or class background, personal experience or educational attainment (Tajfel 1974). Arguably this consideration of privilege and access may also have sat closely with frameworks around habitus and social capital (Bourdieu and Nice 1977).

Indeed, Lizardo (2004) suggests that Bourdieu’s concept of *Habitus* offers the behaviours and approaches to thinking that can emerge from social environments experienced in the past. These experiences, sometimes helpfully, and not always consciously, allow for or condition individuals to react to certain circumstances. In doing so, they can be mindful not of strict rules of behaviour, but rather with consideration of broad social structures’ influences.

King (2000), offers that Bourdieu’s identification of it as those habits, abilities and tendencies that an individual may display having been shaped by class and position, appears flawed by its consequent denial of personal agency or the potential for change. Despite aligning with those others that suggest this lack of agentic consideration, Nash (1999) offers examples that show habitus as those dispositions shaped both through history and social interactions that can reflect a group collectively. Whilst not explicitly comparing to Social Identity, this may be considered similar to SIT’s focus on social categories. Direct comparisons and expressions of similarity between SIT and habitus are however found within Norris (2005), in noting

the active process within habitus of internalising those in-grained perceptions and behaviours drawn from groups, whilst SIT similarly sees role-appropriation and group norms as part of a self-concept. Yet, it is Laberge (2010) that whilst affirming the embedded nature of Bourdieu's concepts within sociology, notes that the discipline of sociology has now developed an ability to address notions of social capital *without* reverting to explicitly Bourdieusian frameworks.

In comparing, I found that whilst habitus does allow for some flexibility and adaptation, it cannot easily account for the conscious negotiation of identity and the dynamics of groups that I felt were emerging in the data. Additionally, SIT would enable a focus on how my interviewees derived their sense of self from social group memberships and consider these group identities as perceptions of them may shift over time.

The consideration of a relevant framework within which to perceive this research was also cognisant of Lave and Wenger's *Communities of Practice* (Wenger 1998), where groups share a common interest or goal, and in doing so work collaboratively to address issues or develop knowledge and capability. The efficacy of which Wenger (1998) notes, may be enhanced or constrained by the strength of those informal relationships present.

A perspective supported by Roberts (2006), who further suggest that it offers advantages in developing or considering situated learning (e.g. in the workplace), albeit this is not something that can be formally created by an organisation. Although, additionally noting that whilst it has an intrinsic consideration of the impact of power dynamics, it can appear particularly challenged when participants are physically distant from each other. Amin and Roberts (2008), however present that physical

distance is no barrier to communities of practice efficacy. It is instead the strength of institutional, cultural and social networks that act as a determinant, rather than physical closeness. Nonetheless, they suggest communities of practice as a concept has lost its meaning, and become an all-encompassing term for situated learning that is liberally applied to social settings that appear beyond its initial construction and blur its original focus on context, social engagement and performativity.

It is Meyerhoff and Strycharz (2013) to which I defer in declining communities of practice as a lens. While it is similar to theories such as SIT, it acknowledges the interconnection between personal and group identities, yet its focus remains upon groups where goals are shared and activities undertaken amidst a group. This is not a requirement in such as SIT, nor easily evident within this research.

It is in choosing SIT that consideration can be given to the idea that some will arguably find such choices of social identification are made for them e.g. by expectations of their social class or religion. However, not all will be pre-destined, in that some will just have preferences for those things they explicitly choose, and have agency to do (Jenkins 2004). It is from here that SIT's perspective of an identity formation *locating* the individual within society can be seen, by the nature of how it positions relationships within social groups (Gecas and Burke 1995). This suggests that identities may no longer be determined by accident of birth. Here the decline of class systems in Western society creates new understandings of self and position, with a consequent ability to manipulate their emergence (Giddens 1991).

Moreover, there appears here a clear concept of choice, in that social identities 'should not be equated with membership…Membership may be voluntary or

imposed, but social identities are chosen' (Brewer 1999 p.477). This becomes evident within developed societies as the presentation of self by 'creating the right impressions' and demonstrative of a developing control that can be seen to be within the gift of the individual, specifically as to how they position amongst others (Cote 1996 p.421). This is therefore supporting the longstanding notions that identities are relational and very much dependent upon interactions with others (Erikson 1959; Goffman 1970). Yet also determining not only what we can expect from these others, but what they can expect from us (Goffman 1959, Brown 2000).

In considering the contrasting approach of Identity Theory, there appears a view of identities that are not contingent upon others, but instead a self-categorization of the individual as 'the occupant of a role' (Stets and Burne 2000 p. 225). From this position, an appropriate set of rules can be determined, rules within which the individual can feel required to engage (Stets and Burne 2000; Hogg 2007). Yet there is also the notion that alongside this compliance, there are unique personal identities or self-descriptions of the individual's own attributes, these can exist beyond simple role-related categorisations; identities that can be varied dependent on the context and so allow for multiple identities to co-exist and emerge as dominant, dependent on situation or setting (Turner and Reynolds 2012; Turner and Oakes 1986).

In seeking to draw explicit distinction between Identity Theory and Social Identity Theory, it is suggested that ideas on both individual and collective identities contrast primarily in that 'the former emphasises difference and the latter similarity' (Jenkins 2004 p.16). There are those who seek to look for what joins them and argue against labelling these as divergent perspectives, contending that 'personal identity is defined, at least in part, by group memberships, and social categories are infused with personal meaning' (Deaux 1993 p.5). Both these considerations of identities

appear to offer the individual guidance in terms of normative behaviours, with Identity Theory suggesting that it is our self-concept and chosen role that can 'motivate social behaviour' (Burke 1980 p.18). Equally Social Identity Theory 'provides us with a sense of who we are that prescribes what we should think, feel, and do' (Hogg 2007 p.80). This debate on what contributes to identities has endured for more than 500 years and appears as yet unresolved (Jenkins 2004).

The discussion above demonstrates that identities can be related both to the roles we are given and those that we choose e.g. husband, mother, son, doctor, dentist, nurse etc. (Stets and Burne 2000; Turner and Reynolds 2012; Turner and Oakes 1986). This adds further complexity to the conduct of this research, as no one is for example, *solely* a doctor, dentist, vet or nurse. They may be a white male nurse or black female doctor, and dependent on the setting, it may then be seen that one or more of these component identities dominate. Using such simple terms may therefore become problematic. However, in suggesting that identity is positioned within or without groups, this sustains the notion of a human need for acceptance, one that can be determined by the desire to associate or dissociate (Tajfel 1974; Fearon 1999; Hogg 2007). Decisions around identity may therefore also appear to be conditional on how educated, socialised or exposed the individual has been, to the existence of certain groups and what appear to be their inherent qualities (Tajfel 1974).

Much of the above presents a long-established debate offering arguably clear but divergent pathways on identities and their formation. It warns that existing guidance on these routes may either be too complex to navigate or may just lead to the wrong destination for the unwary traveller. It is therefore with both Hogg (2007) and Brown (2020) that I align, in determining that whilst Social Identity Theory (SIT) as a lens is

simplistic, it remains easily applicable and relevant to contemporary settings. Albeit assuming one can overcome its focus on positivity as distinctiveness. Additionally, that it allows for greater understanding of the creativity formed by membership of social identities that support how or what we can develop (Haslam et al 2013).

Having considered and chosen from these two differing perspectives on identities of the individual, there is now opportunity to consider the individual within a profession, this being the broader term for that place which the interviewees occupy. The following section considers the origins of the term and what has since been suggested to define this label.

2.3 Determining a Profession

‘Every profession lives in a world of its own’ (Carr-Saunders and Wilson 1933 p.iii).

There appears a lack of clarity on the term or subject of *the professional* (Friedson 1994; Fox 1994). It appears that the difficulty of the definition of the professional has been frequently circumvented in literature by merely listing the occupations to which the term may apply (Evetts 2012). However, the increasing frequency in the application of the use of the term *profession* appears to have led to a reduced meaning for many (Brante 1998), and so the now common connections with monetary reward often merely denote membership of an associated trade (May 1999).

There are long-established perspectives on where and how the label of a profession might apply. Some suggest its historic origins stem from the need to provide ‘a social location in life for the second, third, and fourth sons of aristocrats’ (May 1999 p.80).

However, there does now appear a progression beyond the limitations of what have been seen as the classic or original professions, those of medicine, clergy and law (Power 2008) and that this ‘special (privileged) category of service sector occupations’ may now be in decline (Evetts 2003 p.396). Such privileges and higher status were considered reward for the practice of roles that held at their core an obligation to others in society (May 1999). Yet in contemporary use, this often-cited requirement of a profession to direct its expertise toward a social good (Baume 2006) or in the demonstration of a ‘service ethic’ toward others, now appears diminished (Hearn 1982 p.185).

The alternative and more contemporary viewpoint of an elevated status resulting from capability rather than social standing, appears to have emerged from a time where it was the professional who conducted an activity that could only be acquired by special training (Carr-Saunders and Wilson 1933). This focus on competence as the determinant of what can be a called a profession appears to replace the earlier condition of ‘fit for gentlemen’ (Eraut 1994 p.164).

In healthcare, this appears as a response to the increasingly practical, but arguably less aesthetic demands of such roles as ‘surgeons and apothecaries’ (Eraut 1994 p.164). Eraut (1994 p.201) makes the point, in offering that it is only those in the professions who demonstrate their learning via ‘capability and performance’ (Eraut 1994 p.201) and so provide evidence of this throughout their careers via, for example, Continuous Professional Development (Friedman and Phillips 2004).

From the standpoint of personal status, there is suggestion that a profession can only exist where the characteristics of autonomy, power or prestige apply, or more specifically where there is an ‘implied licence to practice’ (McMurray 2010 p.803). In

stepping further toward such ideas of autonomy, the tradition of a profession's self-direction and the freedom to practice without consideration of hierarchical control (Friedson 1984) appears at odds with much of the embedded language of constraints and expectations of rule-following, in the many debates around the term (Liljegren 2012).

It has also been suggested that access to a profession may not be available to all. In stark contrast to the above, stigmatised groups such as 'ethnic minorities to facially disfigured persons to mentally handicapped persons' (Crocker and Major 1989 p.609) serve as examples of those that may be considered by others in this context as 'tainted or inferior' and so find themselves excluded from opportunity (Slay and Smith 2011 p.86). Whilst descriptions such as this may appear aggravated or extreme (and use inappropriate language), they can serve to highlight how groups and individuals may find limitations placed upon how they can present themselves as professionals or develop their own identities within a profession (Hall 1987). Whilst many professional groups may certainly consider themselves to be both inclusive and exclusive, much of psychology literature aligns the previously identified term of Social Identity Theory with the prevalence of notions of self-esteem and positive distinctiveness in comparison to other social groups (Brewer 1991).

The term of *profession* is disputed and perhaps even devalued. There are suggestions that it is grounded in out-dated practices, often around historic privilege. Whilst the notion of the professional has largely been focussed upon good works and public service, this appeared in return for being left with little external oversight. The new professional models of healthcare organisations such as the NHS, have for more than a decade sought to tailor (if not direct) the activities of the professional by aligning their individual vocational objectives with those of the organisation as a

whole (Moffat et al 2014). However, the term of *professional* has become contemporaneously demonstrative of a level of capability and training, which is often indicative of a status that may be as exclusive as it is inviting. It appears as Evetts (2012) suggests, quite difficult in current parlance *to pin down*. From this basis, the following section seeks to consider how the identities of the professional may be considered to develop.

2.4 Forming Identities in Professions

> ‘Professionalism and professional identity are not synonymous’
>
> Creuss et al (2014 p.1447)

In much the same way as an item of clothing, it may be seen that the identities of *the professional* can be selected, tried out and then a judgement made as to how well they fit (Ibarra 1999 p.764). This does not necessarily indicate constant intentional change or a process of perpetual searching; the individual may often seek continuity and a coherence in their application of these identities rather than arbitrary changes (Clarke et al 2009). The beginning of the formation of professional identities may for some develop from an explicit encouragement toward a certain path. In applying the label of *professional* to a role, an organisation may in reality be marketing themselves to its potential employees, seeking to attract those workers who aspire to enhanced status (Evetts 2003). Such approaches can reach beyond simple recruitment, organisations may intentionally seek to direct their employee’s identities into that of a profession as an exercise of control (Alvesson and Wilmott 2002). To achieve organisational goals, institutions may establish frameworks of 'appropriate work identities and conducts’, which can then be enforced (Fournier 1999 p.280).

Some suggesting that organisations may deliberately structure themselves to advance this. An example considered in healthcare being the designs of new hospitals that commonly remove workspaces traditionally provided for professions to physically meet and confer, thus contributing to a culture of *de-professionalisation* (Siebert et al 2018). However, a less sinister perspective suggests that by developing the concept of a professional career structure, organisations may instead be guiding employees into a process of self-disciplining behaviour, and a self-regulation within the professional hierarchies they have formed for them (Grey 1994).

The conduct of a profession is not sufficient to demonstrate identification with it (Creuss et al 2014). The debate on the selection of identities can suggest that an individual has 'as many identities as distinct networks of relationships in which they occupy positions and roles' (Stryker and Burke 2000 p. 286). This is supportive of a viewpoint within SIT, that it is the ability to identify the social identities available which determines the identities taken. Furthermore, new relationships can specifically be sought to support a continued playing out of identities, and additionally strengthening the hold upon the preferred incumbent identities (Serpe and Stryker 1987). Whilst the path to social and other identities can be formed at an early stage, those of the professional may develop from the 'narratives stemming from a sequence of life events', where identities *most salient* to the individual become focal in determining the narrative they consequently tell (Slay and Smith 2011 p.91).

As can be seen in both Identity and Social Identity perspectives, individual actors have roles to play in determining how their identities form. They are guided by an awareness of choices available, which inform the roles to play or groups to join. This may of course be confounded or supported by the backgrounds from which they emerge, which can in turn be reflective of social status. But as has also been seen,

the behaviour of an organisation or entity could also be the determinant of how that path is laid out.

It is the nature of these contributing factors to identities amongst the interviewees and also the strength of their application, that will be considered in the context of developing social identities when addressing the research questions.

2.5 Diversity amongst identities within healthcare

The career path for a professional may be formed by the institutional structure within which they operate (Grey 1994; Alvesson and Wilmott 2002). In seeking to uncover a similitude of viewpoints within healthcare more broadly, this section offers insight into how specifically those healthcare professions that attend the studied teaching programme consider and align identities in relation to others. The healthcare vocations of medicine and veterinary practice represent those professions of the research participants. Medicine appearing as the most populous, presenting both the broadest range of specialities and the most frequent of this research sample (n=9).

2.5.1 Doctors' Identities

'Medicine is usually considered the prototype of the professions, the one upon which current sociological conceptions of professions tend to be based'

(Bucher and Strauss 1961 p.326).

Doctors' identities have been suggested as emerging before their vocational study, developing as a part of the pre-study or preparation processes (Wilson et al 2013).

Others find this notion troubling, aligned to a view that professional identities for doctors cannot logically begin until their clinical training commences, as it is here that cognisance forms of what such roles truly entail, rather than what may be ill-informed perceptions (Niemi 1997). Likewise, there is recognition that immersion amongst other medical students further facilitates SIT's social categorisation processes (van den Broek 2020). In the complex environment of medicine, the emergence of identities remains reliant upon many variables, yet arguably dependent on the student doctor themselves before, during and after engaging with medical education (Creuss et al 2015). Consequently, the ability to form medical students' professional identities by exposure to a prescribed range of experiences both socially and clinically has now become explicitly central to many medical schools' curricula (Littlewood et al 2005).

For many there has been a longstanding expectation that identities being formed by doctors sought to achieve 'a detached concern' (Madill and Latchford 2005 p.1645). However, others caution that this must be balanced by avoiding 'excessive detachment from patients and from self' (Wald et al 2015 p.753). Further complexities can arise in settings such as private healthcare provision, in tempering the need to separate the potential rewards for treating a patient, whilst ensuring the treatment remains in the best interests of the patient (May 1999). This can appear counter-intuitive to the self-interests of the physician (Welie 2004a) and yet can be related to longstanding notions of a professional's social contract being service in return for status, reward and autonomy (Hearn 1982; Friedson 1984; Baume 2006; McMurray 2010). As will be seen in other professions, this discussion illustrates complexities where identities within a single profession may vary, and in this way remain explicitly contingent upon the context within which the practitioner finds

themselves – in this case, medicine (Turner and Reynolds 2012; Turner and Oakes 1986).

However, there remains longstanding recognition that patient care is the common core of the medical profession (Bucher and Strauss 1961, Kline et al 2020). These physicians' sense of the patient is seen as informing their identities (Schrewe et al 2017). This applies to both students and qualified practitioners, (Warmington et al 2006), and develops through the contexts of their clinical engagements (Arroyave et al 2019; Dornan et al 2020). However, there can appear the application of a 'sense of mission' as a tool for differentiating between specialties (e.g. urology, paediatrics etc), to denote themselves as explicitly distinct entities and be set apart from those others in medicine (Bucher and Strauss 1961 p.326). Offering a narrowing of focus toward practitioner groups' unique facets of healthcare delivery. These remain under the umbrella of medicine, yet can enable opportunities for positive distinctiveness through individuality, feeding both social *categorisation* in defining the social group and social *identification* in aligning to it (Brewer 1999; Deaux 1993).

In looking at processes of identification, the application of *Kegan's Stages of Personal Identity Formation* in medicine can be helpful (Creuss et al 2015 p.719; Jarvis-Selinger et al 2012). The medical student initially begins to accept their idea of role and the beliefs and obligations that they understand will come with it, and similar to others such as nurses, calibrate their previous perhaps inaccurate expectations of the role (O'Brien et al 2008). Secondly, an alignment with the medical profession occurs through having by now formed multiple connections and associations with both other members and their societal norms (Brewer 1999). This social identification for some culminates in emergence as the 'self-defining professional' navigating their profession's social identity using their own beliefs and personal values whilst also

holding a confidence in challenging what is accepted within it (Creuss et al 2015 p.719).

This consideration of identities of doctors in addition to more traditional clinical competencies shifts early educational focus onto what doctors are, rather than what they do (Jarvis-Selinger et al 2012; Lesser et al 2010). This leads to a focus on what medical students *actually* learn from their period of study and one that goes beyond that which they may not be explicitly taught yet might be implicitly learning within their profession from a 'hidden curriculum; (Hafferty and Castellani 2009 p.29).

The structured nurturing of identities appears in addressing the 'management of uncertainty' (Lingard et al 2003 p.612). Medical students have expressed this as a 'consistent set of strategies to project certainty', enabling what is seen by many as intrinsic to the expectations of a doctor by others (Spafford et al 2006 p.81). Indeed, there is clear expectation that such uncertainty management, in the context of professional identities formation, sits squarely within the role of their medical educators (Creuss et al 2015; Jarvis-Selinger et al 2012), particularly through ensuring the medical students' abilities to respond in challenging situations through the promotion of resilience and so delivering what they may consider to be expected of them by their peers (Wald et al 2015).

This section addresses the development of identities within medicine and the increasingly intentional role of their vocational study's curricula in shaping them. The outcomes can result in both a *detached concern* toward patients, alongside resilience in uncertainty for these practitioners. This facilitates both social categorisation and positive distinctiveness through a developed sense of mission, one that can used to compare against other healthcare practitioners or identified out-

groups. The following section considers similar and divergent perspectives that discuss identities within veterinary care.

2.5.2 Veterinary Identities

The love of animals may not be the sole or even primary motivation to pursue veterinary careers, with the previously considered tenets of what makes a profession being competence, societal connection and autonomy appearing here (Cake et al 2019). Veterinary identities appear formed similarly to medicine, through processes that reduce uncertainty in practice (Lygo-Baker et al 2015). However, there appears a diversity of perspectives within the veterinary profession that poses complexity for new entrants establishing or relating to identities that compete between clinical practice, interactions with clients and/or patients and the commerciality of their business (Armitage-Chan 2020). Some suggest that this places a disproportionate focus of much research on student and newly qualified veterinarians, thus overshadowing broader investigations of veterinary identities (Scholz and Trede 2023). However, concerns over early identification processes for veterinary practitioners recognises its similarities to both medicine and dentistry in addressing undesirable *informal* learning and requiring curricula focus upon ethical practice (Mossop and Cobb 2013). As seen in the other professions, veterinary education notes the importance of mentorship in connecting the newly qualified with appropriately experienced practitioners familiar with their local context (Nowland et al 2022; Gates et al 2021).

The emergence of an increasingly corporate presence in the field of their employment appears suggestive that not only should new practitioners be taught to

become business managers, but also be selective for whom they might work, considering where that aligns best to their personal values i.e. clinician or commercial operator (Page-Jones and Abbey 2015). The commercialisation at this larger scale offers additional layers of complexity, with some arguing that for those vets within ‘non-veterinary’ roles i.e. in administrative, governance, research and notably teaching, the connection to the veterinary profession appears far stronger in comparison to those where either clinical practice or commercial management of their practice is dominant, who may relate more explicitly to close colleagues or their specific organisations rather than the profession as a whole (Johnson et al 2006 p.504).

For many, the limited transferable skills of animal care and its related-clinical practice to other roles places a heavy burden, as realities of post-qualification practice often do not match earlier career expectations (Cardwell and Lewis 2017). This can be accentuated when finding clinical knowledge often subordinated to interacting with fee-paying clients, alongside the consideration that professional *colleagues* may also be commercial *rivals* (Knights and Clarke 2018). Additionally, the unique inclusion amongst these healthcare practitioners of their roles in patient euthanasia present further stressors. These are added complexities to an already crowded relationship, where unlike dentists and doctors, the client and the patient are not the same (Crane et al 2023). As such, presenting risks that the client can be perceived as ‘the enemy’, whilst contributing to practitioners reduced mental wellbeing (Armitage-Chang 2020 p.113). However, for those with whom social identities within veterinary care appear most salient, there is evidence that this greater affinity ameliorates some of the clinically-related stress the role encompasses (Crane et al 2017). The ability to balance the interplay between the many ‘veterinary stakeholders’ now seen as

becoming contingent to both professionalism and successful practice (Gordon et al 2023 p.182).

Recent influences such as the increased feminisation of the veterinary sector, created a gendered balance of practitioners since the 1980's (Scholz and Trede 2023), whilst playing to female strengths of care. This appears at odds with the continued male-centric leadership roles of the profession (Scholz and Trede 2023; Gordon et al 2023). This may appear further exacerbated for racialised minority veterinary students, whose identification processes are often confounded by both a lack of academic faculty and role models from diverse backgrounds (Ching and Armitage-Chan 2022).

This section has presented a diversity of motivations within veterinary practitioners beyond animal care. Motivations such as demonstrations of competence, the gaining of societal connections and the achievement of autonomy. Like medicine, their identities can evolve through practices that seek to reduce uncertainty.

2.6 The Medical Educator

This section addresses the final component of research question two; *what are the influences that contribute to the subsequent identities displayed?* It defines the educator within healthcare and offers perspectives on the value of this role from within the varied healthcare professions it supports. Finally, it looks toward the use of Social Identity Theory in healthcare and specifically education within it. This endeavours to explicitly justify the application in the context of this research.

2.6.1 Defining the Medical Educator

A 2015 survey of members of the Association of Medical Education in Europe (AMEE) suggested medical educators saw themselves as defined within a range of 13 roles as diverse as 'professional expert…curriculum developer…undergraduate and postgraduate trainer' (Nickendei et al 2015 p.715). Whilst others suggest it may only be a mere 12 roles (Harden and Crosby 2000) with an expectation that this would distil further to just six within the next decade (Simpson et al 2018), these viewpoints lack suggestions of *who* it is that fulfils them. Consequently, it can be relevant to consider the question; *Who or what is a 'Medical Educator?*

Longstanding organisations that seek to represent the Medical Educator, such as the Academy of Medical Educators (AoME) focus on the multi-professional nature of the role in 'the education and training of students and practitioners in medicine, dentistry and veterinary science' (AoME 2024). The Association of Medical Education in Europe (AMEE) states its membership is open to 'teachers, administrators, and researchers involved in medical and healthcare professions education' (AMEE

2019). Swanwick (2013 p.5) helpfully suggests that they are ‘teachers and scholarly agents of change and improvement within medical education’. Others when defining the medical educator have more broadly suggested the role holds a bias towards *clinicians that practice* in medical education (Steinert 2012). Yet for some there is an acceptance that ‘a medical educator may, or may not, be clinically qualified’ (Bligh and Brice 2009 p.1161). Although medical students may often suggest that they cannot ‘talk the talk without walking the walk’ (Shapiro et al 2009 p.194). However, there appears recognition that specifically a ‘clinical educator’ may follow a different career path to a medical educator (Weinberg 2009 p.240; Simpson et al 2018). Regardless of background, the expectations of the medical educator in the future, have been proposed as becoming less subject matter expert and more about ‘model[ling] ongoing learning’ (Simpson et al 2018 p.245).

2.6.2 The Value of the Medical Educator

Medical educators in both the workplace and *formal* educational settings have been highlighted as those who frequently hold the responsibility for developing the identities of their students (Creuss et al 2015; Jarvis-Selinger et al 2012). Yet educators that develop identities within explicitly *formal* educational settings (such as HEIs), may often be considered of less value than those practitioners in patient care or research (Browne et al 2018; Bartle and Thistlethwaite 2014; Sabel and Archer 2014). van den Berg and Lombarts (2018 p.145) raise concerns that this issue has been largely unaddressed over two decades and has consequently contributed to what may appear as a cohort of ‘lonely’ individuals within formal educator roles that lack clear career paths. Whilst there are those that advocate the creation of strong supportive social

networks to develop medical educators (van den Berg and Lombarts 2018), Snook et al (2019) argue that there is also a tendency to overlook the differences between these full and part-time educators. Their identities (and professional capabilities) being often formed and managed by *different* social groups. This offers support to the notion that for full-time medical educators, teaching institutions engagement with the formation of educator identities, has been in large part to improve teaching quality. Meta-analysis of research on educators within healthcare in transition from clinical practitioners to educators, indicate processes that can last often between one to three years and influenced by emergent vulnerabilities from a perceived lack of applicable knowledge and the feeling of starting again (McArthur-Rouse 2008).

For doctors developing teaching identities, motivations can be embedded in repaying the value of the teaching they themselves received as students, by supporting a subsequent generation of physicians (Steinert and Macdonald 2015), alongside promoting concepts of care and appropriate competence within their students (Macleod 2011). Bartle and Thistlethwaite (2014) suggest medical educators can also seek to improve upon on those poorer teachers that had taught them, or certainly to at least be as good as the better ones they themselves had considered role models. However, some do not fully consider their objectives in becoming medical educators, leaving them initially directionless upon arrival, as a consequence of unexpectedly high levels of self-direction required within the educator role (Bartle and Thistlethwaite 2014). For some this dilemma is overcome in part by presenting as *clinicians who also educate* (Browne et al 2018; Bartle and Thistlethwaite 2014) and for reasons of perceived status, whilst maintaining credibility when teaching students (Sabel and Archer 2014).

The literature on the veterinary educator appears limited in comparison to such as medicine, with a greater focus instead on the student (Mossop and Cobb 2013). However, the balance between clinical practice and client interaction is recognised by the focus of veterinary educators in developing client-facing skills (Dolby and Lister 2015). However, whilst role-modelling has been seen by veterinary students and newer teaching staff as important, evidence suggests more senior faculty have previously given this less priority (Bolt et al 2010) or situated it as curricula *afterthoughts* (Coffman 2002). This has both held veterinary education back and also spawned a newer generation of those keen to both apply and standardise approaches across curricula (Zemjic 2004; Byrnes 2022). This highlights the imbalance between students' desire to develop *professional* skills against some faculties' embedded preference for more *traditional* clinical teaching (Roder and May 2017).

The following section looks at the discussion of SIT in supporting perceptual judgements, especially in hierarchical environments such as healthcare. It finds suggestion of a single identity focus within healthcare, that may result from participants being left to construct their own paths in making sense of them.

2.6.3 Locating Social Identity Theory, Healthcare and the Medical Educator

It is accepted that SIT can be applied to clinical workplaces and that its use amongst medical educators particularly, can shape the identities of their trainees (Kerins et al 2022). However, clinical tribalism, concepts of status differential and stereotyping are also attributed to healthcare workplace cultures within which these individuals exist (Braithwaite et al 2016; Mandy et al 2005). The value of Social Identity Theory and

its consideration in healthcare and education is reinforced by those who note the importance of the resulting differences in perceptual judgements on the world around them, perceptions affected by the social-categorisation (or in-group) within which they place themselves (Burford 2012). This is akin to concerns toward those who denigrate their out-groups by perceiving them as homogenous, whilst in-groups become framed as nuanced, varied and consequently powerful (Simon 1992).

Accordingly, SIT has been suggested to provide a conceptual underpinning for the 'profession-centrism' found within healthcare, one which offers a 'narrowed view of the world' depending on roles taken and where its beginnings often appear from initial vocational training (Pecukonis 2014 p.62). An initiation that is often founded in mentoring and role-modelling (Pecukonis 2014). This social identity attachment and in-group alignment for healthcare professionals may be adopted long before the completion of their vocational training (Burford and Rosenthal-Stott 2017; van Huyssteen and Bheekie 2015). This appears also with the potential for a *dismissiveness* of other healthcare professionals' perspectives (particularly when offering feedback), specifically to those considered as outgroups (van Schaik et al 2016; Miles et al 2021). Miles et al (2021) suggest healthcare practitioners' tendency to offer guidance in specific areas can be dependent on their social categorisation of those around them e.g. doctors preferring to offer knowledge-based feedback, whereas other health professions may focus on workflow improvement.

There is much literature in healthcare education that applies SIT to transitions from trainee to qualified practitioner (Bochatay et al 2022; Sabel and Archer 2014) and yet literature on developing educators within healthcare through postgraduate study and considering their social identities is limited, rarely longitudinal and often with a focus more on programme efficacy or forms of quality control (Sethi et al 2018). Indeed,

the complexity of social identities within medical education specifically, is often seen through the lens of just one identity at a time, rather than an emerging and complex intersection of race, gender and profession (Bochatay et al 2022). In healthcare, this ‘paucity of social contextual perspectives’ leaves its learners to find personal or singular approaches to identities that are often governed by pluralist cultural and professional groups (Mount et al 2022 p.S102). When applied to the educator within healthcare, the social identifications of educators can often be seen as subsumed to those of the clinical practitioner, with the justification that it is the delivery of healthcare that shapes the educator role and therefore rendering indivisible from the clinician (Sable and Archer 2014). Noting the confusion of what or how social identities such as those of educators within healthcare manifest, causes further difficulty, particularly in the social categorisation of the educator role (Sable and Archer 2014). To illustrate further, social categorisation in healthcare often utilises ‘points of comparison’, these being examples observed to support judgements for in-group alignment (Van den Broek et al 2020 p. 278). Correspondingly, objective and common determinations of the identities of educators within healthcare are hindered when largely informed by those varied views on education found within *differing* clinical environments (Cantillon et al 2016; Mount et al 2022).

There is difficulty for practitioners to form similar emotional attachments to educator roles as appears present within their clinical persona, which can be frustrated by ‘ugly duckling’ comparisons of value versus perception (Sabel and Archer 2014). Concepts of the educator in healthcare as an esteem-enhancing role often dampened by perceptions that colleagues, such as those focussing on clinical practice, do not have this same regard (Jauregui et al 2019).

The hierarchies of in-group and out-group statuses within healthcare are suggested as often prone to manipulation, where in-group esteem may be enhanced by selecting an identity's own unique contexts for value. For example, a GP may choose to highlight community service, whereas neurosurgeons may perceive dexterity and knowledge as their own markers for excellence (Burford 2012). In other instances, SIT is considered in the context of the relative perceived value of training undertaken within the healthcare profession. Doctors can consider their training as more valuable than that undertaken by other healthcare professions for example, and a consequent rejection of interprofessional learning that might otherwise erode perceptions of in-group superiority (Baker et al 2010). Such avoidance of those with social identities holding perceived lower status limits the propensity for considering additional in-groups within healthcare. This suggests that a focus on maintaining the superior status (and salary) differential, at times through the denigration of healthcare out-groups, becomes preferable to collaboration or acceptance (Sollamani et al 2018). Indeed, educational institutions are encouraged to recognise such *turf protection* behaviours that emerge from limited interprofessional educational opportunities in healthcare.

Importantly, these embedded 'uni-professional identities' often developed through initial vocational training, are suggested as causal of inabilities to develop multiple social identities within healthcare (Khallili et al 2013 p.448). SIT is used as a justification for greater initial training alongside a broader range of healthcare professions, particularly in attempting to reduce a perceived *stickiness* of social identities within healthcare generally and medicine specifically, where few other social identities are considered (Roopnarine and Boeren 2020).

2.7 Conclusion

This chapter draws upon the notion that identity formation is reliant upon the presence of others (Erikson 1959; Goffman 1959; Mead 1967), moving from identities being considered when displayed to others (Goffman 1959), toward the assertion within SIT that this derives from a desire for acceptance from selected groups (Tajfel 1974; Fearon 1999; Hogg 2007). These chosen groups can locate positions within society (Cote 1996), whilst also offering clarity on normative behaviours and bilateral expectations (Brown 2000; Brown 2020). However, they may still move back and fore to different identities dependent on the context they find themselves within (Turner and Reynolds 2012).

In determining the notion of a profession, the longstanding concepts of obligation to others (May 1999), alongside the demonstration of learning through capability and performance (Eraut 1994), resonate with the identities of healthcare professions. However, it may also be seen for the healthcare professional that broader suggestions of the term's use as organisational or systemic *control* (Fournier 1999; Alvesson and Wilmott 2002) can show its contemporary application.

Having brought relevance to the concepts of *profession* that can apply to these healthcare interviewees, discussion of formation processes offers the importance of individual backgrounds such as family and education (Slay and Smith 2011). Healthcare identities often form in advance of vocational training (Niemi 1997, Wilson 2013), whilst also constraining future career choices once embarked upon (Alvesson and Wilmott 2002). Amongst the health professions, alignment to concepts of care expectedly appear in all. However, contrasts in their application within identities can be exemplified by doctors seeking a level of detachment from the patient (Madil and

Latchford 2005), whilst nursing self-concepts may be enhanced by feedback from patients for whom they care (Fagermoen 1997). For dentists the notion of the patient as client at times appears challenging, yet for veterinary practitioners the patient is never the client, and this additionally presents a dilemma where client relationships and the need for commerciality may conflict with notions of care (Armitage-Chan 2020).

The value of mentorship as education appears across all healthcare professions. The justification for doctors can be seen from orchestrating capability in clinical complexity through example-setting (Hafferty and Castellani 2009). Similarly, new entrants to nursing benefit from mentors' *sense-making* in translating vocational training to the realities of clinical practice (Apker 2001). Formal *orchestrated* mentorship can also address unwelcome informal learning in early and often diverse or isolated practice for veterinary practitioners (Nowland et al 2022).

In defining the medical educator, connection to mentorship in *modelling on-going learning* (Simpson et al 2018) also appears. The role's value often aligned to the development of student identities (Creuss et al 2015; Jarvis-Selinger et al 2012), albeit at times unfavourably compared to those *solely* in clinical practice (Browne et al 2018). Consequently, this encourages educators to project outwardly as *clinicians that teach* (Bartle and Thistlethwaite 2014), thus retaining self-esteem and status (Sabel and Archer 2014). The retrospective sense-making at times indicative of a lack of clarity in their expectations for the educator role (Bartle and Thistlethwaite 2018), resulting from unsupported perceptions of educators in practice (van den Berg and Lombarts 2018). The motivations for becoming educators often appear as providing legacy, for example through doctors sustaining the profession by developing the next generation (van den Berg and Lombarts 2018).

Finally, we begin to draw closer to the areas that will emerge within the two empirical chapters addressing the research questions, where chosen and projected identities may be formed by early influences such as capability or environment. That these identities exert influence on behaviours in practice alongside practitioners' expectations of their future. That for healthcare, the notions of care are omnipresent albeit diversely interpretive within its professions. There is also an alignment of mentor to educator appearing evident in all healthcare professions, however this emerges to address their differing and often unique needs of practice. Yet the educator appears a sometimes-stigmatised role, often encouraging entrants to find personal ways to integrate within own clinical practice. This can often be a surprise, with previously ill-defined determinations of what it means to be a teacher within healthcare, compounding sometimes limited plans for the role in the participants' future.

Chapter Three - Methodology

3.1 Introduction

This chapter explains how I planned to capture the perceptions of teaching identities from healthcare professionals learning to be educators, through three semi-structured telephone interviews with each participant. These interviewees' narratives were interpreted with regard to my own 'positionality' (Miles and Huberman 1994 p.4), one which favoured a situated and variable truth (Braun and Clarke 2022). My interpretations were developed by conducting three engagements with the interviewees, seeking opportunities to note any changes within perceptions of those identities they may have established over time. This repeated engagement enabled a rigorous process that allowed observation of how professional identities influenced perceptions of teacher identities. My approach was informed by my desire to make a change for the better by understanding (Clough and Nutbrown 20212), and so consequently enhancing the learning experiences of new healthcare educators and their students.

The chapter opens with a consideration of my approach to research underpinning the actions taken (see 3.2). The research design (3.3) considers the application of a case study approach (3.3.2) and also how and why 'mixed methods' may have been applied, had circumstances been different (3.3.3). It also discusses the use of my longitudinal approach spanning over three years (3.3.4).

Data Collection (3.4) addresses the *who* and the *how* of obtaining research subjects (3.4.1), why semi-structured interviews align to my own researcher standpoint, whilst investigating the research questions appropriately (3.4.2). Additionally, consideration

is given to the ethical processes put in place to ensure both informed consent of the research participants (3.5.1), alongside preserving their anonymity (3.5.2).

In addressing the data analysis process (3.5.3), the six-step approach of thematic analysis is justified (3.6.1) and considered at each stage.

3.2 My Approach

3.2.1 Ontological and Epistemological Positions

I have sought participants who could offer a personal narrative in specifically addressing my research questions. My epistemology, as Greco (2017) suggests, is a deliberation of what knowledge is, how I may acquire it and how I justify what I believe is possible to know. Crotty (2015 p.8) suggests that by embracing constructionism, we accept that there would be no 'objective truth waiting for us to discover'. My own constructionist approach has led to my consideration that these diverse and unique individuals employed in healthcare, were to be the creators of the social phenomena considered (Bryman 2012 p.710). I therefore have welcomed the opportunity to present my own position as it aligned to my research's specific purpose (Clough and Nutbrown 2012).

Epistemologically, an interpretivist's care was taken to 'explore and unpack' the meanings from my interviewees' responses and investigate why they matter (Braun and Clarke 2022 p.289). Their broad range of responses displayed what could be described as a human distinctiveness (Bryman 2012), and were subjected to my interpretivist focus on 'linguistic interpretations of actors' meanings' (Williams 2000 p.210). Here, I could observe them in such a way that 'individual vagaries and

subjectivity do not cancel one another out' (Cryer 2006 p.78), and so even the outliers were valued.

Maracek (2003) considers the importance of the researcher's ontological frame, suggesting that it is not about what is truth, but more of what is *the truth that interests me*? My constructionist approach aligned to this research's specific purpose (Clough and Nutbrown 2012). Bryman's (2004) positioning of ontology as a dichotomy of the objective and subjective appeared helpful. By focussing on personal narratives, I perceived the 'notion of an objective reality' as a difficult proposition (Robson 2011 p.24). My own approach accepts no 'single truth' (Braun and Clarke 2022 p.187) and recognises that these interviewees as unique social actors building the singular social world that that I seek to observe (Bryman 2012). They offer varied perspectives on this single MHPE programme. My use of semi-structured interviews enabling such diversity to be captured from participants, who initially appeared to lack homogeneity.

As a lecturer teaching on the studied master's level programme since 2017, my broad intention was to gain a greater understanding around the identity development of healthcare professionals that teach other healthcare professionals. This brought about a wariness of *insider research*, being clearly a permanent member (rather than a temporary one inserted for the purpose of research) of the organisation within which the study occurred (Brannick and Coughlan 2007). I may perhaps have been seen to have some vested interest or emotional attachment that could influence both processes and outcomes. As a result, I sought to ensure a continuing methodological reflexivity (Alvesson 2003) within each stage.

My qualitative approach allows for an analysis of not only the nuances of social exchange, but also the multiple perspectives through which they can be viewed (Fossey et al 2002). This therefore demands that those research procedures and protocols being explicitly identified within this chapter, were also rigorously followed (Brannick and Coughlan 2007). As Yin (2009) suggests, my documentation of the work completed has sought to enhance the reliability overall. It also presented my conscious approach to locating as a researcher in the field. Flick (2014) contends that, a balance of strangeness and familiarity needs to appear; *familiarity* in understanding not only what questions to ask of these healthcare professionals (who are also my students), but also how to present the enquiry in a way that encourages their greatest openness. *Strangeness* in appearing and questioning as an outsider, rather than their teacher. In doing so, I constantly sought more explanatory information and those richer descriptions that they might give to the non-clinician that I am.

This study in practice rejected the possibility of a positivist and value-free approach to research, and I found reassurance when noting that this perspective in similar settings has grown significantly over recent years (Punch 2013). I had embraced Mercer's (2007) consideration of insider research in teaching within higher education. This suggests that similarities to those research participants could be both innate and unavoidable (such as gender or background), yet appear on a constantly changing continuum of relevance to them.

3.3 Research Design

3.3.1 Introduction

I understood that my research questions should determine the research design and be supported with a clear description of it, alongside explicitly informing the rationale of the methods of data collection and analysis. Richards and Morse (2012 p.34) describing as 'methodological congruence' my connection of the problem, questions, method, data collection and method of analysis. It therefore seemed to align with Cresswell's (2013 p.55) description of 'the traditional approach to scientific research' in identifying the problem, defining the questions, selecting the method(s) and creating the findings.

In considering the research questions, I sought with the first research question, *'What are the perceptions of teaching identities amongst healthcare professionals on an award-bearing course in teacher education in healthcare?'* to investigate how students view themselves in the context of teaching both prior and subsequent to completion of their studies. In relation to the research's initial aims, there has been regard of the alignment to health professions' perceptions of relative professional status (Eraut 1994). In exploring these aims, this research offers the potential to recruit future teachers within the healthcare professions more effectively, by perhaps widening the appeal of teaching within healthcare to those that may otherwise have not considered that path.

The first part of the second research question of '*In exploring the considerations of change:*

(a). What happens to these healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare? offers

exploration of whether or how, the students' teaching identities develop resulting from the process of their study (Beijard et al 2000). Attention was given to considering whether despite differing professional specialties in healthcare, and consequent differing original professional identities, could these teaching programme participants' teaching identities *converge* in some common way over time? Consequently, the findings could support potential further research into how any supportive development is accelerated and, if appropriate, influenced (McGowen and Hart 1990).

The final part of the second research question of *(b). What are the influences that contribute to the subsequent identities presented?*, considers whether earlier or existing professional identities influence any observed teacher identities. From this it may be possible to determine whether certain healthcare backgrounds are more disposed to teaching than others and begin to consider what influences are present within them to support this. This may, at a future point, allow us to identify how these healthcare specialties engender clearer teaching identities that can stand firmly alongside that of a clinical professional one. This could then support greater competence within their teaching and possibly enhanced clinical functions as a result (Beihl et al 2021).

In this research, the underlying propositions that should be made explicit (Yin 2009), are that the research subjects would hold perceptions of teachers alongside of their own identities formed within their original healthcare professions. Additionally, that identities may change over time.

The next section considers the choice of case study as a route to discovery, and outlines the criteria considered in its application.

3.3.2 The Use of a Case Study

The application of a case study approach enabled my focus on the complex and particular (Stake 1995). I sought to 'understand a real-life phenomenon in depth' (Yin 2009 p.18).

Yin's (2009) helpful and more technical definition supported its use as an inquiry with many topics, multiple sources of evidence to be triangulated, and one that benefits from pre-existing theoretical viewpoints to guide both my collection of the data and my subsequent analysis. Robson's (2011 p.137) suggestion that case studies are now considered without 'special difficulties for the realist view of science' and Van Wynsberghe and Khan (2007 p.80) further offering that it has 'trans-paradigmatic' versatility, displayed its broad applicability for me further.

Yin (2009) suggests that the case study method should be considered if three conditions are met. Firstly, that the form of the research question is explanatory and therefore with a focus on the 'how' or 'why'. Secondly, that the researcher has control over behavioural events and access to the relevant actors. Finally, that the focus is on the contemporary, and where the researcher is without control of the behaviours being observed. However, Yin (2009) also suggests that in my role as a researcher I could just observe one or two variables whilst still *controlling* the exclusion of others that remain outside my area of interest. If applying this approach, my research presents research questions that are clearly explanatory, whilst also reliant on a defined group of subjects to which access has been available over a period of considerable time. In answering the third condition, this research has used the semi-structured interview schedule to focus upon those areas solely around the research

questions and with a conscious effort to avoid leading the subject into areas beyond the scope of the investigation.

Cresswell (2012) suggests that case study research begins with identifying a specific case, or what Bryman (2016 p.61) describes as ‘an object of interest in its own right’. In this research, it could be what is described as the ‘concrete entity’ (Cresswell 2012 p.98) of a group of healthcare practitioners learning to be teachers within healthcare, that are all enrolled on the studied programme. Punch (2013) requires the case itself to be presented as a *bounded system* in relation to time. This would therefore begin with the first interviews at the commencement of my interviewees’ study in September 2019, followed by a second set conducted some nine months after completion and finally concluding in January 2023. The ‘case’ (Yin 2009 p.31), is considered here to be the postgraduate course itself. Van Wynsberghe and Khan (2007) also suggest the importance within an interpretivist setting of delineating the case from the unit of analysis, offering support for my determination that the interviewees are the granular unit of analysis.

Yin (2009) notes criticisms of the case study method can often arrive from the lack of *generalisation* that it may offer. To counter this, Yin (2009) offers that a reliance would not usually be placed on just one source of evidence. Rather, that it should be seen as an opportunity for me as the researcher to contribute to the expansion of a specific theory such as Social Identity (Tajfel 1974), rather than by my empirical promotion of it. Bryman (2016) similarly notes the risk of an inability to support generalisation, so this research has sought to identify the context of the case study more clearly, whilst also accepting that its value may develop if it were to become part of a case group of similar studies looking to develop knowledge or through supporting a replication (Merken 2004), as is suggested in *Recommendations for*

Further Research in 6.4. In this way, it may arguably have been hoped to find the 'critical case' label to be relevant, due to the observance of how or whether a well-developed theory could be applied in this researched setting (Merken 2004 p.62). Yet, as Robson (2011 p.139) suggests, it is a rare example to be encountered. It requires a setting where predicted outcomes expect to be found, and so not appropriate to this research. This work may therefore sit as a 'social group study', due to the occupational (in this case healthcare) generality present (Hakim 2012 p.66).

3.3.3 A Consideration of Mixed Methods

At the beginning of the research design, my intention was to complete the research solely through the use of interviews (see Appendices A1 and A2 for how this was presented to potential participants). This reflected an expectation at the time of a greater number of interviewees being available with a target of n=20. The programme studied had an overall cohort of in excess of 120 students in that academic year of 2019/20. However, with just an initial ten volunteering to participate, the additional use of an online questionnaire was determined, in an attempt to engage with a greater number of participants. I considered their inclusion as an ability to correlate my ten interviews with a broader albeit less rich dataset from that same context. The guiding concern was that from a cohort of over 120, ten participants may not form a sufficiently representative sample, especially if considered against the more common-place 15-30 interviews where patterns are often sought from data (see Braun and Clarke 2013). However, because of the specific and detailed nature of this research, its comparatively uncomplicated or

uncontroversial topics (Bryman 2012), alongside expectations of articulate interview subjects (Morse 2000), I was willing to accept smaller numbers. When considering retrospectively, participants did initially present the programme as of limited importance, compared to the healthcare contexts from which they came. This appears alongside the many challenges that the participants subsequently revealed they faced during their progress within the programme of study. This therefore now seems in some part, to explain the relatively low engagement with a study that centred on a topic of comparatively limited importance and during a notably demanding period.

A self-administered questionnaire was additionally developed. However, at the time of issuing the online questionnaire in March 2021, the UK in general and NHS in particular was still encountering a significant wave of Covid-related illnesses. This was beginning to reduce in late March 2021 (ONS 2023), yet it had placed a considerable strain on healthcare practitioners such as those that might be my potential respondents. Perhaps consequently, there was a low response rate of just five, from a potential number exceeding 120. This meant that analysis would have been more time consuming than it was significant. As a result, the development of the questionnaire did not continue and formed no part of the data analysis presented within this thesis.

3.3.4 The Longitudinal Approach

As identified in 3.3.2, the research covers a timeframe that stretches over three years. Initially, I envisaged only one interview on programme entry in early September 2019 and then one after exiting in August 2020, would be asked of each

of the interviewees. However, due to requirements of restricting research activity on healthcare practitioners during the early phase of the pandemic, the second interviews took place between March and May of 2021 (n=7). As a result of the reduced numbers of interviewees in the second phase, alongside a lack of supporting questionnaire respondents, a third phase of interviews were sought, and these were completed in January 2023 (n=6). This inclusion of a third engagement with the same research subjects or 'panel', offered support to the internal validity of the process (Bryman 2016), although as Robson (2011 p.129) cautioned, it has shown the risks in terms of the attrition of numbers of subjects, dropping from ten to seven and then finally six participants.

This longitudinal approach was also necessary to support RQ2 in addressing the potential for *change* in perceptions of identities over the prescribed time. It offered more depth in considering causal inferences and especially as Bryman (2016) suggests, in order of occurrence. This was a justification for conducting a single case study, albeit a risky one if used as the sole rationale, as it may be found later that the case was not that which it was thought to be (Yin 2009). I should note that it became apparent only later that I had inadvertently followed the approach outlined by Seidman (1991), in focussing more on life history in the *first* interviews, details of the actual experience in the *second* and reflections on their meaning in the *third.* I had within the third interviews also allowed the interviewees to see if the story *I* felt was unfolding, was the one *they* felt was intended to be told by them (Clough and Nutbrown 2012). These amendments to the original Cardiff University SOCSI ethical approval can be seen in the revised application form (approved on 18th February 2022) in Appendix A3.

3.4 Data Collection

3.4.1 Sample & Access

I addressed *insider researcher* concerns around undue coercion, where I as a lecturer approach my own students to participate in what may become highly sensitive discussion for both parties (Brannick and Coghlan 2007). It was consequently agreed that the teaching programme's administrative team would offer the opportunity for voluntary participation to the student cohort. In this way, I could as the lecturer/researcher remain distinctly distant from the recruitment process. I remained at arms' length when addressing any specific enquiries from potential participants and so keeping their identity withheld, until they wished to disclose it as part of their consideration to participate.

It is the potential ability to access appropriate research subjects that often initiates such a distancing approach (Merkens 2004). My selection may have been considered as using a *fixed purposive* strategy (Bryman 2012), in that those approached were students whose experiences were clearly relevant to the research questions (see Table 2 – *A comparative profile of initial interview group using Higher Education Statistics Agency (HESA) data for Postgraduate Taught students on part-time study in academic year 2019/20 (HESA 2023),* with the initial sample remaining unaltered as the research progressed. However, this sampling would (as with the previously discussed self-reporting questionnaire), have been exposed to potential respondent bias, insofar as by volunteering, these students may have their own personal agendas (Young 2015, Robson 2011). Additionally, despite the difficulties in trying to gain more than 10 interviewees during the first phase, I was mindful that the

snowballing approach to sampling, i.e. using existing interviewees to recruit others, may have led to a greater and unhelpful like-mindedness (Merkens 2004). I had also considered that those who explicitly did not participate may have reasons of a perhaps systematic nature, and so their absence may distort the overall direction by not capturing them also (Merkens 2004).

However, my representativeness of the sample was, perhaps by chance, at least similar to the Higher Education Statistics Agency's composition of student gender and ethnicity for their 2019/20 academic year for part-time postgraduate taught students (see Table 2 - *A comparative profile of initial interview group using Higher Education Statistics Agency (HESA) data for Postgraduate Taught students on part-time study in academic year 2019/20*).

In considering how many is enough, such small sample sizes in qualitative interviews are not uncommon, especially if employing a *theoretical justification*, identifying a point of thematic saturation alongside showing the greater homogeneity of the research subjects, as can be seen in these practitioners in healthcare studying on the same programme (Bryman 2012). Yet, I understood that a simple selection by virtue of convenience was insufficient to demonstrate academic rigour, so deliberation was given at the time as to whether the non-respondents to the request for participation were sufficiently different or systematic in some way to those that did respond and thus create a bias within the sample (Denscombe 2003). That all of the respondents were practicing healthcare professionals, alongside attending the same master's level study programme in teaching at the same time, seemed supportive in that they were not a notably divergent or separate category within the chosen sample frame. I have differentiated amongst the four healthcare professions most commonly found within the studied programme's cohorts within Section 2.5 of the Literature

Review. However, due to the small sample size of initially nine interviewees from medicine and one from a veterinary discipline, I have chosen during the discussion of the data within both Chapters 4 and 5, to present them more generally as *healthcare professionals*. I therefore only draw out specific vocational *peculiarities* in the data if it is both manifest and relevant.

Table 1 - The profile of each interviewee within this research

Identifier Name	Gender	Age Range	Ethnicity	Professional Background or Position	Highest Qualification Held	Time Since Qualifying for Profession	Time in Current Position	Brief Outline of Interviewee	Interviews undertaken
Peter	male	41-50	Asian British Indian	Medical doctor	PG Cert (L7)	25 years	1 month	An experienced medical researcher now working in a large teaching institution as part of his role.	#1
Odette	female	41-50	other white background	Medical Doctor	Doctor of Medicine (L6)	22 years	Over 10 years	General Practitioner	#1, #2, #3
Esther	female	31-40	white	Senior Vet[2][3][4]	Doctoral level (L8)	16 years	16 years	A senior level veterinary specialist	#1, #2, #3
Florence	female	31-40	white Scottish	Medical Doctor	PG Cert (L7)	7 years	1 month	A clinical practitioner who also works in teaching specialist area students.	#1
Dennis	male	21-30	other white background	Medical Doctor	Doctor of Medicine (L6)	3.5 years	2 months	A junior doctor whose role is to teach medical students.	#1, #2
Amanda	female	21-30	black British African	Medical Doctor	Doctor of Medicine (L6)	3 years	2 months	A junior doctor whose role currently is to teach medical students.	#1, #2, #3
Hayley	female	21-30	white British	Medical Doctor	Doctor of Medicine (L6)	3 years	2 months	A junior doctor whose role is to teach medical students.	#1
Andrea	female	21-30	white English	Medical Doctor	Doctor of Medicine (L6)	2 years	2 months	A junior doctor whose role is to teach medical students.	#1, #2, #3
Heidi	female	21-30	white British	Medical Doctor	Master's (L7)	2 years	2 months	A junior doctor whose role is to teach medical students.	#1, #2, #3
Kevin	male	21-30	British	Medical Doctor	Doctor of Medicine (L6)	2 years	2 months	A junior doctor whose role is to teach medical students.	#1, #2, #3

[2] The World Health Organisation developed an approach to more closely integrate human and animal healthcare professions called 'One Health' (WHO 2017).

[3] The consideration of the collaborative emergence of both human and veterinary medicine is longstanding (Woods 2017).

[4] The consideration of human and veterinary healthcare working jointly has developed particularly since the Covid 19 pandemic (Mackenzie and Smith 2020).

Table 2 - A comparative profile of initial interview group using Higher Education Statistics Agency (HESA) data for Postgraduate Taught students on part-time study in academic year 2019/20 (HESA 2023).

Characteristic	HESA 2019/20 data	Interview Sample
Female	62%	70%
Male	38%	30%
Other(gender)	>1%	Nil
White	74%	80%
Asian	14%	10%
Black	7%	10%

3.4.2 Using Semi-structured Interviews

Potter and Hepburn (2005) imply the interview is often the default position of the qualitative researcher. The choice of interview approach ranging from fixed questions, through semi-structured to the completely unstructured has been suggested to link in large part to the '*depth* of response sought' (Robson 2003 p. 278). In this instance, my choice of a semi-structured interview was founded by an interpretivist ontology, that I sought to justify from the outset (Crotty 2015; Hopf 2004). It allowed a more open enquiry into the interviewees' meanings and for clarification in the moment. As the researcher, I became more informed between these three sets of interviews spanning nearly 30 months, through listening to the

stories of these healthcare practitioners (Seidman 1991), as they specifically addressed my own research questions (Braun and Clarke 2013).

I conducted a pilot interview using academic colleagues and former students of the programme to be studied (n=6). This considered the questions, their order and importantly enhanced the *prompts* I placed after them within the schedule, to support and develop interviewee responses.

3.4.3 Conducting the Interviews

Telephone interviews were considered to offer cost-effective and efficient access to interviewees (Bryman 2012), who may be widely spread geographically (Trier-Bienek 2012). Additionally, reducing response bias to my own reactions to the interviewees' answers (Knox and Burkhard 2009). They allowed me to engage in friendly conversation, where elaboration could be requested, but did not act as hints or cues for the respondents (Seidman 1991). Additionally, from a more practical stance, the interviewees would often be in hospital/NHS settings with limited/poor Wi-Fi connections. Using Teams/Zoom was quickly rejected by the pilot group of interviewees as a result.

The potential length of the interviews did become a concern as it had been suggested that telephone interviews would rarely succeed if reaching beyond 25-30 minutes (Robson 2008; Bryman 2012). Yet others found little evidence of such a ceiling (Novick 2008; Irvine et al 2013), with examples of similar qualitative telephone interviews reaching two hours in duration (Burke and Miller 2001). I felt justified, when considering that telephone interviews could be shorter and yet still encourage participants to seek greater clarification in the questions and offer more clarification

for the interviewer (Irvine et al 2013). The range of the interviews' duration and average length is found in Table 3 below.

Table 3 - Range and average durations of each set of interviews conducted

	Shortest	Longest	Average
Interview Set #1	40 mins	58 mins	50 mins
Interview Set #2	44 mins	74 mins	67 mins
Interview Set #3	42 mins	55 mins	47 mins

As a non-clinician, my risk of what Olukotun et al (2021, p.1413) describes as *over-identifying* with the participants appears reduced - the similarities between us limited, and the appearance of blurring biases diminished. Whilst Olukotun et al (2021) further suggest that research is always political in addressing an agenda, here my power position within their student landscape, as a lecturer, adds complexity and demands further reflection.

Holmes (2020) notes the difficulties for novice researchers in defining and expressing positionality, despite expectations of their supervisors. Like Olukotun et al (2022), expressing the importance of reflexivity as a tool in assessing how they are influencing the study undertaken. Equally, they suggest a view of insider and outsider roles as *a spectrum,* one that demands the researcher balances subjectivity with objectivity in the approach taken. It is Jacobson and Mustafa (2019), who offer the application of a structured social identity mapping process, thus enabling the researcher to reflexively plot their influences on the research process undertaken, alongside their relationships with those participating.

Aware of the ‘inequities of power between the observed and the observer’ (Reich 2021 p.578), I took care to ensure that shortly after each interview, I reviewed how my position as a lecturer may have impacted upon the responses from the interviewees. This was repeated sometime later, using the gap in time to make this now a more unfamiliar conversation, assessed as if from a distance (Berger 2015). This emotional intelligence being necessary, where such as a university lecturer seeks to ask their own students to participate (Collins and Cooper 2014).

Tracy (2010) notes a lack of structure generally found within qualitative research in comparison to quantitative methods. Yet, in offering a more general framework to assess the rigour of the research, suggests that in areas such as power dynamics, an overtly ethical approach should be sought in mitigating imbalances of power. This appearing specifically in such a manner that finds resonance with the participants.

Indeed, Olmos-Vega et al (2023) do much to draw these many considerations together, and especially around power dynamics vis-á-vis the position of the researcher. Like others, they recognise the inherent nature of power within such research, not withstanding *normal* conditions of the researcher being both the interpreter and arbiter of validity of data received. They suggest acknowledgement of the uniqueness of the participants’ knowledge and viewpoints alongside a mediation, if needed, of pre-existing relationships such as those of the lecturer and their student in this instance.

Their guidance in this context appeared in addition to these already noted approaches, ensuring opportunities for participants in later interviews, to give feedback on the researcher’s initial perceptions of earlier interviews more broadly. This allowing for a sense not just of participation, but also power within the relationship. Alongside an avoidance of the interviewee being formally or

summatively assessed (within their taught studies) by the reseacher, at the same time as participating within the study.

With just a few exceptions, all the interviews were conducted in the morning between 9am and 1pm. This was because of my own week-day work or childcare responsibilities limiting my availability. Many interview participants offered their time during rest days or before or after shifts. For clarification, as Covid-19 emerged after the first series of interviews and the second set were postponed until March 2021 as a result, the pandemic's impact was minimal in the timing, length or function of the interviews. It did however appear in the narrative of the interviews, as will be shown in 3.5.4 later.

3.5 Ethical Considerations

3.5.1 Informed Consent

Each potential interviewee was offered as much information about the aims of the research and the nature of the subject to be discussed as possible. This was limited to my initial research objectives, broader interests, and likely approach. I was unable to identify at the time, the then undecided methods of analysis which I intended to deploy (Weatherall et al 2002). Minor transgressions that are apparently not uncommon in much social sciences research (Bryman 2016).

However, a participant information sheet and consent form requiring signature using Cardiff University SOCSI templates, were presented to all (Braun and Clarke 2013, Denscombe 2003) (see again Appendices A1 an A2). Confirmation of the participants' consent being discussed at the outset of each interview and recorded

within the transcript, allowing time for questions, but also informing interviewees of my obligations to them as the researcher (Robson 2011).

3.5.2 Confidentiality and Anonymity

All participants were assured of the confidentiality of their responses, although I already felt fully aware that as a non-clinician, my interviewees were allowing me an initiation into the information they held. This required a delicate balance between betraying confidences and self-censure, alongside great care in its use (Wolff 2004).

I applied pseudonyms to the interviewees during their first interview's transcription. However, it was not until significantly later that I appreciated these subjects may have wished to choose their own (Braun and Clarke 2013), which was by then too late.

I had taken for granted that the interviewees sought anonymity, removing details of the individuals in both their transcripts and in the interviewee overview table that may have allowed for identification (Robson 2011). Further reading suggested that this becomes of greatest concern in areas where the participant may find practical or emotional difficulty in reconciling their words with the use of another's name, e.g. a discussion of the loss of a child (Grinyer 2009). I felt supported by Vainio's (2013) suggestion that the approach must be determined by the specifics of the research process, which in this case would be somewhat *less* emotive. Combining with Robson's (2011) guidance that it is the subjects who should be able to identify themselves. Those adjustments I made to assure their anonymity, would not adjust the outcomes from the data (Vainio 2013; Bryman 2016).

3.5.3 The ‘Insider Researcher’

Flick (2009 p.111) suggests that maintaining the perspective of the outsider should be considered in maintaining an ‘attitude of doubt’ over what is presented. This role of the *professional stranger*, as offered by Agar (1980), did present challenges for me as the researcher. As a lecturer on these students’ programme, I could not be considered unaware or a stranger. Yet neither would I become an ‘initiate’ (Flick 2009 p.111), as I was not a healthcare professional, as these interviewees were. I settled for ‘visitor’ status (Flick 2009 p.111), receiving knowledge through questioning, but not giving up my outsider’s perspective completely. Still aware that I may have multiple insider and outsider positions, that may vary with the context (Braun and Clarke 2013). In teaching, an *insider*. In clinical practice, a clear *outsider*. This intersectionality or existence of multiple identities can appear to complicate further the idea of the value-laden researcher (Paradies 2018). And yet acceptance of the educational researcher *rarely* arriving unencumbered is clear (Delamont and Atkinson 1995). Mercer (2007) suggests the dichotomy of insider or outsider be replaced with a continuum that is more suggestive of multiple dimensions. These offer the access, familiarity and benefits of rapport, but contrast with an intrusiveness and the potential for bias from both the researcher and equally importantly the informant. An understanding is therefore needed of the willingness of interviewees to share with a researcher that of which they may hold very personal perceptions.

My quest for knowledge, albeit contextual and coloured by own experience could be reduced to an outline of a perception, if my stated perspectives became too nuanced (Hekman 1997). Hekman (1997 p.359) helpfully suggests the adoption of Weber’s

‘ideal type’. In so far as I would make explicit the subjective perspective of being a white, middle aged, male with a social science rather than clinical background, and consciously highlighting this frame throughout the process.

3.5.4 The Impact of Covid on Data Collection

The pandemic’s appearance in March 2020 placed a strain on the healthcare professionals that were my interviewees. Many, I subsequently found, were placed on *surge rotas* that took them away from their usual roles and/or gave challenging workloads. My initial plan to conduct second interviews in late September 2020 was delayed by six months in recognition of the change in priorities. When returning to these students, whilst all had initially agreed to the delayed second phase, three of them were no longer responding to my emails by March 2021.

These seven interviewees had all completed the teaching programme, albeit the third and final part of their studies had used a mix of synchronous (via video tutorials) and asynchronous teaching, the university being closed to face-to-face teaching. By the conclusion of the third interviews in January 2023, the pandemic appeared to be subsiding, and these interviews showed less of the strain outlined in the prior phase.

3.6 Analysing the Data

3.6.1 Choice and Overview

The choice of a qualitative analytic method was initially influenced by my lack of clear direction on what was available to apply within the research. It appeared that the *clear rules* of quantitative analysis were not to be present here (Bryman 2012). An

initial investigation of grounded theory in its originally envisaged form from Glaser and Strauss (1965), suggested its ability to explain a social process such as mine (Charmaz 2008). However, this required my own suspension or awareness of theories or concepts that may be relevant (Bulmer 1979). I found at its heart 'the belief that knowledge may be increased by generating new theories rather than analysing data within an existing one' (Heath and Cowley 2004 p.142). I was confident in attempting to 'discover the key components or general principles underlying a particular phenomenon' (Denscombe 2003 p.119). Yet, I was reticent at this stage in my development, to *generate* theories grounded in my own data (Zaidi 2022).

By contrast, thematic analysis (TA) appeared to demand less of the inexperienced researcher. It was acceptable to both practitioners and policymakers, although concern was needed in ensuring details of the procedures undertaken were made both evident and explicit (Robson 2011). It was also suggested that in its later development in moving away from grounded theory origins, it had begun to find a structure that would support a research novice like me (Braun and Clarke 2014). Braun and Clarke's (2022) description of reflexive TA as *an adventure* was attractive, especially when underpinned by what they suggested to be the reflexive TA researcher's focus on meaning rather than cause, yet still retaining what they present as *the analytic orientation to data* which could allow me to code it using the lens of theory. The following sections are structured predominantly around Braun and Clarke's (2022 p.35) 'Six Phases of Reflexive Thematic Analysis'. These are not linear steps, but rather allow for a recursive approach, where new data may be

encountered, and earlier steps consequently revisited for new and differently informed investigation (Kiger and Varpio 2020).

3.6.2 Familiarising Myself with the Data

Braun and Clarke (2022) suggest becoming immersed in the data, yet with a critical distance. I had initially read and re-written my interview notes alongside reviewing transcripts after each of the three interview phases. I first looked at the dialogue as a life story, as one would a novel. I determined my telephone interviews had made the experience for the interviewee feel anonymising, and encouraging their greater disclosure to me (Trier-Bieniek 2012). In later interviews, these stories with which I had by now become familiar from an early stage, may as a result have unfolded more clearly in later conversations (Toma 2000). I had then taken that second more distant view and sought to look at the components of the dialogue in smaller parts, considering what the interviewee may think they are telling me, alongside how I might be interpreting it. Following Goldsmith (2021), I read and re-read transcripts, making notes and building tables of what may be coming out and in what directions (see Appendix A4 for one *well-thumbed* example of my notes in this process). Even at this early stage, trying to make this rich data from three years of interviews appear strange and distant (Gunderson 2020), as if I were coming new to their setting.

3.6.3 Coding

Taking guidance from Braun and Clark (2022), I began coding by reviewing all data items to check for connections to my research questions. I was completing this at a granular level, but also with an understanding that a reductionist approach may miss the nuances of semantic, descriptive, or conceptual data. In accordance with Tucket (2005), I continually sought to ask why the data appeared?. However, also noting that if only very limited repetition of my codes occurred, that I may have become too 'fine-grained' in this approach (Braun and Clarke 2022 p.69). The process was completed across all datasets, as part of one singular and systematic process (Clarke and Braun 2013). This also developed my connections with an underpinning framework, whilst identifying and labelling these codes. These emerged as 11 distinct themes initially. During this process, I found myself constantly and perhaps automatically looking for links between them (Denscombe 2003). Using codes as 'the building blocks for analysis' (Braun and Clarke 2022 p.69). I understood that the initial literature review would need to be revisited, as it had been just a beginning to support both my development and my understanding of the research questions (Tuckett 2005). Subsequently, I would later need to describe the assumptions which underpinned my analysis (Kiger and Varpio 2020). I was not selective, and a complete coding approach meant that with so many items of data within 23 interviews, spanning up to 75 minutes, the use of NVivo software felt appropriate. This allowed for the capture of coded items, but also the ability to review the context of each coded instance to search for the underlying content, as well as the explicit (Bryman 2016). I remained mindful that such computer-assisted mechanisms can, by their design, influence my ontological and epistemological approaches to the data. Yet I balanced this favourably, with the ability to cover large data sets with greater

efficiency (Braun and Clarke 2022) and presenting my data visually when connecting to underpinning concepts (Hilal and Alabri 2013), which appears within *Figures 1, 2 and 3* that follow.

Figure 1 most effectively presents the three tiers of themes which appear as the layers of construction, an analogy that Braun and Clarke (2022) suggest results from the *bricks and tiles* of my initial codes. As can be seen, the four highest-level themes vary in numbers of their of connections to the eleven lower-level themes, with *Perceptions of esteem informing decision-making process* showing relationships with the most (10 lower themes), although none of the higher-level themes demonstrate relationships with any less than seven of the lower-level themes that underpin them.

3.6.4 Generating Initial Themes

In seeking to create themes, I understood the difficulty of not working to simply *categorise* data at this early stage. Instead, I looked to offer more interpretation and so capture latent meanings, or which has been described as that which may lie beneath the data (Kiger and Varpio 2020; Braun and Clarke 2022). An example of this being where I considered what the interviewees appeared *not* to tell me, such as their inability to define *the teacher within healthcare* (see s 4.4, 5.3, 5.5). The analysing, combining, and comparing of these codes and their resulting themes lead to connections between them (Kiger and Varpio 2020) which informed all four of the highest-tier themes, rather than just a summary of their topics (Braun and Clarke 2022). In order to support this process, I wrote theme definitions, these presented both their focus and boundaries (Braun and Clarke 2013). This was ensuring my clarity on a central organising concept for each (Braun and Clarke 2022). I remained

mindful that my constructionist ontological viewpoint sought not to uncover a *hidden truth* within this process (Crotty 2015). Instead, I was mindful of Silverman's (2006) perspective that a theory without some observation upon which it is to be applied would be much like having a tractor but no field to work in. From these initial themes, my understanding of the *field* developed, and my subsequent integration of literature into its analysis (Braun and Clarke 2013), as it evolved into four key themes in addressing the three elements of the two research questions.

3.6.5 Reviewing Themes

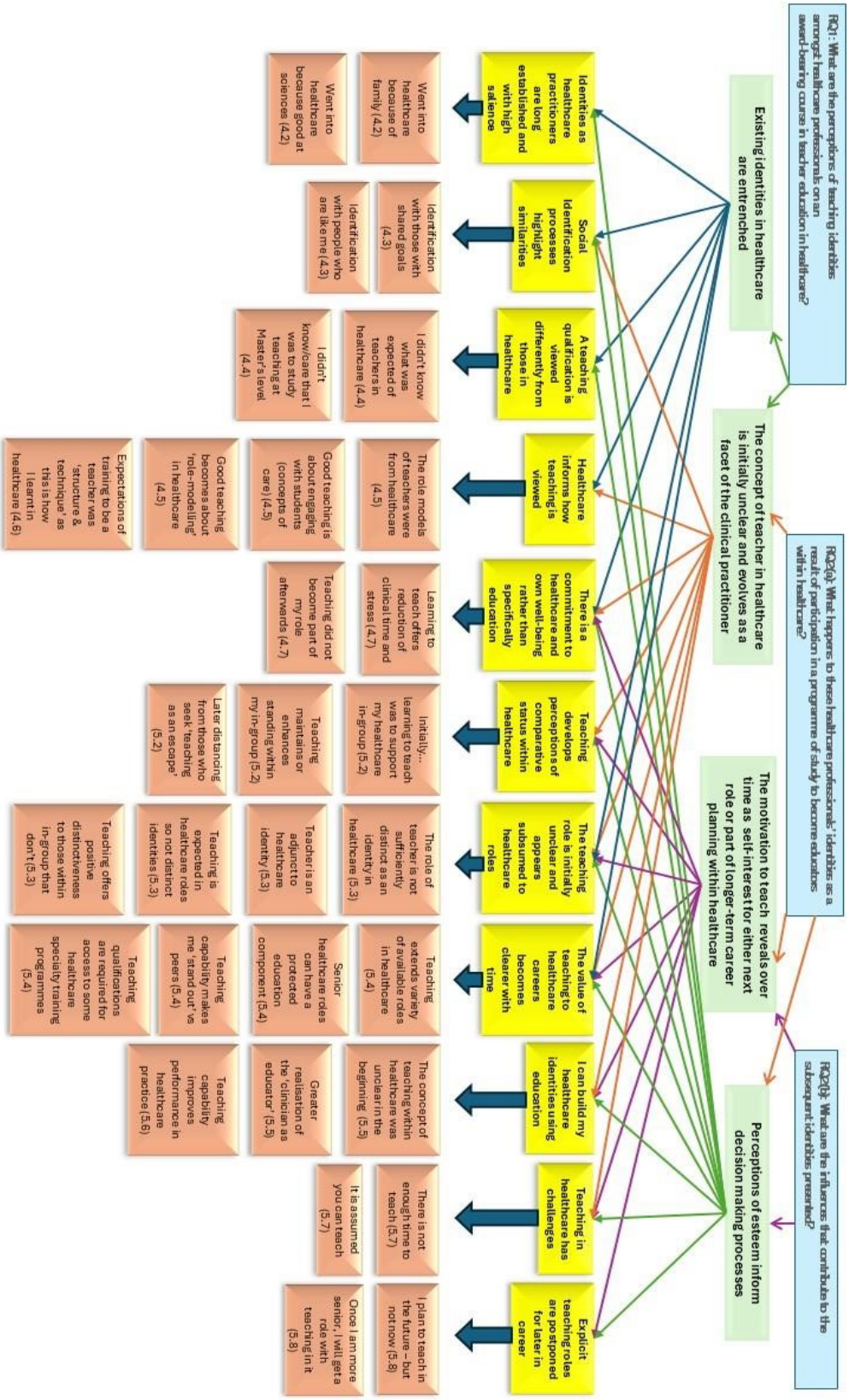
My higher-level review of each constituent code reflected on appropriateness and applicability to each theme (Kiger and Varpio 2020). Braun and Clarke (2022) suggesting that each initial theme could then be treated as a candidate for progression, justifying its position in addressing the research question. As such, I was required to ask: What are its boundaries? Does it hold sufficient evidence in terms of supporting data? Was the data sufficiently connected and not too diverse? Finally and perhaps most importantly, *did the theme convey something important*?

Whilst the above sought to use recurrence to justify themes, there would still be items of 'salience' undeveloped due to limited appearance, and thus by definition not appearing *thematic* (Buetow 2010). Examples of prevalence can be seen to appear in the higher frequency of data informing themes in; *healthcare informs how teaching is viewed*, that *teaching roles are initially unclear* for the interviewees, and that *the value of teaching to healthcare practice appears to unveil over time*, which will appear in the following *Figure 1* in 3.6.6.

3.6.6 Defining and Naming Themes

Having completed a thematic mapping exercise supported by the NVivo platform (Hilal and Alabri 2013) in the way that Robson (2011, p.476) describes as ‘creating thematic networks’. I sought final justification for my individual themes. Were their titles appropriately descriptive? Had new sub-themes emerged and were there unique insights to be found within them, ones that may connect to other themes (Kiger and Varpio 2020)? I focussed on the difficult task of ‘integration and interpretation’ in finding, summarising, and interpreting patterns within them (Robson 2011 p.476). I considered whether I would use my extracts as examples to support my ideas, or instead analyse the content itself, in seeking those latent ideas which I determined may be more supportive of my constructionist approach (Braun and Clarke 2013). See *Figure 1* for a visual representation of the final thematic network addressing both research questions.

Figure 1 - Demonstration of thematic network addressing both RQ1 and RQ2 combined



3.6.7 Producing the Report/Manuscript

As outlined earlier, the final stage from Braun and Clarke's (2022) model required the connections of the data to the literature and the research questions. I could then explicitly demonstrate these as in keeping with my research perspectives. I felt it was here that I must begin to draw some conclusions, ensuring my 'good story doesn't fizzle out' (Braun and Clarke 2022 p. 146). I needed to bring together the earlier stages and make clear not just a description of what had been found, but a justification of what it means and why this is important (Kiger and Carpio 2020).

3.6.8 Reflecting on the Methodology

In considering my own development in light of this chapter's construction, it was the re-reading that told the story. I found understanding of my constructionist viewpoint in a much greater sense, having followed my own justification using the tools of literature to explain myself (Crotty 2015, Braun and Clake 2022). It seemed strange that when applying my constructionist approach (Mann and Macleod 2015), this was with interviewees that seemed thoroughly grounded in the positivism of healthcare (Bunnis and Kelly 2010).

Finally, I found the uncovering of the latent to be challenging going beyond the re-telling of the manifest (Walliman 2011), whilst also understanding my own part in this process, which was in itself *part of the process* (Maseide 1990).

3.7 Conclusion

This chapter has presented the key components of my ontological and epistemological foundations that have underpinned the choice of research methods. It has then discussed the deliberation given to applying these methods, whilst also applying clear ethical procedures to protect those that generously volunteered to participate. The next chapter will predominantly explore the first research question whilst discussing how the data presented by the interviewees addresses it and considers this in parallel with existing literature.

Chapter Four - Developing, Identifying and Justifying Identities

4.1 Introduction

This chapter offers a discussion of RQ1: *what are the perceptions of teaching identities amongst healthcare professionals joining an award-bearing course in teacher education within healthcare?*

In considering the first of the two research questions, it is this chapter that predominantly offers the foundations or sources of the initial perspectives presented by these interviewees. They are what participants arrive with, as they commence the process of becoming *educators within healthcare.* In some respects, this chapter seeks to unearth that which has already occurred. It acts as a foundational support to several of my research's key assertions, in presenting that interviewees' *identities are deeply entrenched within healthcare*, that *the identities of teachers within healthcare are initially unclear to the interviewees* and begins the work, later concluded in Chapter 5, that *perceptions of esteem within healthcare inform decisions on roles in teaching* (these are also summarily presented graphically in *Figure 4* within Chapter 6). It is therefore a contrast to the subsequent chapter, which addresses both components of RQ2 by revealing where *changes* to identities are observed and considers the *influences* for them.

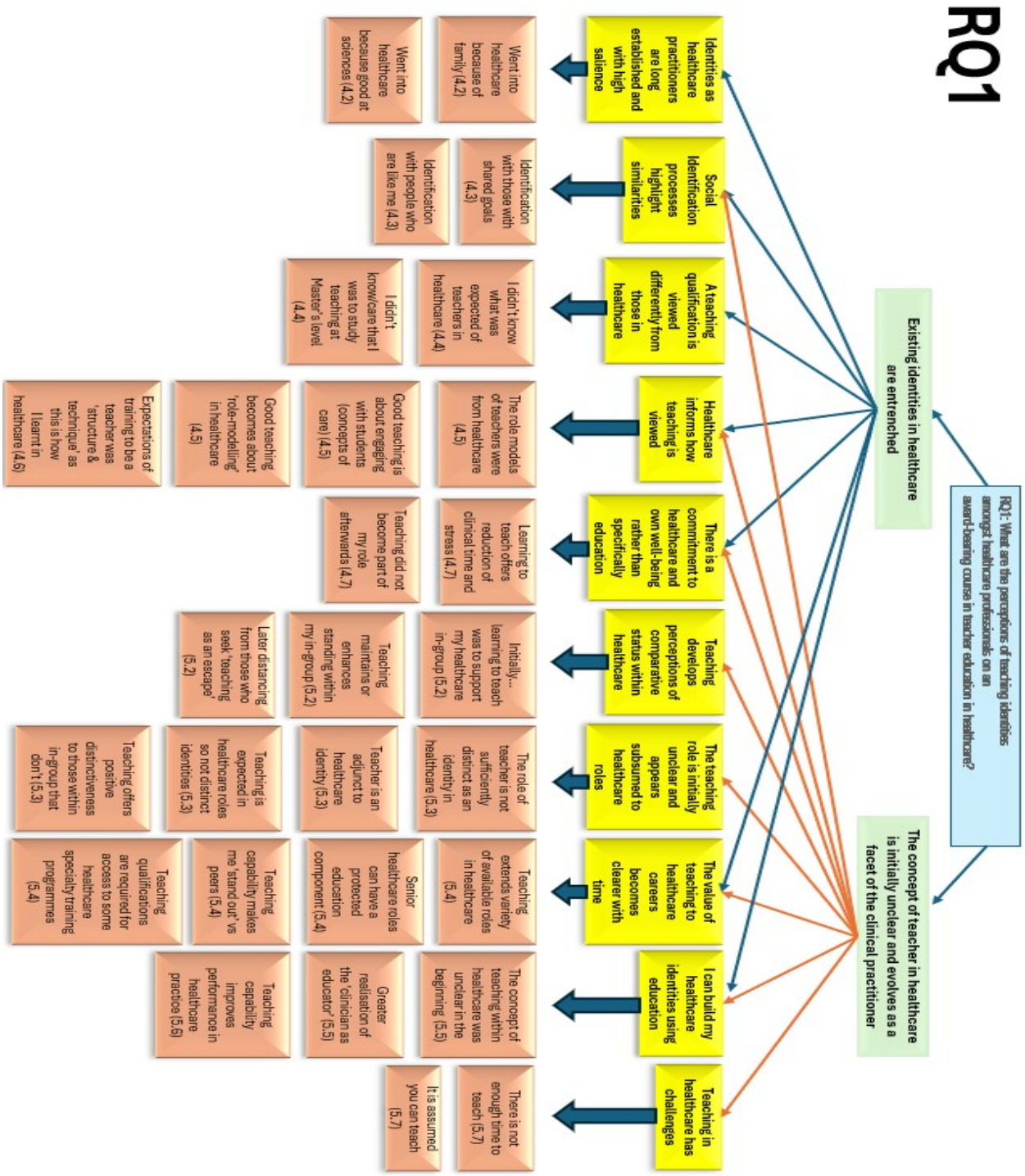
Section 4.2 begins in considering when these interviewees determined healthcare as their original choice of career and what were their contributing influences. Exploring the depth and formation of identities in healthcare is preparation for 4.3, which

discusses identities within which the participants present their alignment, as they join a programme to learn to become teachers within healthcare.

Section 4.4 first discusses how the participants perceived teachers *broadly* and teachers within healthcare *specifically,* investigating how perspectives of both these roles may have been informed. Section 4.5 unpacks interviewees' notions of *good* teachers and what makes *good teaching* in healthcare, explicitly considering the frames of reference through which these perspectives have emerged. This develops into the subsequent discussion of interviewees' expectations of what learning to become a teacher entails (4.6) and explicitly what informed these expectations. Before the chapter concludes, Section 4.7 explores the motivations espoused by participants in seeking to become teachers within healthcare, unpacking how these rationales develop over the three years of this study.

Figure 2 below demonstrates the thematic network of connections uncovered in addressing RQ1, as they will be presented within the following sections. It presents the structure that they build in supporting higher-level themes and finally in addressing the research questions themselves.

Figure 2 - The thematic network uncovered in addressing RQ1



4.2 The influences of Family and Capability

In seeking to understand how these interviewees arrive at a programme to become teachers within healthcare, this section considers what had brought them initially into healthcare and explores the depth of connection to these identities. It is specifically the contributing factors that may have been frequently present and seeking at what point they manifest. This whilst additionally connecting these influences' impact to notions of esteem that inform the stability of the existing identities, and the likelihood of their being adjusted.

The children of doctors are reported to be twenty-four times more likely to become doctors themselves than those whose parents were from other professions (Friedman and Laurison 2020). The influence of a family background within healthcare is apparent within many of the interviews. Five of the ten initial participants had parents or close relatives from within healthcare.

Amanda gives examples of the importance of a family background upon her decision to enter healthcare professions and the effect of this immersion over time:

> I know that ever since I can remember I've wanted to be a doctor, and I've had certain role models, aunts, uncles in the medical field, so as a child you aspire to be what you see. (Amanda, 21-30, medical doctor of 3 years, #1)

She elaborates further on the idea of visibility of choices in her second interview over 18 months later:

> I have family members who are doctors, so it's something I've always seen as a possibility because I feel like you can't really be what you can't see in action sometimes. (Amanda, 21-30, medical doctor of 3 years, #2)

Amanda's explanation of family connections making a career in healthcare not only visible, but removing uncertainty, was echoed by Peter, an experienced medical research doctor:

> When you come from a family of physicians, generally you're kind of familiar with what is on the table as a career. (Peter, 41-50, medical doctor of 25 years, #1)

This can appear as what Aaltonen (2016) describes as middle-class families *cultivating* children toward aspirational roles, perhaps equally presenting what Reay and Ball (1998 p.439) describe as 'a middle-class strategy for parents getting their own choice'. However, I present that this can be considered as these interviewees' opportunities or exposure to careers in healthcare also being a constraint, one that appears as a 'choice within pre-determined limits' (Reay and Ball 1998 p.439). These extracts above can be seen as an example of Hodkinson and Sparkes' Careership Model (Hodkinson and Sparkes 1997), in so far as it is such social structures that mediate the free choices available.

I find these choices toward healthcare reducing what Knifsend and Juvonen (2014, p.709) describe as the 'degrees of difference' between these interviewees and their respected family members. It becomes easier for interviewees like Amanda and Peter to develop a social categorisation for these groups, having *seen* their reference prototypes in family members (van Veelen et al 2016).

This was not unexpected. Where salience with a group is high, such as joining in-groups of their parents, individuals' behaviours can easily develop to what is seen as expected by the group (Sachdev and Bourhis 1991). The suggestion that SIT misses socio-cultural influences (Bettencourt et al 2001), seems inapplicable here. In pursuing social categorisation and identification cues, despite the absence of an

explicit interview question, it emerges that half of these interviewees are following in familial footsteps.

This builds support for my assertion that the social categorisation and identification processes being used by these interviewees in aligning to healthcare was longstanding. These having been influenced by pre-existing structures from their adolescence (Johnson et al 2012; Roberts 2000).

There is also my assertion that the academic abilities in the early teens of these interviewees, inform decisions to enter healthcare in almost all instances. Nine of the ten interviewees presented this as occurring prior or during their GCSE choices and seven noted specifically because they had an expectation of good grades in the sciences at school.

This was for some a simple process, one requiring only limited deliberation. A point that Peter, made clearly in his first interview:

> In the days that we were recruited into medicine we didn't have such questions coming up, it's just that I got excellent grades and... and you went into medicine. And if you had an empathy as a skill then that... you usually... it was a subconscious decision you make, it wasn't like mentioned. So subconsciously you think, I like to help sick people and you get good grades, enough to get into medical school…that was the way people entered medicine in those days. (Peter, 41-50, medical doctor of 25 years, #1)

Peter's experience appears similarly elsewhere, albeit by a later generation. For Hayley, a junior doctor, this route seemed somewhat similar, although occurring approximately two decades later:

> And because I was good at science and my school encouraged everyone who was good at science to apply for medicine. (Hayley, 21-30, medical doctor of 3 years, #1)

For some however, the observation of gender alongside capability emerged. As Odette, the experienced GP recalled, over 30 years after leaving school:

> I don't think in my school there was much career guidance, but if you were a *girl* [some emphasis here], and were good at science, there wasn't really that many other options presented to you, if I'm honest. (Odette, 41-50, GP of 25 years, #1)

I find akin to Martiny and Rubin (2019), that the consideration and acceptance by such as these interviewees in the social norms of their time cannot be removed from SIT research.

What can be seen here is the identification process described within these interviewees' narratives. The selection process such as these interviewees' choice of *appropriate* GCSEs had become the initiating factor within the formation of their identities in healthcare (Hafferty and Franks 1994). Importantly, in terms of an embedded nature, it is an identity which began some considerable time before any specific vocational study such as a medical school (Yakov et al 2021). As suggested by Jarvis-Selinger et al (2012), I also see this identity formation and group selection as interlinked processes. However, these interviewees offered no suggestion of the linear deconstruction and reconstruction of identities that Jarvis-Selinger et al (2012) further suggest occurs through a process of reassessment.

Underpinning this formation of identity and bonds to healthcare, appears a willingness to present their entry into the healthcare professions as a result of their noteworthy capabilities from an early age. This appears as a recollection of how they viewed themselves as a person at that time, feeding what Rubin and Hewstone (1998 p.5) describe as a global self-esteem or 'the esteem in which one holds one's overall self-image, whereas specific self-esteem refers to the esteem in which one

holds in particular'. This specificity manifesting here as membership of an identified healthcare group, albeit one which at that early career stage, these interviewees had not yet *formally* joined.

This section has sought to support my position that these interviewees grew into social identities in healthcare from their youth, with the expectations of their families and their educational abilities connecting them to notions of esteem. This enables positive self-concepts from identification with these social identities of healthcare to develop. These are self-concepts that later can become very difficult to dislodge.

In contrast to this section's presentation of the interviewees' longstanding affinities toward the healthcare professions being engendered by their families (in at least half of the instances), and appearing representative of capability with resulting esteem, the next section presents how interviewees described those particular social identities they felt resonated with them and the factors that contributed to their levels of salience.

4.3 Where Do I Belong and Why?

This section continues in addressing RQ1, by exploring the social identification (chosen in-groups) initially presented by the interviewees whilst considering their espoused influences. In unpacking their identification processes, this becomes an opportunity to determine what influences identities amongst these participants.

When asked what groups they felt themselves to be a part of, interviewees often leaned toward those within which they spent most time, and with whom they shared a common purpose. These interviewees offered choices often characterised by

shared goals, values or purposes such as patient welfare, efficient healthcare delivery, or collaborative practice. These tending to appear more as a set of shared principles.

For Amanda, a junior hospital doctor, it was a shared purpose of patient care that merged an otherwise diverse group of healthcare professionals into one within which she felt she belonged:

> …working on a ward or within a team I definitely feel a part of that team, whether it be other doctors or nurses, senior doctors, junior doctors or doctors junior to myself and in some specialties more so than others. (Amanda, 21-30, medical doctor of 3 years, #1)

The similar sense of shared goals appeared for Kevin, a junior doctor, amongst his fellow specialty trainees. By his second interview in April 2021, he had joined a closely-knit specialty training programme and the connection through collaboration was evident:

> ...but you very much feel part of your group. Your tribe. And you're all working towards the same aim and helping each other out with the practical aspects of it. (Kevin, 21-30, medical doctor of 2 years, #2)

This sense of *tribe* appeared implicitly within many of the narratives presented, but it is strikingly explicit and notably positive here. It is relevant to apply Braithwaite et al's (2016) consideration of Tajfel and Turner's (1979) in-group and out-group frames when explicitly defining *tribalism* in their healthcare context as *those with shared tendencies clustering together*. However, in contrast to Braithwaite et al's (2016) judgement of clinical tribalism as being overwhelmingly undesirable, Kevin's example demonstrates a positivity arising through in-group support in achieving shared/similar goals. Brewer (1999) can offer further support to this perspective, by

proposing that the presence of in-group affection does not necessitate an out-group antagonism.

For Amanda and Kevin, the foundations of their social categorisation of groups and consequent social identification when aligning to those most relevant or *salient*, appeared in the collaboration toward achieving a ward's or a specialty's unique purpose. However, for Odette, it was the shared and agreed values that she and her GP-partner colleagues applied along the way, that provided initial social identification and a consequent categorisation:

> So definitely my partners in my practice. There's five of us and we're quite a cohesive bunch together in terms of how we make decisions, what our values are. We've spent a lot of time defining our shared values and using those to inform how we make decisions about what's best for us and what's best for us individually, as a group and also for our patients and our staff. So, I would say that's probably a group of people I identify with. (Odette, 41-50, GP of 25 years, #1)

These examples offer support to Burford et al's (2012) contention, that healthcare specialties can find positive distinctiveness to others through choosing their own specific *markers for excellence* when comparing to other clinical practitioners e.g. GPs may choose to highlight the social value they offer to their communities, whilst surgeons may highlight their ability to perform complex procedures or high percentages of successful outcomes. This principle of selecting one's *own favourable points of difference* will be discussed later, specifically in considering how in-group membership rather than inter-group rivalry may also be the subject of *positioning* amongst these participants.

SIT considers that identification can be plural, where *identity packages* are formed by holding *groups* of memberships (Deaux 1993). This also connects to the notion of *salience* in attributing greater or lesser relevance to these interviewees'

identifications dependant on context (Fearon 1999). This becomes evident with Heidi, a junior doctor, locating her place within a community that held very similar roles and were within a single clinical environment. Whilst identifying with them, she still considered herself to be on the periphery, as she lacked some of that group's shared history:

> I feel like I've been on the fringes for a couple of years because I've done… I worked abroad for a while… And then when I came back, I was on the outside because everyone else had been an F1 in a hospital and knew each other and I didn't. This year I'd say I was on the edges of the <specialty removed> community. (Heidi, 21-30, medical doctor of 2 years, #1)

Heidi's situation might also be explained by theories of *Communities of Practice* (Wenger 1998), showing not only that the shared interest of the chosen in-group team binds it, but also by focussing on depth of engagement with her informally created group she is establishing her position and relative value within it (Li et al 2009).

A *superordination* of identification, or specifically where otherwise disparate groups align toward a singular common goal, appeared notably within Odette's responses. Here, within this experienced GP's second interview, whilst initially identifying herself within a broader group of student teachers in healthcare, the processes of both positive distinctiveness and in-group favouritism, alongside relative salience for those whom she perceived as similar to her own seniority, emerged. A perception of her own greater vocational experience made her feel outside of the main student group at times (Gecas and Burke 1995), but this was also frustrating her identification with them through finding *reduced* similarity (Brewer 1991) and her observations of notable differences (Jenkins 2000):

> I was surprised literally every single one was a doctor and I would say there were three of us maybe who were not really, really *junior* doctors, who were [not] doing educational teaching fellowship type thing at the university where they were teaching medical students…I felt, a little bit on the periphery of that. There was another girl was doing psychiatry who was almost at the end of her training, almost a consultant, and she had been a mature student so we kind of found each other. (Odette, 41-50, GP of 25 years, #2. Participant's emphasis)

The plurality of social categorisations available to the interviewees and their consequent identification through comparative salience (Roccas and Brewer 2002; Tajfel 1974), was evident with Esther, a senior veterinary specialist's explanation of her identification going beyond collaboration, purpose or seniority and social meaning (Deaux 1993) and simply aligning with *working mums*:

> …I enjoyed like the camaraderie that we had between some of the groups…the people that I particularly linked with were in a… in a similar situation to me. So, full, or nearly full-time working mothers. (Esther, 31-40, Senior Vet of 16 years, #2)

Similarly for Dennis, a junior doctor originally from outside of the UK and having completed his initial medical training in an overseas medical school, there appeared a balance of his identification within his own clinical specialty alongside that of an overseas specialty entrant:

> I've been involved in the past in recruitment of foreign doctors, and I understand the challenges they face when they come to the UK, because obviously the trainees…understand how the system works better... So I definitely identify as a foreign… foreign graduate for work… yeah, work training with… yeah, or foreign people who become foreign professional graduate medical graduates. (Dennis, 21-30, medical doctor of 3.5 years, #2)

Here SIT can accept the perspective that Dennis seeks *belonging* and *shared purpose* from his specialty group (Tajfel and Turner 1979; Brown 2000), yet it is also supportive of a self-concept where connection is to groups with similar

characteristics (van den Broek et al 2020). It is apparent that the application of identification in this context sits as a *cross-categorisation* (Reimer et al 2020), one which sees the demonstration of in-group attitudes toward both the UK-based clinical specialists and the non-UK specialty candidates. Something, that as Dennis explains later, would still create an in-group bias toward those UK colleagues because of his hierarchical/status-driven desire for their acceptance.

I find Roccas and Brewer's (2002 p.90) 'dominance model' is helpful here, in understanding where a single primary group identification, such as *clinician*, subordinates all other nuanced identities like those offered by Odette, Esther and Dennis above. These becoming aspects of the self within the primary group, essentially one taking precedence and absorbing all of the others.

I present the above examples as connecting with RQ1. They show these interviewees' social categorisation of groups and their resulting identifications using specific decisions around purpose, values and personal characteristics, with each in some form enhancing their self-esteem (Brown 2000). However, I also begin to address RQ2 in exploring their influences, demonstrating social identity complexity in my highlighting of salient, yet competing social identities (Turner and Reynolds 2012; Turner and Oakes 1986). I offer these as the interviewees presenting considered identities to the world (Goffman 1959), ones which have been explicitly chosen (Brewer 1991). This cross-categorisation balances in-group biases (Tajfel 1974), whilst providing guidance for their behaviours in the differing contexts within which they may inhabit (Hogg 2007). It is here that I show these interviewees' identification processes can be *considered and not instinctive*. They are also therefore able to be *conditional.*

There has been longstanding acknowledgement of the roles of others in the formation of identities (Erikson 1959; Goffman 1959; Mead 1967). However, SIT explicitly presents an individual's self-concept as deriving from their membership in social groups (Roccas and Brewer 2002; Tajfel 1978). In the healthcare settings of these interviewees, this translates to practitioners perceiving themselves not only through their clinical specialty but also as part of a broader group, such as a patient care team (Bucher and Strauss 1961; Kline et al 2020). These healthcare practitioners can identify with multi-professional teams, aligning with an in-group formed through *shared purpose* (Van den Broek et al 2020). As already noted, SIT also allows for the concept of the *superordinate* (Turner and Reynolds 2012; Turner and Oakes 1986). Through this, healthcare professionals can identify with a larger group (e.g. a collective of health care professionals) rather than just a specific specialty role by using broader and more general points of comparison (Stryker and Burke 2000; Van den Broek et al 2020).

In the above, I build upon the identification processes discussed within the prior paragraph, demonstrating that these conditions for in-group identification judgements can be both highly subjective and reflective of very personal esteem-building concepts.

In addressing RQ1, this section supports my exploration of the identities presented by the interviewees and reveals how they centre on those in-groups which are most relevant (salient) to them. However, there also appears here examples of how broad such chosen identities can be within healthcare contexts. Identities of the healthcare professional within which the notion of the educator may be caught. It also presents the identification process of the interviewees as one of deliberation rather than instinct. These participants choosing characteristics by which to measure and align

membership, with notions of self-esteem often appearing at the surface. Later sections will build upon my presentation here of *broad* social identities being *explicitly* chosen and determined using often *esteem-related* determinants alongside an examination of personal relevance to the interviewee.

The next section considers the interviewees' engagement with their profession's expectations of teachers and investigates how this reflects in their approaches in comparing teaching to healthcare practitioner roles.

4.4 Expectations of Teaching Within Healthcare

From the first interviews, there appeared a lack of awareness for the teaching standards required within these interviewees' own professions. From the nine healthcare professional interviewees regulated by the General Medical Council (GMC) and one regulated by the Royal College of Veterinary Surgeons (RCVS), none were able to identify specific requirements for those that teach within their profession[5] during their first interview, as they began the process to become teachers.

It was Andrea, a junior doctor at the time of her first interview, who appeared most able to elaborate on what may be expected:

> I don't know in a lot of detail but I know teaching is recommended, part of the GMC duties of the doctor, so education of doctors junior to yourself and medical students is thought to be part of your career that you can't avoid, for example, if you wanted to. It's part of being a doctor. (Andrea, 21-30, medical doctor of 2 years, #1)

[5] See GMC (2023) and RCVS (2023) for examples of professional body expectations of teachers within medical and veterinary professions.

However, within other interviewees' first interviews, the detail of published expectations of teaching for their profession appeared elusive. In terms of whether they existed:

'No, I'm not aware of any formal guidance' (Heidi, 21-30, medical doctor of 2 years, #1).

'Probably did once. I can't say I've refreshed my mind recently' (Florence, 31-40, medical doctor of 7 years #1).

Or what they *may* be:

'I know they have targets…I couldn't quote you' (Kevin, 21-30, medical doctor of 2 years, #1).

This apparent disinterest in the responsibilities of a teacher within healthcare, notably from extensively regulated professions appears surprising. Especially when three years after beginning their teacher training programme, the expectations of these interviewees' own healthcare professions for teachers remained unclear. Kevin and Esther's openness on their lack of understanding appeared representative of the group:

> I think it does appear in something like Good Medical Practice, the GMC say doctors ought to be teachers but I can't confess I've got…enough to know what they actually say about it. (Kevin, 21-30, medical doctor of 2 years, #3)

> 'No. No, no, no. I've no idea what the professional body actually wants us to do.' (Esther, 31-40, Senior Vet of 16 years, #3).

This may however be reflective of healthcare educators more broadly. Over 40% of a surveyed range of practicing healthcare educators (who identified as part of a

regulatory body), had not been appraised against that body's applicable standards (Browne et al 2021).

However, such often emphatic denials of the understanding of any professional teaching regulation or recommendation draws back to the previously noted *salience* and specifically what was important to these interviewees (Tajfel 1978; Tajfel and Turner 1979; Brown 2020). This aligns to the suggestion that more generally, those who most strongly identify as teachers, invest most. Both Trautwein (2018) and Beauchamp and Thomas (2009) highlight the importance of social context and interaction on identity development. Yet my research appears in contrast to Trautwein (2018) in that these new teachers are not demonstrating their expected concerns of *omniscience* and *responsibility for every student* as part of their journey. Further, I find that there appear no suggestion of the explicit examples of the discussions and dialogue that new teachers have in forming their identities over time, such as those proposed by Beauchamp and Thomas (2009).

What I do however find is disquiet in teaching being seen as *subordinate* to clinical practice (see van Lankveld et al (2021) and Browne et al (2011) exploring this). Interestingly, these two publications also diverge. van Lankveld et al (2021) propose remediation in enhanced reward systems or mentorship programmes for teachers within healthcare. However, this appears to offer little relevance in strengthening teacher identities within healthcare, certainly not in the contexts raised by this research. By contrast, Browne et al's (2011) recommendations of clear and verifiable standards for HPE curricula alongside developing widely published expectations of competence for teachers within this setting are apposite here. Their proposal addresses these interviewees' need for clarity in what *was* or *was not* involved in teaching and better informing their development of social categorisation and social

identification processes (Randolph-Seng et al 2012). As a PGCE-qualified teacher myself, it is notable that teachers studying for a PGCE have broad certainty of what teacher training offers in advance of attending[6]. This does not appear within healthcare.

This section has so far presented the interviewees as comparatively disinterested or unaware of the explicit obligations for a teaching role within healthcare. Whilst this makes the social identification process in this context more complex for them (Brewer 1991), in addressing RQ1 it supports my premise that the interviewees referred to above, did not expect significant differences in their obligations beyond those they already held as clinical practitioners, as a result of becoming teachers within healthcare.

The lack of comparisons between teaching and healthcare appears further evident, when questions in the first round of interviews addressed the level of the qualification the interviewees were about to study. They were surprised that their study in teaching would be master's level (L7), yet their own original healthcare profession's qualification to practice was often lower, at Level 6. I present this as their implied judgement on the lower status and value of teaching and its qualifications.

Within the ten initial interviewees, one had a PhD, one had a master's degree and two had qualifications from their own healthcare specialty's Royal College, but the holders of these were unclear if they were at an equivalence to the master's-level qualification of the teaching programme they were about to commence. The remaining interviewees all identified as having their highest qualification at Level 6.

[6] A clear and explicit example of teacher training expectations for the generic PGCE can be found on https://getintoteaching.education.gov.uk/train-to-be-a-teacher/initial-teacher-training.

The viewpoints of several interviewees toward qualifications that did not have a clinical focus was epitomised by Esther. She viewed her research PhD (Level 8) as below her diploma (Level 7) in clinical practice:

> Dependant. So, from my clinical point of view, it's my Diploma in internal medicine, but from a kind of, strictly University Academic point of view, it's the PhD. (Esther, 31-40, Senior Vet of 16 years, #1)

To some this comparison was unimportant, especially in terms of the level represented, beyond that it just had to be completed. Odette noting this dilemma in her third interview:

> … when you're teaching a medical thing. You know, obviously teaching, in general, is paid less, but within our profession, you're expected to be more qualified to be teaching, but then to do the teaching, you take a pay cut. (Odette, 41-50, GP of 25 years, #3)

Odette sees here that teaching is a demonstration of enhanced capability, albeit it is punished by the lower rewards which appear commensurate with the lower esteem with which clinical practitioners may hold it. For others, this was viewed similarly, but from a more basic perspective. Andrea suggested that the qualification was a helpful *tick in the box* within healthcare, during her third interview:

> I think it's a matter of some people were just doing it, for example, as a tick-box exercise for a surgical career because it is… it's heavily weighted in the points for a surgical career, I think people would have been more reluctant to tell you that before they got the qualification… (Andrea, 21-30, medical doctor of 2 years, #3)

As Odette notes earlier, the completion of the teaching programme would have been unlikely to offer enhanced salaries to any of the interviewees. I show here that what supports these interviewees' limited enquiry into a non-clinical qualification, is the common perception of educators within healthcare as 'the poor relations compared

with scientists and clinicians' (Sabel and Archer 2014 p.1474). This is aligned with a tendency for those in healthcare to cluster amongst professional *tribes* to bolster their esteem concepts (Braithwaite et al 2016).

This section highlights the lower regard for a qualification in teaching held by these interviewees, when compared to one from *explicitly* healthcare (Browne et al 2018; Bartle and Thistlethwaite 2014; Sabel and Archer 2014). Notably, each of these three works suggest the importance of developed social networks amongst new educators in addressing this to find value and embed identities as teachers within healthcare. This does not appear within the context of any of my interviews, suggesting it has either not been considered or it has not been considered *important enough* by the interviewees. The section does however offer interviewees' perceptions of identities in addressing RQ1, it feeds into the thematic consideration of RQ1 (see *Figure 2*), in both demonstrating the entrenched nature of identities within healthcare, but also the subsummation of such as teaching to appear as a *facet* of the clinical practitioner. The section also begins to consider RQ2's *What happens to healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare?* It presents the constraints for interviewees by their unwavering single point of focus to their healthcare origins (Bochatay et al 2022).

The application of these interviewees' espoused perspectives fails to find the complexity that Bochatay et al (2022) suggest emerges within healthcare identities from the common intersections between race, gender, profession and often other facets. It instead presents teaching as only a supplement for the interviewees' healthcare foundation or as a sub-set of an identifying healthcare group, using solely cognitive perspectives or 'cold cognition' rather than the emotional and behavioural

commitments that Ellemers and Haslam (2012 p.90) suggest is often associated with group identities.

The next section considers what perceptions of teachers and teaching these interviewees were initially applying, and how this consequently directed their social identification in aligning to *who they are like*.

4.5 Good Teacher as Role Model

Each interviewee was asked to consider who their teaching role-models were during the first interview. Apart from Esther, who recalled a demanding but personally supportive Chemistry teacher, all the remaining nine examples offered were from medical schools or healthcare workplaces.

Florence recalled a senior peer who had helpfully unpacked the clinical experiences she encountered as a clinical trainee, within parts of their shifts together:

> my clinical practice is much influenced by a registrar…when I was a second-year doctor, and the way he taught me as a very junior doctor on night shifts and on calls and stuff and took his time to actually be an educator in our clinical work. (Florence, 31-40, medical doctor of 7 years, #1)

Andrea similarly noted both the practical aspect of teaching in healthcare, but also the connection to becoming what was seen:

> I think the role-modelling aspect of it is something you can only really see in someone who you aspire to be like or is doing the job you want to do and obviously at school I didn't have that. (Andrea, 21-30, medical doctor of 2 years, #1)

Similarly, the connection to salience in what *influences* social identification are made explicitly by Amanda:

> I don't really think about my primary school years very much just because the setting isn't the same, and it's very much more paternalistic and the dynamic between teacher and learner, I suppose is what I'm trying to say, it's much more different here. (Amanda, 21-30, medical doctor of 3 years, #1)

The focus on recalling teachers of note above, became overwhelmingly linked to these interviewees' vocational training due to the prevalence in this setting of the prominence of group membership linked to both emotional associations with the group and in-group ties (van den Broek 2020). These identities also emerged through a process of *sense-making* in their clinical experiences (Arroyave et al 2019; Dornan et al 2020). We see in these instances a salience or explicit relevance, with interviewees choosing to prioritise the clinical setting in finding their own path to identifying good teachers. This represents an embrace of both the social context in identification alongside a recognition of the intentional impact of faculty members, which Mount et al (2022) offer as *purposive* role-modelling.

After identifying teaching role models, the interviewees were then asked *what makes a good teacher?* instead of *who was a good teacher*? These answers developed frequently around personal engagement with students, most expressing the importance of building rapport with students through communication and empathy.

As we see from Florence's first interview, what had worked most effectively in her own teaching practice, was what informed her positive view around ensuring engagement with students:

> …how you've taught yourself and groups and actually what's worked for you…I've certainly had very nervous inexperienced F1s, F2s and I think they've always done better if it's just one on one, on a night shift and stuff like that, and sat down and let's talk about what we've seen and stuff but I think they get on much better if you have been approachable and supportive with them and been enthusiastic and that was a really interesting case, let's sit down and talk about that. (Florence, 31-40, medical doctor of 7 years, #1)

Like Florence, Odette similarly noted that she considered *good teaching* to be what works for her personally and this comprised engagement:

> I would prefer to be taught by and I prefer to be a teacher who's a facilitator…So someone who can, kind of, tune in to what needs to be facilitated, to what direction and how far a student needs, you know, to be taught or to be facilitated so that they can then make that next step themselves rather than just showing somebody how to do it. (Odette, 41-50, GP of 25 years, #1)

Like Florence and Odette, Hayley's first interview offered that good teaching was recognising the students need to connect with teachers on a more personal level:

> Well number one, it's a human being and within that you have to have an element of communication and engagement with your people, with your students… And I think it has to go both ways. You have to engage with them and they have to engage with you. And then once you've got that, you know, human connection, then you use that for the flow of information and to communicate whatever it is that you're trying to communicate. (Hayley, 21-30, medical doctor of 3 years, #1)

We see the above interviewees overlaying onto *good teachers* what they consider effective practice from their own experiences, This appeared to develop further during first interviews, as I uncovered the importance to these interviewees of role-modelling in perpetuating or passing forward the support they had received when students (Steinert and Macdonald 2015). Both the interviewees and I specifically noted that this was also being deployed as the tool of an educator.

For Esther, the act of role-modelling was an effective educational approach that also offered a personally satisfying experience as moments of learning emerge:

> I do identify more with the clinical people than necessarily more of the people who are purely educational. I'd like to do both. I want to…I like teaching the students the skills that they will potentially use for the rest of their careers. It's

> a very, very satisfying feeling watching the penny drop, it really is. (Esther, 31-40, Senior Vet of 16 years, #1)

Similarly, Andrea focused on the importance of being a role-model, yet unlike Esther, she saw this as placing a heavy burden upon her, one that required carrying the responsibility for future generations of practitioners:

> I think they're all the things that makes someone a good teacher and I think role modelling as well is really important, probably the most difficult in medicine for me actually, being a role model so trying to demonstrate that you are the kind of doctor that the student would like to be in the future. (Andrea, 21-30, medical doctor of 2 years, #1)

This application of role-modelling and teaching through practice was presented also as an intentional practice in healthcare by Odette. Yet this, she offered, was due to its institutionally embedded nature within healthcare environments:

> So, kind of this feeling within the practice that, you know, like that it takes a village to bring up a child, it's very much that sort of ethos of training within that practice, you know. The trainees are [nominally] attached to their trainer but actually the whole practice trains them. And we all train each other, so we're always learning. (Odette, 41-50, GP of 25 years, #1)

In contrast to it being a deliberative educational tool, a rewarding practice or a professional responsibility (or even burden), it was Heidi that suggested role-modelling as simply being instinctive for some in her profession, appearing as neither overt nor explicit:

> …made me develop as an individual and as a doctor and have made big differences at crucial times and they probably didn't realise they were doing it. One of them was a SHO [Senior House Officer], who just let me, essentially, shadow him, but just inspired…I probably couldn't tell you much knowledge that they taught me, but the skills and attitude served me well. (Heidi, 21-30, medical doctor of 2 years, #1)

This section began with the interviewees' examples of good teachers coming overwhelmingly from healthcare contexts. The interviewees' perspectives of explicitly *what good teaching is* allows comparisons to the previous section's disinterest in the *formality* of teaching. The now evident focus on teachers' engagement, communication and role-modelling aligns to healthcare practitioners' expectations of patient care through communication, personal motivation and goodwill (Hudelson et al 2008). Equally, it applies to those concepts of patient well-being, offering empowerment, compassion and an appreciation of complex needs that many entrants to medicine particularly, find as their components of *the good doctor* (Coventry et al 2022). The interviewees here highlight a bias toward what Steinert (2015 p.777) describe as *clinicians that practice as educators*, in their finding of those that describe themselves as 'physician-teachers', appearing in the context of presenting the inseparable nature of teaching to clinical practice. However, Steinert (2017) also found that many had an interest in teaching that pre-dated their entry into healthcare (e.g. sports coaches, tutors or camp counsellors), and additionally that a motivation for becoming teachers in healthcare was as its stimulus for personal learning and renewal – the presentation of *keeping current* and avoiding professional obsolescence. My research here appears divergent, as none of these interviewees identified interests in teaching *prior* to entering healthcare or indeed during their vocational training. However, the presentation of opportunities to remain current as motivation may have been manifest had a greater percentage of the interviewed cohort been more established within their careers.

There appears little distance from *patient-centred* healthcare perspectives (Bucher and Strauss 1961; Kline et al 2020) in determining clinical role-models and good educational practice. This appears supportive of Shapiro et al (2009 p.193) in their

presentation of a ‘trustworthiness critique’, where medical education fosters a reliance on *insiders* or explicitly the in-group of physician instructors, resulting in students’ mistrust of the nonphysician humanities instructors. Critically, I must reject Shapiro et al’s (2009) assertion that non-physician instructors should primarily be used to support physician instructors in their teaching of the humanities. In addressing RQ1, these interviewees’ perceptions of identities in teaching and explicitly expectations of the *who* and the *how* of good teaching do appear collectively embedded in their origins as healthcare practitioners. However, their commentary on their own taught processes in learning to become teachers, appears unconcerned as to the origins of those by whom this is delivered.

The next section draws upon the initial expectations of the interviewees in what learning to become a teacher would entail. Continuing to address RQ1, it considers what may have informed these perspectives and in considering both components of RQ2, looks at how these move over time whilst exploring the interviewees’ justifications for this.

4.6 Expectations of Learning to Teach

When asked during their first interview what they expected their teaching within the programme of study would entail, most explained that it would be likely to include *structure and process* as the key components. However, when addressing the same question in their second interviews, answers became less functional and more emotionally-centred, offering a much greater focus upon the learner.

Of the 10 initial interviewees, seven explicitly noted their expectation of a focus on theory, with another one implying (but not as explicitly), that this would be fundamental to the process. Of those that mentioned expectations around technique, there were eight that explicitly mentioned it. For those that mentioned structure of teaching, there were five.

Andrea's initial expectation of theory was something she recalled clearly in her second interview, and something she felt did occur. Yet the inclusion of practice over such a short period, did not seem to meet her expectations on technique. This she offered, may have been due to a lack of immersion:

> I think I probably thought I was going to get good theoretical basis in learning, which I think I did actually get. I think I was probably… I thought I was going to get something that was more practically useful for my teaching and I think there was less of that than I expected but I suspect that's probably in part because I only did the PG Cert rather than the full Master's. (Andrea, 21-30, medical doctor of 2 years, #2)

In Heidi's second interview, she similarly recalled her prior expectations of theoretical focus, but in contrast to Andrea, appreciated the practical inclusion of teaching practice and found these developed an affinity with those who were like-minded toward teaching within healthcare:

> I think I probably expected some teaching days, learning some education theory, and then learning what it is in practice, and then some assignments to kind of crystalise the theory that we learned…I think the thing that I probably most enjoyed, but maybe I didn't know was going to be a part of it, I can't remember, were the practical sessions, the micro teaches, and analysing each other. Yeah, those experiences of teaching to a group of teachers, and a group of people who are interested and motivated about teaching. (Heidi, 21-30, medical doctor of 2 years, #2)

In her second interview, Esther also recalled the positive experience of collaborating with others that teach:

> So, yeah, I think the… you know? The practical side of things were… were… were good, and I enjoyed like the camaraderie that we had between some of the groups. (Esther, 31-40, Senior Vet of 16 years, #2)

On the third and final set of interviews, I explained to the interviewees that many of their first interviews focussed on expectations of structuring and technique, whilst the second set had moved toward discussing softer skills and more *interpersonal* teaching approaches. Whilst the recollection of expecting theory and technique remained evident, as Odette explained, its application nearly three years later, could now be made much more affective and so support the learner experience:

> …it's also about… yeah, so creating that kind of safe space that they [her students] can expose their vulnerabilities and ask the questions without feeling mocked or… or also any shame, so… and… and giving them a space where they can test out their reason, ideas and… and then, hopefully, then find their own answers… So, at the beginning… it's a bit like learning to drive. At the beginning, it's all kind of like mirror-signal then you… then you use that structure to kind of support you. And now, although that structure is still there, I'm doing it much more unconsciously, I think. (Odette, 41-50, GP of 25 years, #3)

Kevin, in his final interview offered an explanation as to why healthcare professionals appeared wedded to the ideas of theory and structure, despite the teaching experiences of an intervening three years:

> People you are teaching [referring to his fellow teaching in healthcare students] are all fairly sort of… hard evidence and facts and like to know things and like to have knowledge and going through that sort of functional stuff. (Kevin, 21-30, medical doctor of 2 years, #3)

Similarly, Amanda in her third interview suggested a reason that the theory would remain, but also why the emotional focus became larger in later interviews:

> …having the base structure of what it means to be a good teacher, you know how to deliver information, and ways in which to teach, means that those aren't things that you're necessarily using the full brain to think about, you

> know, and so you can devote more time and attention to making sure that there's that culture of psychological safety, but at the same time, I think, being on the receiving end sometimes of hostility and incivility, you are more aware of it in the work environment. (Amanda, 21-30, medical doctor of 3 years, #3)

Esther's third interview offers further connection to both Odette and Amanda's perspective of teaching structures as facilitating a reduction in the cognitive burden of teaching practice. She also presents a similar viewto Kevin, in offering that the embedded behaviours of clinical practitioners are present in seeking theory to support action:

> most of us medics want to be quite clear… certain and clear that what we're… what we're saying is right, so to a degree, that initial, very clinical approach to it is kind of how we work and how we function, because it's like a list of something that we would have read that we kind of know and understand as like the dogma set of it as to what makes a good teacher… [theory makes teaching] not effortless, but it requires less effort to do and feels more comfortable in doing so, and therefore, yeah, it becomes more sustainable as a thing. (Esther, 31-40, Senior Vet of 16 years, #3)

These initial expectations of structure and technique were grounded in what had been expected of these healthcare professionals, delivering a service through pre-determined routines (Fish and Coles 2000), one requiring a 'detached concern' (Madill and Latchford 2005 p.1645), albeit avoiding excessive detachment (Wald et al 2015). However, in developing their initial clinical identities, these interviewees' initial vocational healthcare training encouraged what Wald et al (2015) describe as a combination of reflection, relationships, resilience, experiential learning and feedback. These, alongside the ability to share personal narratives and challenges, appear predominantly missing from the recollections of these interviewees in their descriptions of becoming teachers within healthcare.

It is therefore unsurprising that these interviewees demonstrated both the maintenance of an existing self-concept positivity (Brown 2000) and a continuation of *what may be expected* of healthcare professionals within their broader social identification (Brewer 1991; Jenkins 2004). These professional caregivers, revert to a focus upon the subjects of their work (being previously patients), although unlike that presented by Schrewe et al (2017), this appears not to consider them as purposive clinical commodities from which to learn, instead here is a desire to engage and support. It is Creuss et al (2015) who helpfully suggest that identities in healthcare practice do form through focus upon patients, by viewing the patient role positively as a very central *stakeholder* to ensure the public's trust within their profession. The importance of such social interactions is similarly noted by Jarvis-Selinger et al (2012 p.1186) as intrinsic to the development of identities within healthcare, but they suggest the expectation of 'crisis moments' in experiences (similarly to Wald et al 2015), will be factors to solidify them. Crisis moments appear markedly absent from the recollections of these interviewees. So, these behaviours toward the student whilst informed by healthcare are not the same. Indeed, they appear unwittingly to the interviewees. It is Hafferty and Castellani (2009 p.15) that demonstrate learned behaviours of healthcare practitioners in forming their identities do occur unknowingly, being driven by the presence of an 'innocuous, innocent and invisible' hidden curriculum within which they learn in healthcare.

In this research, the process of identification to become teachers, whilst still including the central figure of the student as a replacement for the patient, appears to lack the moments of social engagements or even crises from which identities emerge. The social world of the teacher, for these interviewees at least, does not appear.

The overlay of these health professionals' origins appears repeatedly and yet mostly without explicit comparisons to clinical practice. Additionally, the suggested status differentials between teaching and healthcare that Sabel and Archer (2014) present in large part as teaching being seen by clinicians as a *fallback* for less skilled practitioners, is missing. There also appears little within this research to support the premise of the juggling of identities between teaching and healthcare that Sethi et al (2017) suggest, albeit with the one exception of Odette (the longstanding GP practitioner) who noted both unfavourable pay differentials and the systemic lack of time allocated to teaching within her third interview (see 5.5). I find support for Cantillon et al's (2019) assertion that teachers within healthcare, such as these interviewees, perceive and enact teacher identities dependent on the observed value placed upon teaching by their own institutions. Yet in contrast there appeared no evidence of the suggested application of 'regimes of competence' (Cantillon et al 2019) where these interviewees develop teaching approaches *stylised* specifically to align with their own unique healthcare specialties.

The examples of justification for embracing theory, such as Kevin's explanation that healthcare practitioners are about 'hard evidence and facts' or Esther's suggestion that it forms the basis of *how clinicians function*, further develop earlier sections' assertions that these interviewees struggled to create distance from their original healthcare identities. It is from this that they demonstrate the *stickiness* of the social identities formed within healthcare (Roopnarine and Boeren 2020). Those perspectives being applied to teaching within healthcare were viewed through the lens of the clinical practitioner. It is Amanda who suggests that concern for the well-being of her taught students stems from her own understanding of the aggression they may often face in clinical practice. Her own clinical experience informing her

approach here as educator. It is Pecukonis (2014) who rejects the possibility of broader benefits from such profession-centrism within healthcare, due to a suggested narrowness of perspectives that emerge from it, alongside a tendency to in-group bias. My research here offers a contrast, that the broad shared goals and values such as those seen in 4.3's in-group determinants, alongside intuitive understanding such as that expressed by Amanda earlier in this section, place profession-centrism as underpinning and supporting the healthcare professions positively.

This section has revealed how the interviewees remained entrenched within their healthcare origins in their approaches to teaching. The following section explores further the motivations to teach considered in both RQ1 and RQ2, with examples of interviewees presenting teaching as an opportunity to reduce exposure to clinical practice and for some to address the burden that practice places upon their well-being.

4.7 Teaching Offers Other Options for Now or Later

The pressures on healthcare practitioners within the UK between 2019 and 2022 were present both prior to Covid-19 and afterwards. They have been well-documented (Alderwick 2022; O'Dowd 2022; Iacobucci 2022). Despite emerging six months before Covid-19 restrictions were applied, these tensions can be explicitly aligned to many of the interviewees' first interviews and indicate the expectations by some that a teaching capability or qualification would offer opportunities to reduce clinical time and its consequent stress.

Many of the interviewees' first interviews considered the opportunity teaching presented to reduce clinical practice. For Dennis and Amanda, it offered the potential to spend more time in the future within academia or educationally focused roles. For others like Florence, it could justify an avoidance or reduction of clinical practice:

> …work within a district general hospital but with an interest in acute [specialty removed] and postgraduate education and simulation and maybe try and avoid some of the medical. (Florence, 31-40, medical doctor of 7 years, #1)

Esther suggested the opportunity might even remove clinical practice completely:

> I mean, from a work point of view, it potentially will open up more avenues, like, it'll add to my CV. Like, if I were to apply for a purely University role or a University role that involves clinical work. (Esther, 31-40, Senior Vet of 16 years, #1)

For some it was planning for the future, both Heidi and Andrea saw the opportunity to incorporate teaching within future clinical work in more senior roles. Andrea was however explicit in a consideration of her own mental well-being:

> I hope that it will be something that is at least half, if not a majority, of my career going forward alongside clinical work, so probably I hope to do maybe 50:50….I do enjoy my clinical work but I find it quite stressful if I were doing it all the time and one of the things I really enjoy, still very seldom find stressful and it gives me a lot of satisfaction in teaching. So it's something that actually complements clinical work quite nicely and it enables me to keep a level head. (Andrea, 21-30, medical doctor of 2 years, #1)

This focus upon personal well-being and mental health had also been part of the decision-making process when applying for the programme for Odette. Additionally, like Dennis, Andrea, Heidi and Amanda, this was alongside a possibility of diversification of role:

> I was looking for something to re-invigorate my career a bit really and so I was looking to make a decision about doing something as well as just being a GP. And how do I feel about the teaching side of things? I think it's just, sort of,

> evolved naturally really. Definitely more comfortable with that than the other option and I don't think I could just stay being just a GP…I think I would burn out. (Odette, 4150, GP of 25 years, #1)

Hayley, a junior doctor, was more explicit and immediate in teaching's value for supporting both her career and her wellbeing. She explained that she was recovering from the pressures of her foundation training and considered teaching as a potential mechanism to address this, whilst also offering a safety-net for the future:

> I wanted to still be involved in the clinical work but have a little bit of a step back because F1 and F2 is quite full on, and I thought I would really enjoy teaching… So yeah, I think in terms of having another card to play, basically, in terms of building a medical profession that I can live with for the rest of my life. (Hayley, 21-30, medical doctor of 3 years, #1)

The views expressed in 2019 were not those of 2022, as three years later during their third and final interviews, these interviewees were asked about what had previously appeared as clear considerations. The answers around the reduction or even avoidance of clinical time then appeared quite differently.

Kevin, who in his first interview had suggested that teaching was an opportunity to pause and consider future healthcare career options, had become a clinical specialty trainee. He now presented a clear distance between his approach and those that sought to reduce exposure to clinical practice:

> I would hope that nobody goes into it purely for trying to get away from something else, then you're not going to make a good job of it are you? As something that I was always drawn to, it certainly fits that bill very nicely and it is still something that I'm looking at in the way of, you know, it's another string to the bow and it's something else that I would like to keep actively doing but it does sort of have the side-effect of being able to reduce some other things or really the positive way of looking at increasing variety and diversity in what you do, isn't it, and maintaining interest and enthusiasm. (Kevin, 21-30, medical doctor of 2 years, #3)

In contrast, Esther understood why some might consider using education to avoid clinical practice. However, she felt she was not one of those:

> …there are certainly individuals that I have come across who are… appear to be cautious when it comes down to clinical work and… I mean, I certainly… there are certain aspects of clinical work which I avoid like the plague. I didn't do the educational thing to shy away from clinical stuff but I can certainly see how some people have done that…it wasn't me trying to reduce clinical work, I'd already managed that. (Esther, 31-40, Senior Vet of 16 years, #3)

For Odette, there was an acknowledgement that reducing clinical workload and its pressures had been the intention. However, the additional workload presented by Covid-19 meant the opportunity to teach occurred in addition to a clinical workload, rather than reducing it.

> So, part of that intention to pursue teaching further was to try to and reduce clinical time. I would agree with that in terms of that's how I felt. What has happened is that it hasn't, it's ended up being squeezed in around the edges and created additional work. (Odette, 41-50, GP of 25 years, #3)

Others had similarly and subsequently experienced the limitations of opportunities to teach in place of clinical practice, because of Covid-19 and related pressures on the healthcare system overall. Andrea had initially seen teaching as offering a reduction of clinical work but felt that this latterly only offered meaning for her if the teaching conducted was within her clinical practice. She considered the pressures facing the NHS at that moment meant there was no *protected* time for teaching:

> I think it doesn't always reduce clinical time, to be honest, but even if… I'd far rather that the time I spent not doing clinical stuff is still linked to my clinical work, if that makes sense…so the few times I have other students like, in with me, it's been a completely unsatisfactory experience for me and for them because they hardly… I just don't have the physical time to hardly even talk to them between patients. (Andrea, 21-30, medical doctor of 2 years, #3)

The portrayal of increased pressure on these interviewees' healthcare provision also appears to align with a more explicit resentment. Jauregui et al (2019) suggest educators place their clinical identity to the forefront, as recognition of the value from educators appears less frequently than for practitioners. For Heidi, there was an acceptance that clinical practitioners can *look down* on teachers within healthcare, which van Lankveld et al (2021) suggest diminishes the strength with which those in teaching hold specifically teaching identities. However, there remained an understanding that for many, teaching was needed to add variety to their role overall:

> I've sort of seen some colleagues and thought they're having a bit of an easy ride because they've picked up the teaching thing…when you're just completely slammed with clinical commitments all the time, then doing something different like teaching is a really helpful break from it… (Heidi, 21-30, medical doctor of 2 years, #3)

For most interviewees, reducing clinical time through teaching appeared extensively in their first interviews, for Florence, Esther, Andrea, Odette and Hayley it was explicitly to ameliorate clinical pressure or stress. However, during the three years between their first and last interviews they experienced the constraints of a pandemic and a resulting positive shift in public mood toward healthcare generally and the NHS specifically (Stewart et al 2022; Kerasidou and Kerasidou 2023).

Concerns over healthcare workers' burnout post-Covid are many (Sadh et al 2023; Murthy 2022). However, these first interviews were six months prior to Covid-19 restrictions in the UK. The final interviews three years later, saw most interviewees considering that reducing clinical time through education was not appropriate for them.

This section has shown that interviewees like Kevin, Esther and Andrea, sought in part to maintain their positive self-concept as health workers battling a pandemic. De Camargo and Whiley (2020) note the emergence of a wartime narrative from healthcare workers experiencing newfound public adoration. Additionally, that for some like Heidi, there developed an out-group consideration and consequent prejudice toward these healthcare *others*, who seemingly benefit from less clinical practice and pressure. However, examples presented from Florence, Esther, Andrea, Odette and Hayley all show that many interviewees initially sought the benefits of supporting their existing healthcare identification with the benefits of educational practice.

In its connection to RQ1, this supports my assertion, that as Odette noted, identification with teaching social identities were in many cases tempered by the judgement of the comparative status of social identities these interviewees already held within healthcare (Browne et al 2018; Sabel and Archer 2014). This contrasts quite markedly with Bartle and Thistlethwaite (2014) who whilst finding a focus on incorporating teaching within clinical practice, saw motivations to become educators as the desire to offer better teaching than they themselves had received alongside a self-belief in their own ability to teach.

Had Bartle and Thistlethwaite's (2014) work been longitudinal, they may have also observed what appears in some of my later interviews, a 'cognitive crafting' of a renewed or orchestrated meaning to their clinical practice (Wijngaards et al 2022 p.227). As presented within the previous section, interviewees approached teaching in 2019 with the perspectives of clinicians seeking the advantages of teaching. They emerged in 2022 as clinicians that could but did not teach.

The next section draws together the key components of this chapter in addressing primarily RQ1, *what are the perceptions of teaching identities amongst healthcare professionals on an award-bearing course in teacher education within healthcare?*

4.8 Conclusion

In addressing '*What are the perceptions of teaching identities amongst healthcare professionals on an award bearing course in teacher education in healthcare?'.* I argue that the perceptions of teaching identities amongst those healthcare professionals interviewed, whilst initially unclear, were entrenched within their origins as clinical practitioners, subsumed as the *supporting acts* to those healthcare roles that had held a greater salience for so long. Therefore, they were ill-equipped to dislodge longstanding attachments to social identities often formed in early-teens or even during childhood. Their social identities primarily as healthcare professionals had been reinforced through extensive vocational education and an induction which had often sought to orchestrate identities in explicitly addressing the patient-centric demands of their peculiar professions. These identities had survived within longstanding hierarchical cultures, where self-esteem concepts were often connected to role-based status and where teaching particularly, does not figure highly.

In addressing RQ1, and some aspects of RQ2, this chapter has followed the often-common path for interviewees in narrowing the expanse between healthcare practitioner and the educator within healthcare. The chapter initially draws upon many of the interviewees' familial connections to healthcare, often alongside

longstanding notions of esteem through their frequent and common presentations of *capability in science* whilst in their teens (4.2). This presents the tethering of these interviewees to healthcare profession identities and through their avoidance of identity complexities, reduces the *identity distance* from family members already within healthcare. It also presents a connection to esteem-enhancing in-group selection, where these interviewees' membership is granted as recognition for early academic achievements (4.3).

The explicit influence of family members already within healthcare alongside GCSE choices guiding toward it, appear consistent with both Slay and Smith's (2011) assertion of identities developing through narratives within life events and Stryker and Burke's (2000) connection of social identities to one's breadth of personal networks. Yet this finding also appears underpinned by Tajfel's (1974) original suggestion that social identities often become apparent and are influenced as a result of accessibility through background or class. These interviewees' personal experiences add credibility for an alignment to healthcare identities that can emerge even *before* attending vocational training (Johnson et al 2012; Roberts 2000; Wilson et al 2013; Burford and Rosenthal-Stott 2017; van Huyssteen and Bheekie 2015).

The limited enquiry by these interviewees into their profession's expectations of teaching (4.4), the predominance of recalling good teachers *only* from healthcare settings (4.5) and a majority determining that good teaching and role-modelling were both homogenous and systemic within healthcare structures, serve to reduce the space between healthcare practice and healthcare teaching. In doing so, this also offers and accounts for their lack of definition of *the educator in healthcare*.

These interviewees drew almost exclusively upon teaching role-models from within their own vocational training, identifying in this way what excellence in teaching means and often promulgating desires to replicate this for their own students and trainees. This supports both Wald et al (2015) and van den Broek's (2020) assertions of the notable impact vocational training has on developing identities within healthcare and offers credibility to those who advocate explicit inclusion of identity 'tailoring' within vocational curricula for such as healthcare (Kerins et al 2022; Creuss et al 2015; Jarvis-Selinger et al 2012).

Alignment appears with Bartle and Thistlethwaite's (2014) notion that many clinicians seek to become enhanced versions of existing clinical role models as teachers. However, in contrast to Bartle and Thistlethwaite (2014), I propose that these interviewees do *not* present a belief in their inherent abilities as teachers being motivators to obtain teaching qualifications. Additionally, and unlike that suggested by Steinert et al (2015), I find that there are no expressions of *prior interest* in teaching before entering healthcare. Further, whilst I assert that the perceptions of the teacher within healthcare is initially unclear, I also present (explicitly in 4.7 and 5.8) that there is no evidence from amongst these interviewees that they fell into teaching HPE *unwittingly*, as is proposed by Sabel and Archer (2014).

These interviewees do however hold a common focus on the value of role-modelling, one which is supported by the literature in healthcare framing the importance of practitioner as educator (Steinert 2012; Weidman 2013; Fiedl et al 2020). More specifically, connection can be made between many of the interviewees' espousal that clinical practice is necessary to teach credibly within healthcare (Sabel and Archer 2014) and in the similar perspectives found amongst healthcare students, as explored by Shapiro et al (2009). However, I find no evidence (e.g. 4.6 and 5.4) to

suggest or justify the subjugation or removal of *non-clinical* teachers due to a lack of perceived credibility amongst practitioner students as Shapiro et al (2009) further suggest.

The interviewees' insistence on holding practitioner credentials, however, do resonate with Browne et al's (2018) suggestion that from this develops the aspired persona of being *the clinician that teaches*.

These related concerns around perception and status are raised explicitly by some interviewees, highlighting negative connotations observed around the educator within healthcare. This offers support to a vein of literature that similarly discusses the consequences or more explicit risks for the recruitment, practice and retention of the educator within healthcare. We can see, for example, Jauregui et al (2019) who discuss the dampening of self-esteem for educators through the contempt sometimes evident toward them by clinical practitioners, or van den Berg and Lombarts (2018) who suggest that this is exacerbated by the comparative (with clinical practice) lack of clearly signposted career paths for these educators. Additionally, we may note both Browne et al (2018) and Bartle and Thistlethwaite (2014), who suggest that from such disdain as this (or to satisfy the expectations of credibility from their students (Sabel and Archer 2014), emerges the coping strategies of presenting themselves as those clinicians *that also educate*.

In focussing on theory and structure as their initially expected foundations for becoming teachers within healthcare (4.6), these healthcare practitioners sought to minimise the distance of their approaches between healthcare and education further. This repetition of what may otherwise be expected within a healthcare subject is further evidence of an inability to look beyond their own healthcare identities (Khallili

et al 2013). I present this is also an example of *entrenchment* within the comfort of those well-worn social identities that make one feel safe (Hogg 2023).

The opportunities they sought from developing capability in these areas (4.7) appeared in the expected enhancements of personal well-being through reduction of clinical practice, alongside a diversification or enhancement of career-related choices in healthcare. Unlike that proposed by Trautwein (2018), I found no discussion or examples here of the concerns of omniscience or hyper-responsibility for the student, as being any concern for these new HPE teachers.

The impact of stress resulting from Covid-19 has spurred much literature, showing the difference in levels of resilience between differing healthcare professions and the coping strategies undertaken (Croghan et al 2021; Finstad et al 2021), alongside the efficacy of varied avoidance strategies deployed in healthcare (Vagni et al 2022). Whilst examples can be found of academic enquiry during and post-Covid-19 into mental well-being in healthcare generally (Sheehan et al 2023), little appears of the longitudinal nature that I demonstrate within this research. I address both pre *and* post Covid-19 perspectives, that Giusti et al (2023) suggest is lacking, and go beyond the limited examples of retrospective and quantitative approaches that frustrate Gostoli et al (2023). Importantly, it remains that the role of the educator within healthcare in this post-pandemic context appears as yet broadly unexplored.

Drawing together the multiple threads above, begins to provide support for my developing argument that often within these healthcare practitioners there is an avoidance of the *liminal space* between the identities of healthcare educators and healthcare practitioners, both intentionally and also unwittingly. This will be explored more in the in the next chapter, as I address more comprehensively both components of RQ2. In Chapter 5, I observe *change* through the temporal unpacking

of interviewee motivations toward teaching and locate a clearer positioning of where teaching within healthcare resides for these participants, as they present it over the three years that follow the commencement of this study.

Chapter Five – What Studying Education Can Offer

5.1 Introduction

This chapter places its focus upon RQ2's two components of *What happens to healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare?* and *What are the influences that contribute to the subsequent identities displayed?*

In the previous chapter I presented data showing that participants' social identities on arrival are unsurprisingly embedded within healthcare, reflecting the numerous influences to which they had already been exposed *before* arriving to become educators within healthcare. It is now within this chapter that I argue they *remain* steadfastly entrenched throughout this research process that spans over three years. I offer that whilst the motivation of learning to become an educator within healthcare is often presented by them as supportive of identified in-groups (in healthcare), it is also underpinned by the demands placed upon these interviewees by their healthcare settings or their ambitions within them. This chapter develops further the work of Chapter 4 in supporting my argument that *perceptions of esteem within healthcare inform decisions on roles in teaching* and additionally demonstrates my assertion that *motivation to teach is fuelled by self-interest in healthcare.* These claims are further made apparent in an overarching graphical representation of the thematic networks within which they sit, that is shown in *Figure 4* within Chapter 6.

In making my argument, I highlight the problematic nature of social categorisation

(identifying identities) and social identification (aligning to identities) for these interviewees in the context of education. I demonstrate the difficulties for them in visualising the reality of *the educator within healthcare* and offer examples of the challenges interviewees faced in aligning to the social identities of teaching, notably when these have been unclearly initially defined (Roccas and Brewer 2002; Tajfel 1978). I previously discussed, in 4.2, 4.3 and 4.5, the interviewees' own approaches to social categorisation and their consequent social identification.

In this chapter I explicitly develop these further in considering the *identity packages* they created, demonstrating both the relative importance of identities to the interviewees (Deaux 1993) and their resulting enhanced self-image (see the generalised expectation within SIT on this quest for esteem in Brewer 1991; Deaux 1993; Fearon 1999; Brown 2000). Additionally, I explore where this offers them a sense of how they may consequently *think, feel and act* when within a specific in-group (Hogg 2007). This combination supports the assertion that healthcare identities once formed, become dominant and difficult to dislodge, perhaps unsurprising as Burford and Rosenthal-Stott (2017) propose such examples as an *anticipatory categorisation* of medical students aligning to *doctor* and not *student* identities even in advance of attending their vocational training. However, I will also present similarities with van Huyssteen and Bheekie's (2015) work, that identifies how it is both socialisation and reflective practice that contributes to the creation of social identities. This will become relevant as we unveil the considerations of the interviewees over time in unpacking the previously unseen nuances of their existing healthcare roles and how teaching has or can integrate. Reflections that were informed by participants' experiences whilst studying to become teachers within healthcare, but importantly afterwards also.

My examples offer the justifications voiced by several interviewees, that acquiring teaching skills had been sought to benefit their established identified in-groups within healthcare, and by many in how they demonstrate the educator role benefits their clinical practice (Sable and Archer 2014). However, through unpacking the subjects' own reflections over more than three years, additional strata of justification for learning to teach emerge. These have been seen in the previous chapter as demonstrative of a self-protection (4.7) through seeking acceptance within chosen social identities of healthcare (Tajfel 1974; Fearon 1999; Hogg 2007) and will be seen in this chapter (5.2 & 5.4) as a *strengthening of position* within existing or aspired-to in-groups (Cote 1996), that are specifically clinical. Both show the *stickiness* of social identities that are wedded to original healthcare specialties (Roopnarine and Boeren 2020).

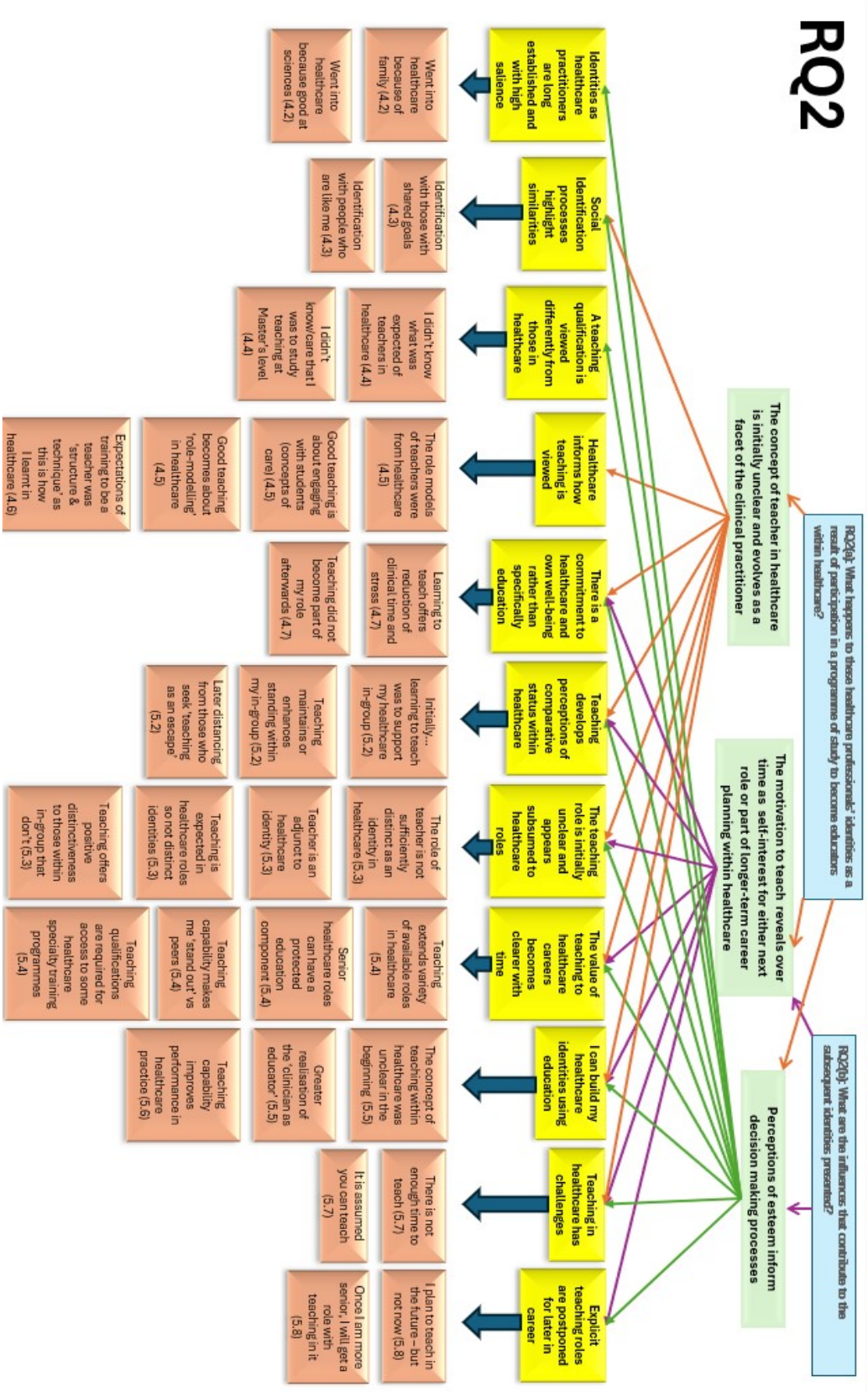
This chapter discusses the interviewees' initial frames of reference on the practice of teaching and argues that the participants' categorisation of educators within healthcare was initially too narrow. It highlights examples of perspectives (but not identities) moving over time amongst the subject group, toward a set of coalescent examples that they apply within teaching. Further, it indicates that interviewees hold often unclear initial identifications of those who are the teachers within healthcare (Bartle and Thistlethwaite 2014). These they admittedly present subjectively, through the differing influences of varied clinical environments (Burford and Rosenthal-Stott 2017; van Huyssteen and Bheekie 2015). Yet, clearer and broader definitions do subsequently emerge, formed with their experiences arising from learning to teach, thus offering greater exposure to 'points of comparison' in the identification (selecting) of social identities (Van den Broek et al 2020 p. 278). These demonstrate

the unguided and highly personal approaches taken by interviewees in considering the identities of educators within healthcare (Mount et al 2022).

Finally, in seeking to understand what has influenced interviewees' views on education and educators, the chapter moves to examine their observations on the presence of teaching within their own healthcare contexts. These unveil to both the interviewees and interviewer alike, a greater complexity and therefore wider presence within their clinical workplaces of teaching behaviours and teaching (Khallili et al 2013). These newly informed and broader selection of markers of excellence in performance (Burford 2012), provide the participants with more healthcare-related examples upon which to determine in-group membership (Van den Broek et al 2020).

To summarise, this chapter connects the initial rationales for learning to become teachers that they espoused in initial interviews, to the participants' own later acknowledgements of self-protection or self-advancement within their explicitly clinical careers. Additionally, by demonstrating examples of dysfunction in social categorisation and social identification processes within the interviewed cohort, there is evidence of a blurred vision in identifying both *who is the teacher* and *what is teaching* within healthcare at the outset. This supports my assertion that long-standing social identities within healthcare, narrow definitions of educators and education in context, alongside perceptions of reduced esteem for them as educators within healthcare, are influences that combine to dispel or limit social identification change. *Figure 3* demonstrates the thematic network of connections uncovered in addressing RQ2, as will be presented in the following sections.

Figure 3 – The thematic network uncovered in addressing RQ2



5.2 Teaching and In-group Membership

In considering the motivations presented for learning to teach, this section begins where the interviewees initially connect this to support of their in-groups and seek opportunities to identify with them, whilst often distancing from identified out-groups.

As considered in the previous chapter, many of the interviewees initially offered only brief explanations of their motivation for attending a teaching within healthcare programme of study. To begin with, motivations often considered supporting identified in-groups within healthcare. As will be evidenced, these further developed during the second and third interviews.

Dennis, a junior doctor who had qualified overseas, explained in his first interview that whilst he was employer-funded, it was encouragement from British colleagues in his specialty that had prompted him to attend. However, during his second interview, Dennis[7] revealed that he had also sought the experience of studying within a UK university. The desire for a British university experience subtly feeding a need for in-group acceptance:

> One of the things was that having not graduated from a UK university, I wanted to pass through a UK university to understand how… what… what the standards are and what is accepted and how they go about things, how the structure in… UK educational structure is… (Dennis, 21-30, medical doctor of 3.5 years, #2)

Turner (1975) identifies the desire for acceptance within an identified in-group. It is with this that locates Dennis within a context to which he is a new entrant but seeking approval (Gecas and Burke 1995). However, this can also create a reduction of

[7] Dennis did not complete participation in the third series of interviews as he was by then practicing overseas with a third interview aborted due to poor phone connections.

perceived difference (in being that of an overseas-trained clinician) to the UK-educated identified in-group (Tajfel 1974; Fearon 1999; Hogg 2007). This reduces the risk of extremes of judgement by these group members, by increasing Dennis' similarity to them (see discussion of Novarra in Tajfel 1982 p.5). This strengthening of membership, whilst not explicit, can also offer a defensive approach for Dennis, against those exclusionary tactics that LaTendresse (2000) suggests may be found within hospital in-groups.

However, in referring to *Figure 3* again, those lower-level theme tiers of *teaching maintains or enhances standing within in-group* (5.2), [teaching] *supports my healthcare in-group* (5.2), [it] *offers positive distinctiveness to those within in-group that don't teach* (5.3*), teaching capability makes me 'standout' vs peers* (5.4) and *teaching improves performance in healthcare practice* (5.6), these would all support Dennis' approach.

Esther's initial motivations for learning to become a teacher in healthcare were like Dennis in relating the purpose as supporting fellow clinicians. These also adjusted over time. During her first interview, Esther presented the value of bringing back new teaching ideas to share with her colleagues:

> I think it's useful to go and see how different people are doing things and then bring them back in to have like a melting pot of ideas. (Esther, 31-40, Senior Vet of 16 years, #1)

However, by the second interview, concerns around her own approaches began to appear, the presentation of what had motivated her attendance became more explicit:

> I wanted to learn a bit more about teaching, because I felt frustrated that I wasn't doing as good a job as I could do…there'd be times when I was trying to help the… trying to facilitate a student's learning but felt that there was

> something stopping that from happening, or that maybe there were better ways of doing it. (Esther, 31-40, Senior Vet of 16 years, #2)

The unpacking of purpose evolved further in her third interview when Esther defined her motivation even more concisely:

> …part of my frustration when I was applying to do the PG Cert. was the feeling that I could be doing it better. (Esther, 31-40, Senior Vet of 16 years, #3)

As can be seen from Esther's comments in the first interview, she suggests a motivation of bringing best practice back to colleagues, implicitly strengthening her position within a professional in-group, through evidence of capability through qualification driving enhanced practice (Cantillon et al 2019). It is van Lankveld et al (2017) that identifies this justification of supporting clinical practice with educational ability, as one of the commonly used mechanisms that enable new teachers within healthcare to integrate teaching into their identity. However, my research observes none of their other suggested mechanisms, such as those that trivialise conflicts between healthcare and teaching, or alternatively present a negativity associated with clinical work that compares unfavourably when framing teaching as a *positive* alternative.

Esther had already identified (4.6) that her own profession expected its more senior members to teach and to do it effectively. In healthcare, seeing the clinical setting as *the place for learning* can be common for trainee healthcare practitioners and consequently shifts focus toward the teacher-clinician (Steinert et al 2017). Whilst Esther did not appear to feel a threat of exclusion, Ellemers et al (2002) note that attempts such as hers, to strengthen existing social identities through capability, can also be the result of commitment to in-groups, rather than fears of exclusion from

them. Commonality here for Esther and Dennis was that their initial motivation presents as supporting identified in-groups. However, later interviews demonstrate this to be only part of their purpose.

For Andrea, whilst her new employer had funded the programme, she explained her choice of the role was in large part because it offered a teaching qualification enabling her to support enhancements within educational practice in healthcare:

> I'd also like to make a wider difference to medical education by being in a leadership or kind of curriculum development role within university because I feel like a lot of the changes that can frustrate teachers on the ground. (Andrea, 21-30, medical doctor of 2 years, #1)

By her second interview, Andrea remained focussed on the practice of teaching and a desire to understand the relevant theories as a result. Within her third interview, she remained consistent in expressing her enthusiasm for teaching as a motivation for attendance. However, when I offered how motivations observed from other interviewees had altered over the interviews, she suggested that not everyone was there for the same reason and may not be comfortable admitting it:

> I think it's a matter of some people were just doing it, for example, as a tick-box exercise for a surgical career because it is… it's heavily weighted in the points for a surgical career, I think people would have been more reluctant to tell you that before they got the qualification knowing that you're kind of… I mean, I know obviously it's all… what's the word… con… anonymous and things, but just the knowledge… or even to themselves maybe. (Andrea, 21-30, medical doctor of 2 years, #3)

Throughout each of her interviews, Andrea locates herself as a clinician seeking a strategic role within medical education to benefit her profession, whilst also embracing the practice of teaching. However, during the third interview, this extends into highlighting a difference in motivations between her and some of the fellow

students from three years earlier. Andrea's initial alignment to educators as 'agents of change and improvement within medical education' (Swanwick 2015 p.5), alongside *clinicians that teach* as an in-group (Leach et al 2007). It is later used as an opportunity to rebuke other teaching programme students. In suggesting their limited commitment toward education, it is both enhancing her in-group esteem (Brewer 1991; Deaux 1993; Fearon 1999; Brown 2000), whilst also distancing from others within her own social identity group. This is described by Ellemers et al (2002 p.384) as 'social competition'. This categorisation of in-group members as holding less regard for education overtly demonstrates the application of selected 'marking of difference' (Jenkins 2004 p.20), picking out chosen attributes within which one may find a sense of superiority.

This is an important demonstration of *optimal distinctiveness* using social identities to offer Andrea both a sense of inclusion with, but also a chosen distinction from others that she may otherwise closely resemble. My suggestion of seeking superiority appears in contrast with Leonardelli et al (2010), who suggest that when applying optimal distinctiveness, it is for the subject to achieve a balance between inclusion amongst the group and a distinction from those others within it. They do however suggest it may be perceived as seeking superiority.

In a similar approach to Andrea and Esther earlier, Odette's first interview suggested a motivation to support healthcare in-groups. However, in the second and third interviews, Odette's own needs became more apparent. She explained during the first interview that attendance on the programme whilst funded, was specifically chosen as it delivered in a face-to-face format. Importantly, this format enabled her to network and develop with health professionals who were similarly interested in education and so support the educational element of her role in GP education.

By the second interview, Odette was unpacking her route to education within healthcare further. She explained that what had brought her to the role was a desire to specialise in a clinical area of general practice and with this would come a greater expectation of formal teaching. Yet by the third and final interview, Odette revealed that whilst the move toward teaching had certainly been to develop her practice of it, the foundation of this choice was for her own personal well-being:

> I think I was most ready to go [leave] three years ago as a way to look at that. Perhaps… I think… I don't know what I said at the time, but now, in hindsight, I think I… it was perhaps looking for a way to diversify my career and recognise it, but… you know full-time general practice wasn't… was… was going to burn me out and that I needed to look for other options and other strings to my bow. And I was also interested in what… learning some skills that would help me to support my colleagues with the learning. (Odette, 41-50, GP of 25 years, #3)

Odette presents as an experienced and long-standing healthcare practitioner. Her final interview reveals an attempt to maintain her current position and status, through using educational practice as both a safety valve and a coping mechanism, in some way juggling or merging this within her self-concept (Sethi et al 2017). She had elsewhere noted the lowered esteem with which she felt clinical teachers to be held (4.7) and therefore sought to negotiate a retention of her high-status group membership (as a GP) rather than suffer a perceived loss of self-esteem (and income) from movement to a seemingly stigmatised group such as healthcare educators (Cantillon et al 2019).

The use of education as a career *safety-valve* resonated also with Hayley, a junior doctor in the early part of her career, she explained that she similarly sought to step back from her clinical role to some extent, whilst additionally being interested in obtaining a qualification that could be used at some point in developing her career in the future. This expectation of gaining a qualification for future rather than immediate

benefit also manifests in Heidi's responses. As a junior doctor, she similarly considered the certificate in teaching would be an enhancement to her CV, although she presented an additional motivation as being to develop her capability in teaching, rather than reduce the burden of clinical practice.

During Heidi's second interview she re-iterated this, but also noted:

> …it will make me better at teaching, and the [teaching certificate] will probably get thrown in as a bonus, and will probably help my teaching, so all of that was kind of focused towards my career as a [specialty removed] doctor as a whole. (Heidi, 21-30, medical doctor of 2 years, #2)

Heidi presents a differentiation like Andrea's earlier, within her own third interview also. Having already offered education as within a focus upon her clinical career in both earlier interviews, she suggests that for some other course participants, the clear motivation toward education was not evident:

> I like teaching, I think it's important, I think it's part of our role, and I sort of thought a course might help me get with that, but maybe it was another line on the CV, and it came with the job that I would do… there were some [other students] that really [didn't] and, you know, hadn't really actually thought out much. (Heidi, 21-30, medical doctor of 2 years, #3)

Hayley and Andrea's identification of those less committed, supported their own self-image whilst again developing the optimal distinctiveness (Brewer 1991) of those who were motivated to teach. This presents yet another example of how abstract concepts such as underlying motivation can be used to define or delineate within the social categorisation and identification processes (Brown 2000), appearing in addition to a subtle or possibly passive out-group discrimination (Sollamani et al 2018).

For Amanda, whilst her first interview had expressed interest in teaching theories, her second interview offered more detail on teaching's perceived personal benefits for her and specifically her clinical career:

> …it's really good as part of your portfolio to show that you've intentionally engaged in this and you've done this and it shows that you're more dedicated as a teacher… (Amanda, 21-30, medical doctor of 3 years, #2)

During her third and final interview, Amanda acknowledged that her justification of attending the teaching programme had only become apparent through a process of reflection over time. A process that brought out an important but previously undisclosed motivation:

> …so you want to pursue it because that aligns to what you're thinking about, but then after doing it, I think the significance and the importance of it, and the power becomes more relevant to you… as a woman of colour, being in that position and having pursued the course, and now having the qualifications, being able to teach and being in the spaces where I am able to influence other women and people of colour like me, is super important. It's not something I necessarily considered prior to starting the course, but I think having…I know that personally in the past, having someone that looked like me in those spaces, being able to understand, or having that realisation that, you know, I can see someone who's like me doing this, which means then I am also able to. (Amanda, 21-30, medical doctor of 3 years, #3)

Amanda's gradual revelation of purpose in pursuing the course of study, appears retrospective, but nonetheless important. It develops a bifurcation of gender and ethnicity in example-setting. This is an example of social identity complexity in not only highlighting identities that are most important (Deaux 1993) and most meaningful (Deaux 1993), but also the influence of background on those choices (Tajfel 1974). It importantly offers evidence that multiple identities can co-exist, and their dominance varies dependent on context (Turner and Reynolds 2012; Turner and Oakes 1986). In creating greater strength of identification to what may be considered as minority groups within the landscape of healthcare education, this can

also be positioned as a model to protect self-esteem (Verkuyten 2006). Alternatively, a social identity complexity perspective that uses teaching to bridge otherwise diverse social identities through its capacity as a *gateway group*, one that allows access to other previously impenetrable groups (Levy et al 2017; Levy et al 2019).

I present within this section the evidence that despite most interviewees initially focusing their justification for joining a teaching within healthcare programme being as the functional acquisition of skills, this was often alongside a presentation of service towards identified in-groups. From exploration of this as a *service to others* in later interviews, I find the emergence of examples of optimal distinctiveness (Brewer 1991), or more explicitly the creation of interviewees' uniqueness coupled with distinction from others (including other teaching students) less invested in education. Finally, it is these espoused motivations, that whilst diverse, offer a commonality of focus on the interviewees' clinical contexts, where education is presented as a supporting act, rather than the main event.

This next section considers why we may observe such outcomes amongst the interviewees. It begins to address the second component of RQ2, *what are the influences that contribute to the interviewees' resulting social identities?*

5.3 Becoming a Teacher-Healthcare Practitioner

The previous section offers examples of the changing explanations from interviewees when presenting their justifications for learning to become teachers within healthcare. Each highlighted participant espoused participation initially as support for their own perceived healthcare in-groups and therefore demonstrated *positioning* within their chosen identities (Cote 1996). However, later interviews unveil other

reasons, such as the self-protection sought from the stress of full-time clinical practice seen by Odette and Hayley, the aspiration of Dennis to become more alike UK-educated clinical peers in his workplace and Amanda's presentation of becoming a racial and/or gender-based teaching exemplar. Equally importantly for Andrea, Odette, Hayley, Heidi and Amanda, there appears a connection of teaching capabilities with career-development in healthcare. The teaching qualification contributes both to a sense of inclusion and yet also a distinctiveness explicitly within their clinical social identities (Leonardinelli et al 2010).

This section focusses upon why we may observe such outcomes amongst the interviewees. It begins to address the second component of RQ2, *what are the influences that contribute to the interviewees' resulting social identities?*

I argue in this research that the identities of teachers *explicitly* within healthcare were not perceived as sufficiently separate or distinct to become something wholly new within this landscape. This appears in some small contrast to Khallili et al's (2013) assertion that clinicians become so deeply ingrained within a clinical identity that they cannot easily form new ones. Whilst they (Khallili et al 2013) do not suggest a conscious rejection, it is proposed as demonstrative of ties to their established practices and boundaries within healthcare. My assertion is that teaching identities appear subsumed within these interviewees' clinical ones, which sets against Bochatay et al's (2022) determination that although some possibilities for integration of identities may emerge, this would be highly dependent on collaborative efforts of a systemic nature, involving considerable structured interprofessional co-operation. They instead suggest that the construction of identity 'silos' (Bochatay et al 2022 p.85) formed through progression in healthcare and strengthened by investments (of

energy and time) in clinical specialities harden over time, making such subsummation as I offer unlikely.

I do however present that a change in identities was not *inevitable*. These participants, without exception, designated the teacher within healthcare as that of an adjunct or supporting role to the practitioner, whilst remaining fixed to the social identities of their own original clinical professions. The interviewees offer justification in learning to teach, often only as supportive of their clinical focus (see other similar examples of this approach by clinicians in van Lankveld et al 2017). These healthcare professionals' long-held social identities allegiant to clinical practitioner in-groups (Roopnarine and Boeren 2020), already presented in Chapter 4, reinforce a social identity salience that required greater *social meaning* than that offered by their experience of learning to be a teacher within healthcare (Deaux 1993).

It is notable that a shift in *weltanschauung* or worldview emerges within the interviewees' later considerations of meaning within teaching (Brown 2000). The participants develop a cognisance of *variant strains* of social identities, such as those of teachers, variations previously unconsidered when making their *similarity and difference* judgements (Jenkins 2004). Unlike that suggested by both Bochatay et al (2022) and Khallili et al (2013), this presents a more nuanced and less role-focused social-categorisation, where social identity complexity appears through the context-dependent interplay of identities (Turner and Reynolds 2012; Turner and Oakes 1986). The latter is often clustered for these interviewees around perceived motivations for learning to practice teaching within a healthcare role. Here the interviewees frequently sought to present a *satisfactory image of the self,* based on the selflessness of their own motivations in learning to teach (Brewer 1991; Deaux 1993; Fearon 1999; Brown 2000). This in-group ingratiation was explicitly amplified

by Andrea, Heidi and Amanda in comparing themselves to the perceived lack of motivation found in others on their teaching course (5.2).

This presents a dismissiveness, sometimes seen in healthcare, of those that are considered outgroups[8], alongside the nuanced differentials sometimes sought and found *within* clinical in-groups by their own membership (Miles et al 2021). These may be found where there is a lack of clarity within groups toward other specific clinical groups or those on its training programmes (Muddiman et al 2016). However, these may offer a status differential by highlighting or creating a favoured point of difference (Sollami et al 2018). Although van Schaik et al (2016) suggest that this *stiffening* toward observed comparisons amongst groups may only emerge after an extended period of time within clinical roles, Miles et al (2021) consider contrastingly the possibility of a softening of own perspectives towards other healthcare professions' identities with time and experience, thus allowing greater opportunities for collaboration and integration. This research offers agreement with Miles et al (2021), as the evolution of interviewees' conceptualisations of teaching identities within healthcare do emerge over time, compelling their integration of the concept within their clinical identities. This research is therefore unsupportive of van Schaik et al's (2016) proposal of perspectives on identities *hardening* in such a context and in doing so this work offers a clear example of healthcare professionals drawing selected 'points of comparison' to support judgements for their in-group alignment (Van den Broek et al 2020 p. 278) and a positioning within it.

[8] See prior reference to example of dismissiveness in s.4.4 in views on teaching requirements in healthcare

The argument is further supported by my observations presented below in how some of the interviewees expressed their perceptions of teaching and its intrinsic nature to clinical practice.

For Odette, teaching as an expected component of clinical practice was presented as part of her GP practice's ethos. An approach which sought both people development and enhanced practice or service provision. It was one in which all were engaged:

> The trainees are [nominally] attached to their trainer but actually the whole practice trains them. And we all train each other, so we're always learning. (Odette, 41-50, GP of 25 years, #1)

Peter's first interview, in advance of attending his teaching programme, outlined his surprise in obtaining a role with teaching being so formally positioned and recalled his perceptions of teaching behaviours always being present, albeit subsumed within his own clinical practice for over two decades:

> This is the first job I'm doing solely for education. So it's interesting…with my personal interest in teaching along with the way it works in NHS or else, wherever I practice medicine, teaching went along with it. (Peter, 41-50, medical doctor of 25 years, #1)

Peter's long-held perception of teaching as integral to clinical practice did not appear solely as the trappings of an earlier generation of practitioner. For Amanda, with only four years of qualified clinical practice, the integrated nature of teaching to clinical practice and its lack of separation in terms of identities was evident. Having completed her teaching programme participation six months earlier, Amanda's second interview revealed her steadfast belief in the integration of teacher and clinician:

> I think as a health professional of any kind working in England, I don't think you can run away from education. There are always students around, nursing students, physiotherapy students, medical students and I think whether you like it or not they are going to learn from you, so you can either be intentional about it or not. I think education fits. It's always going to be integrated I think in life for me as a doctor and it's something that I can't really escape… (Amanda, 21-30, medical doctor of 3 years, #2)

A repetition of this theme can be seen from most of the other interviewees. Florence's first interview presented it as an obligation (albeit a *chore*), Esther, Andrea, Kevin, Odette, Hayley and Heidi all presented the integration and expectation of teaching as a clinician, within their interviews. These perceptions were all (except for Kevin, who raised it on his second interview) offered in advance of beginning their teacher training within healthcare programme, emerging during the first interviews. These 'uni-professional identities' appeared as embedded beliefs that would be carried into their teacher training experience, rather than resulting from it (Khallili et al 2013 p.448).

However, perspectives on these obligations of clinical practitioners to teach were heterogenous in nature, suggesting similar influences, albeit multifarious, dependent upon their healthcare origins (Pecukonis et al 2014) and specifically the profession creating their 'work identities' (Fournier 1999 p.280). For Esther, the senior veterinary practitioner, there was a feeling expressed during her first interview that the expectation by her own healthcare profession to teach, became more apparent and pressing as clinical experience and seniority of position grew. However, she also raised concerns that whilst it was expected, the quality of delivery was not always what should be accepted:

> Whether or not you have the ability to teach or not, and there's not been a huge amount of oversight or feedback for that teaching, you just crack on and do it, whether or not it's effective. (Esther, 31-40, Senior Vet of 16 years, #1)

It is from such positioning as Esther's, where the established social identities considered appear to coalesce toward notions of capability and motivation, that interviewees develop their own teaching approach, determined by the interviewees' own perspectives on what is expected by their in-group. The concepts of both maintaining esteem (Gecas and Burke 1995) and acknowledging the comparative salience of identities (Deaux 1993; Fearon 1999) support the interviewees' bonds to clinical practitioner as a social identity. However, again I note desires for positive distinctiveness and in-group acceptance (Tajfel 1974; Fearon 1999; Hogg 2007) emerge within these interviewees' comparisons and from their consequent distancing to those others within their own social identities, who teach less or less well, an example of interviewees selecting their own *markers for excellence* against which to provide comparison with others (Burford 2012a). However, this research presents examples of *mild rejection* for those that teach less. This is something that allows the interviewees a presentation of superiority, but one that strengthens their in-group membership. In contrast to this work, Burford (2012a) suggests that such in-group comparisons are primarily made to ensure a continued *fit* with the in-group selected, rather than a means of distinction.

In Hayley, a junior doctor's first interview, she appeared similarly explicit in her understanding of a practitioner's obligation to teach. However, like Esther, she felt this did not translate to a uniform standard of delivery, the result of either differing levels of capability or explicit motivation:

> But I think that all medical professionals have a duty to be a good educator to those below them, whether that's the juniors on their team or the medical students that come with them, or the nurse that asks them a question, or that kind of thing. And some people are naturally good, and some people aren't

> naturally good, and some people work at it and some people don't. (Hayley, 21-30, medical doctor of 3 years, #1)

In contrast to Esther's earlier conformity with expectations of her profession to teach, Hayley appears to suggest that for some the label of the profession and its consequent autonomy (akin to that proposed in the broad definitions of *a profession* by both McMurray (2010) and Friedson (1984)), allows a distancing or freedom to practice without such an obligation.

Analogously, during Andrea's first interview, she also expressed clearly that teaching was ingrained within clinical practice, yet like Esther and Hayley, she too had already noted its application by other healthcare practitioners could vary in terms of their engagement or capability. By her second interview, Andrea had expanded further here, with the support of a very personal example. She felt that many healthcare colleagues were like her boyfriend, those who lacked the confidence to teach and so chose to avoid it:

> …he's always like, 'I don't feel like I know enough to teach,' which is definitely something that everyone gets at some stage, worrying whether they know more than the students they're teaching, but I've got over that hurdle. We were teaching the Oxford graduate students last year and that was absolutely terrifying because all of them had PhDs and it was still really easy to teach them because what we were teaching them, they didn't know already. (Andrea, 21-30, medical doctor of 2 years, #2)

Kevin's second interview, six months after completing his HPE teaching programme, showed agreement with Hayley, Esther and Andrea in terms of the varied degrees of engagement amongst peers. However, he presented engagement with teaching more explicitly and as a capability-dependent position. He compared himself to other trainees on his current training programme to become a specialist practitioner:

> …I personally don't think we do enough teaching but that's because I quite enjoy it, and I know a lot… some people don't. (Kevin, 21-30, medical doctor of 2 years, #2)

Having already suggested in her first interview that a knowledge of teaching was 'absolutely vital' to clinical practice, Heidi's second interview appeared to vent frustration at those who, similar to Esther's, Andrea's and Kevin's observation, were not sufficiently engaged. She appeared clearer in her position toward the presence of teaching compared with her first interview, 19 months earlier:

> …there needs to be more of a culture shift towards the medical profession as a whole towards teaching and training being a very important part of a job. (Heidi, 21-30, medical doctor of 2 years, #2)

Throughout these later examples, the sense from the interviewees is one of clear connections to their clinical practitioner in-group. They perceive teaching as a part of the clinician's role. This research presents this appearing not as a result of the impermeable nature of social identities within healthcare, as others have implied (Khallili et al 2013; Bochatay et al 2022). Nor does it suggest evidence of a hardening of views toward other healthcare identities over time (Van Schaik et al 2016). It instead suggests evolution (Miles et al 2021).

As in this section's earlier examples, the concepts of esteem-building and positive distinctiveness through their own alignment to in-groups appear at the forefront. However, complexity emerges as their own willingness and ability to teach becomes compared within these groups. It is set above others (Gecas and Burke 1995) and related to their own personal meanings (Deaux 1993). Nonetheless, this presents generally more as mild disappointment than explicit distancing. Yet my data offers an example of in-group positioning that sits at odds with Burford's (2012a) expectation

that such comparisons are attempts at reassurance of their fit with the in-group. They do not overtly seek to raise themselves up above others within their established social identities yet are expressing about their in-group what Hogg (2007) would suggest being *that which is expected of its members.* It is the desire to see these others elevate to join them that appears to manifest, delivering what they expect as conditions of a membership (Goffman 1959; Brown 2000).

This section addressed the second component of RQ2 in considering the *influences* on social identities that were present for these interviewees. It supports my argument, and thus contribution, that the identities of teachers within healthcare were not perceived as sufficiently separate or distinct by the interviewees to become something wholly new within this landscape. There is demonstration of nebulous distinctions between clinical practice and teaching and a fixation upon existing and embedded social identities that hold most relevance. This is often evidenced within the explanations of teaching concepts as general clinical support. However, there emerges a consideration by the interviewees over time, of differences in clinicians' motivation to teach or teach well. Although, this appears in examination of the obligations of membership to social identities, rather than in seeking differences from them.

The following section continues to consider the *influences* on the resulting identities. It discusses the interviewees' perceptions that learning to teach could offer development of their own specifically clinical careers.

5.4 Learning to Teach for Career Progression

I have argued within the previous section that salience and esteem concepts compel these interviewees to retain allegiance to clinical practitioner in-groups, presenting little motivation for change. I have also offered examples supporting the emergence of a complex dynamic within their practitioner social identities of positive distinctiveness mechanisms in setting apart those with teaching capability and engagement in it, to those deemed lacking. This is a distinction this work draws upon, against those who suggest in-group comparison is primarily the continuing test of in-group *fit*.

In exploring the motivations of interviewees that are directed toward the self rather than in-group membership, this section continues to address the second part of research question two, *what are the influences that contribute to the interviewees' resulting identities?* It presents examples of the interviewees' consideration of teaching capability as a catalyst for clinical career enhancement. In highlighting prior intent and orchestrated outcomes, these contrast to the previous section's focus on the in-group expectations of clinical social identities around teaching and are more suggestive of the self-interest of the interviewees.

To create a richer picture, the focus is placed upon Odette, Andrea, Amanda and Dennis, who have each offered explicit and developing stories over time within the period of the research. These small pictures offer a range of motivations from opening career variety opportunities within healthcare for an established practitioner, to those planning an explicit and calculated application in future interview processes within healthcare practitioner roles. However, all are focused on the self and on development of social identities that appear to have changed little over time.

It is the intention of this section to present a picture of entrants to teaching within healthcare, for whom educational capability was never an intended direction of travel beyond its support and enhancement of their future clinical roles in healthcare. For most (except for Dennis, who is explicit from his first interview), these develop from their second interviews (approximately eighteen months after the first) and third interviews (approximately three years after the first).

For Odette in her second interview, she reveals teaching as offering an extension to the options for a clinician such as her. The chance to use the new outlook created by experiences in learning to teach was opening new career routes in her primarily clinical roles and with potential for more:

> So I guess it's creating a niche to step away from that clinical patient management role into something more strategic…so I've got other things that have come out of it so I've just started in April as a [part-time clinical teaching mentor] …I think the course has given me the confidence to do that… (Odette, 41-50, GP of 25 years, #2)

By Odette's third interview, this ambition to reach more diverse roles within clinical practice had diminished. The limited amount of time available to work within them, since the pandemic had meant they no longer appeared as attractive:

> I also had a couple of roles, I had facilitation roles, I think I mentioned, and I was kind of hoping that I… I could perhaps build on that with GPs that were ready...What have I kept up with? I really don't like training other GP… and people to become GPs, I really haven't enjoyed that at all, so I'm going to be dropping that from [date removed] …, actually. But I really enjoy…It's incredibly time-consuming, that actually, I don't really… and it's not enjoyable enough to offset that. (Odette, 41-50, GP of 25 years, #3)

Odette shows the opportunity to advance within her healthcare specialty and obtain more variety, if not more seniority, had been the motivation for seeking formal teacher training. This had later been thwarted, as she explained, by not just by the

Covid-related surge in demand, but also reflecting her organisation's reluctance to value (or allocate) the time she spent applying education within her role. Whilst disappointed, she appeared understanding of it, as both she and her healthcare colleagues were under pressure with service provision, and so it was not unexpected that educational practice would be relegated by those perceiving it to be beyond their focus (Braithwaite et al 2016; Mandy et al 2005). This comparison of relative values she noted clearly, was one that set favourability toward clinical rather than educational practice (see examples within Sabel and Archer 2014 and further justification within Sabel and Archer 2014).

For others, the connection of education to longer-term career planning within healthcare specialties was evident. This 'profession-centrism' clearly placing value in supporting an existing social identification (Pecukonis et al 2014 p.62), especially where these are long-established healthcare ones (Burford and Rosenthal-Stott 2017; van Huyssteen and Bheekie 2015). My assertion appears in contrast to Pecukonis (2014), who finds that there is little opportunity to absorb or integrate elements from other identities into existing clinically-centred ones, other than on rare occasions of systemic interventions. However, for several interviewees within *this* research, it may be seen to occur intuitively.

For Andrea, the connection of education to clinical career progression had become very clear, but remained subordinate to her clinical practitioner role:

> …I think it will help me get where I want to go in my clinical role, which is in five years I'm kind of hoping to be a senior [specialty removed] registrar…but I think the educational aspirations I hold would be more suited to kind of consultant posts. I suppose I will be applying for consultant posts in about five or six years but those will be me saying, 'I've got this interest in teaching. I've done this PG Cert, slash, PG Dip, slash, Master's,' whatever I've managed to do by that stage, and I'd like a job in helping education medical students or

> being the director of the dermatology placement at a hospital, etc. (Andrea, 21-30, medical doctor of 2 years, #2)

By Andrea's third interview, this application of teaching to develop a particular clinical career path becomes much more explicit. However, the presence of social comparison and some distancing to those who chose to pursue education for overt self-interest appears here also:

> I do know a lot of my colleagues who have undertaken teaching, have done it not through interest in teaching but more as a stepping-stone to get where they want to go…it did open doors in terms of this is my tool for understanding the background of how medical education research and some of the theories. I was more able to engage with colleagues on educational projects which, from a very practical point of view just got me where I wanted to be in terms of [specialty removed]. (Andrea, 21-30, medical doctor of 2 years, # 3)

Andrea continues in developing her position away from those seeking educational qualification for less altruistic reasons. She is open around the positive impact teaching had on her career progression clinically, yet she presented that it had not initially been the intention to use it in this way. Her career direction remained the same, although the pace of progress had certainly been improved as a result:

> I think it helped [me] get where I wanted to go. I don't think it was part of my plan to help me get to where I wanted to go and I think it did that nicely and I don't think I… I feel very fortunate that I haven't had to or wanted to deviate from my career path so far. I am… like, I am where I was expecting to be from kind of when I signed up to TLHP… Mainly speed, but not direction. (Amanda, 21-30, medical doctor of 3 years, #3)

As has been seen in earlier sections, the role of motivation continues to appear. The rationale of *self* being compared to others in initially connecting to education. It becomes an identifying characteristic and so falls within the interviewee's social categorisation mechanisms in identifying such groups and whether an identification with them is appropriate (Sollami et al 2018; Van den Broek et al 2020).

This connection to future opportunities continued, as Amanda recalled her initial hopes during her first interview for how education would benefit her and then suggested during her second interview that this had remained and indeed appeared more clearly so:

> I think I might have said that it would sort of enhance me as a candidate for [healthcare role removed] and I think it was definitely done, because I got my top choice [of subsequent roles]. Like I've sort of alluded to earlier, I think it's going to take me further. I think in future I would like to build on it, just because I think it's just been so beneficial to my work as a doctor and sort of just my general personal professional development. So I think I'd like to build on it and I think it's also kind of… it brings up different opportunities… (Amanda, 21-30, medical doctor of 3 years, #2)

By her third and final interview, she outlines a realisation of these ambitions. However, unlike Andrea who had sought to distance herself from the calculated self-interest of others, here we see evidence that experience of teaching had made Amanda perceive herself as consequently better seen by others as a capable clinician. However, with feelings of being unrewarded for this, beyond the satisfaction of her contribution or capability:

> I think it's definitely benefited me, I think, in being able to obtain this training post as a [specialty removed]. I think it definitely made me stand out amongst my counterparts. And then in terms of progression of training, I think, in transforming my perspective and the way in which I'm able to learn, I think it's helped me progress, not faster but better. (Amanda, 21-30, medical doctor of 3 years, #3)

Not all interviewees sought to distance themselves from the overt and self-interested motivation of using teaching as a career catalyst. Similarly to Andrea and Amanda, Dennis made clear that learning to teach was initially something that he felt would support his clinical career trajectory over a long period of time:

> They want the [specialty removed] … the [specialty removed] registrars and consultants to be able to teach well, so I'm hoping that this degree will help

> me in getting one of those posts, but also it will give me insight on how it is to have a teaching job as well. (Dennis, 21-30, medical doctor of 3.5 years, #1)

By Dennis' second interview, this expectation was considered to have been achieved, yet he also offers a greater expansion of how education could much later be applied, once clinical career goals had been met:

> Yes, so… so basically, it has already helped me, because it counts with my [specialty removed] training interviews, and I might have to re-interview in two years' time and it will count then in those interviews. So in that aspect, it has progressed my career, and secondly there is… there are jobs in the future where… where consultants and even registrars [inaudible] do take up 50/50 roles, which could be an option. (Dennis, 21-30, medical doctor of 3.5 years, #2)

Dennis appears in some contrast to the three earlier viewpoints. They had chosen to understand or justify differences between themselves and others, often focussing on motivation. Dennis had instead highlighted his planned and purposeful intent for those benefits now received, but also sought to ameliorate his own motivation with the potential for returning to these useful teaching skills at some future point.

This section supports my argument that teaching capability is often perceived as a catalyst for clinical career enhancement. This therefore influenced social identification processes for these interviewees. It presents a picture of entrants to teaching within healthcare, for whom capability in teaching was never an intended direction of travel beyond its support and enhancement of their future clinical roles in healthcare. As in the previous section, the notion of motivation influencing social categorisation, identification and comparison continues here. Importantly, there is also a consistency in literature's expectation that within healthcare's social identities,

pursuing postgraduate study more broadly, is often intended to support career advancement
(Zwanikken et al 2013). There is agreement that completion of such MHPE programmes do offer enhancement to clinical practice (O'Callaghan et al 2024). However, as O'Callaghan et al (2024 p.4) additionally note within their scoping review, there are no examples such as this research's longitudinal study of MHPE programme participants' 'downstream impact on teaching and learning'.

The following section returns to addressing the first component of RQ2, *how do healthcare professionals' identities change as a result of participation in a programme of study to become educators within healthcare?* It presents examples of a movement over time of the interviewees' perspectives on *what teaching means*.

5.5 Developing the Concept of Teaching

The studied participants' concepts of teaching within healthcare changed over the three years of the study. As discussed in Chapter 4, teaching capability was often initially viewed in terms of its delivery within a structure and following a process. The ensuing examples build upon the previous section, where the focus was upon clinical practice. The following now offers evidence to support my assertion that the interviewees' demonstrated an emergence of recognition that education in their own context holds a much closer proximity to clinical practice than previously considered.

For Odette, the second interview outlined her continued belief that understanding structure was important to teaching, yet there was also the expectation *a*

performance[9] in front of the students (Smith and Foley 2016). This was something with which she felt uncomfortable. However, through experience and reflection, she appeared to find her own more accessible route into good teaching. This, she noted, was that *non*-formal teaching or *by example* (Eraut 1994), appeared more frequently in healthcare than she had previously considered. Whilst often not explicit, it remained important:

> So I have a huge amount of respect for them and, when I look at how they deliver teaching, you don't see it but it's very structured and I suppose it's changed my perspective on the informal teaching that happens in medicine all over the place…I'm in awe of the ones who can stand up and deliver things and be performers really, I suppose, acting on the stage with the teaching as their script, their play and keeping people engaged and keeping people on task…I think I always saw that's what teaching was and therefore that was something I probably couldn't do but now I can see there are other things that teaching is. (Odette, 41-50, GP of 25 years, #2)

By Odette's third interview, she explained that for her, a clarity around the purpose of teaching within her own specialty of General Practice had appeared. She concluded that teaching needed to be more engaging, specifically as this would overcome some of the difficulties in attracting new students to the profession. It was this and not Covid-19 that presented a current challenge to General Practice she felt:

> …you're in this kind of cycle… vicious cycle really, where if we could train them then they might come. But they're not going to come… become GPs if what they see is that training them is stressful and they see all of the rest of the problems around. (Odette, 41-50, GP of 25 years, #3)

However, despite the obvious importance of teaching within her specialty, she felt it was unlikely to change due to the culture that surrounded it:

[9] Odette's description aligned very closely with Alison King's assertion of moving from the 'transmittal model' of *knowledge-giving through performing* to a constructivist approach that develops learner engagement. See King, A., 1993. From sage on the stage to guide on the side. *College teaching, 41*(1), pp.30-35.

> But unfortunately, I… I don't think it's valued. But then that's probably always been the case. And certainly, you know it's… it's not valued by colleagues, and it's paid less most of the time. (Odette, 41-50, GP of 25 years, #3)

Odette had moved from determining teaching within healthcare as a functional process to more of a complex engagement between the teacher and student (Hopkins et al 2018; Wu and Shea 2020). However, despite this, she still saw her own profession appear to be dismissive of it (Hafferty and O'Donnell 2015; Cuff 2016).

Andrea, like Odette, had initially seen teaching as grounded in structure. However, by her second interview, she doubted whether this and educational theory had underpinned much of the teaching she had experienced in healthcare:

> …I think a lot of teachers, their interest lies more in subjects that they are teaching which isn't medical education theory and therefore their medical education theory isn't as interesting to them. (Andrea, 21-30, medical doctor of 2 years, #2)

Andrea's third and final interview presented a reconciliation of the importance of structure, with a view that structuring her teaching from the perspective of the informal learning, that others had also described, would be the most attractive for her. Like Odette, she rejected the perception of the formal classroom as the venue for teaching:

> I'm more passionate about that because I can see the difference that it makes by teaching students about what I do, if that makes sense, rather than kind of abstractly… even though examples are hugely important, the arranging [timetables] in sort of second year medical students in taking blood pressures is probably going to be less rewarding for me. (Andrea, 21-30, medical doctor of 2 years, #3)

Heidi's second interview presented a realisation that, similarly to Odette, teaching within healthcare often involved previously unobserved skillsets. Additionally, like Andrea, that whilst she had previously separated her teaching from her clinical practice, they were mutually supportive and not as distinctly different as she had suggested in her earlier interview:

> I think in my head there's still a divide between my professional job and my role in teaching other people to do my professional job, or being taught to do my professional job. But actually, I think probably the divide is artificial and they feed into each other, and probably if you're a good teacher, you are a better [clinical specialty removed], and vice versa…I think I really appreciate a good teaching session now, and the work that goes into something good, and really appreciate people giving their time to prepare and teach…And I think I have probably got a new awareness of the cost of teaching, if you like, and the skill that goes into it. Perhaps I view the skill more highly than I did before, I think. (Heidi, 21-30, medical doctor of 2 years, #2)

In Heidi's revelation above, the identification of the teacher appears synonymous with the demonstration of clinical practice (Shapiro et al 2009). Her final interview strengthened comparisons with both Odette and Andrea's perspectives in arriving at an application of informal learning within her views on teaching:

> …it's a mentorship that I see, a sort of academic extension of role-modelling. And I try to remember that. I find [that] and what other people are going to observe about me and what we demonstrate…And then the kind of informal teaching on a case based, ad hoc way, I… it's all a big part of the job. (Heidi, 21-30, medical doctor of 2 years, #3)

For Odette, Andrea and Heidi, the concepts of teaching had now broadened to incorporate demonstrating their clinical practice. Esther in her second interview, confirmed her previously held views on the need for structure in teaching. Yet she also now saw the combination of knowledge and experience with *example-setting*. However, not in the same way as she had originally been taught. The application of teaching structures had now made her more effective:

> …it helps to realise that you do need […] to have had some formal teaching to know how to teach better […] to optimise facilitation of learning […] More knowledge certainly makes it better in terms of being able to be a better facilitator. (Esther, 3140, Senior Vet of 16 years, #2)

When completing her last interview, Esther's concerns appeared similar to Odette's on propensity for educators within healthcare to change:

> … if we as teachers are not prepared to participate in the learning process, then we really shouldn't be teachers. (Esther, 31-40, Senior Vet of 16 years, #3)

In Kevin's second interview, like Esther there was a realisation that repeating what had been experienced as part of his own vocational education, did not now appear as the right thing to do:

> Whereas I think now you've got a much more understanding of where the learning actually comes from, and it's less just copying the format, and more thinking about how you produce… you know? Stimulate the learning, and… and that kind of thing. So, yes, I think it's changed both from more of a… less of a cookie cutter format of teaching to actually what are you wanting to get out of the student as the focus. (Kevin, 21-30, medical doctor of 2 years, #2)

Kevin, like the other interviewees had initially focussed on teaching as structure-driven. In his second interview similarly to Odette and Esther, he considered its use most valuable when connecting to the student. By Kevin's third interview, a further reflection on teaching prompted his realisation that he had been unsure of what teaching really was prior to learning to teach:

> I think…appreciation and respect for what goes into it. Yeah, I think most of us grow up not really knowing what teachers do…Later on you look back and reflect upon what it takes to teach. (Kevin, 21-30, medical doctor of 2 years, #3)

Amanda's third and final interview draws together many of the others' reflections. In promoting what she considered *informal* learning, she explained this could be more effective through a proactive application of her taught teaching techniques/structures:

> I think medical students are always around, but being able to make those less formal kind of educational sessions… more structured is the wrong word, but I think more useful for them, I think involving them, being more aware of them in that sense, not just doing my work and having them watch. I think taking that a step further, and being able to use various ways in which to involve them, and in which to enhance their teaching is one way. Secondly, I think it's made me more equipped in being able to see for myself teaching opportunities are more proactive, and just doing those. (Amanda, 21-30, medical doctor of 3 years, #3)

This section demonstrates that for many interviewees, the concept of teaching in healthcare was unclear at the beginning (Bartle and Thistlethwaite 2014; Lee et al 2020). The impression of repaying their own vocational training is present (Steinert and Macdonald 2015; Lee et al 2020), yet more importantly is also realisation of the extent of the clinician's role as educator (Browne et al 2018; Bartle and Thistlethwaite 2014). This broadened for some their understanding, but the identities of the clinician remained deeply embedded in attitudes toward teaching (Lee et al 2020; Sable and Archer 2014). However, unlike the conditions for transitional success from clinician to educator identified by Lee et al (2020), this research finds nothing in the narrative of its interviews that alludes to the presence of mentors for these clinicians once qualified as teachers, or the existence of a supportive organisational structure (although examples to the contrary are offered) to support them in their transition.

These interviewees' initial challenges in conceptualising teaching within healthcare do appear explicitly and distinctly, which alongside its perceived low regard, pose disruption in both social categorisation and identification processes. These reinforce

notions of ‘uni-professional identities’ within healthcare (Khallili et al 2013 p.448), where few other social identities in healthcare are considered or given credibility (Roopnarine and Boeren 2020) and awareness of the complexity of multiple identities encompassing education within healthcare appear limited (Bochatay et al 2022).

Having considered in this section what teaching within healthcare entails, the next section returns the focus toward causation. It considers why we may observe such outcomes amongst the interviewees, in addressing the second component of research question two, *what are the influences that contribute to the interviewees' resulting social identities?*

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5.6 Education as a Tool for Identities

It has been presented already in this research that teaching was often considered functionally (see 4.4 discussing interviewees' expectations of structure and planning). Although in later interviews its value became focussed on the *affective* consideration that educators within HPE must hold, when amongst students or clinical colleagues that are often more junior. In this section I return to addressing the second component of RQ2, *what are the influences that contribute to the interviewees' resulting identities?* I argue, with the following examples, that interviewees primarily locate themselves as healthcare practitioners. As such, they present their acquired teaching practices and the educational concepts that emerge from their study on the MHPE programme, as solely performance-enhancing tools in that context. Their teaching capability is framed towards its value.

These interviewees offer explicit examples of developing the clinical practice of others through application of teaching concepts and for developing themselves. During Odette's second interview, she explained that she had used concepts found in teaching with a GP who was in training, earlier that week. When supporting experienced and yet still junior colleagues, she explained that she felt more able to develop them and reach a higher cognitive application within a healthcare project:

> I don't want you coming out of this and saying, actually, my project is to know the causes of atrial fibrillation. What your project needs to be is to appraise the different managements and evaluate them and then design a protocol for GPs in [location removed] to use. I mean, it needs to be higher level, not I'm going to know about this and then I'm going to find out about this and then I'm going to learn a bit more about this. (Odette, 41-50, GP of 25 years, # 2)

She also presented that her own clinical practice had specifically been enhanced by the application of teaching techniques:

> It's made me really focus more on asking more open questions in all aspects of my life because obviously I have to think about it much more carefully when I'm asking a trainee questions to develop their knowledge. I think it's helped, it's changed how I approach feedback, both asking for feedback and interpreting what comes back so I think that's been helpful. (Odette, 41-50, GP of 25 years, #2)

Odette's social identification and alignment to clinical practitioner in-groups remain clear. It is her application of teaching skills (here giving feedback) as tools within them that is of note.

For some interviewees, the broader application of education within their wider healthcare roles beyond clinical practice was also evident. For Andrea, in her second interview it was the developed experience of writing teaching rationales and consequently citing academic literature from differing positions (both being requirements of summative assessments within the MHPE programme attended),

that supported her clinical research rather than her clinical practice. This changing her approach to the research part of her role and allowing her an opportunity to have the work published:

> …[not] in my medical job role but in my research role it absolutely is [helpful]. I wouldn't have been able to do the research that I've done without having some of that knowledge, if that makes sense…I might have taken it on but I don't think I would have had the knowledge to do it well, so it ended up we wrote it up and it got accepted by a journal and I don't think it would have been accepted by a journal had I not done that…(Andrea, 21-30, medical doctor of 2 years, #2)

For some interviewees, the tools of teaching encountered on the MHPE programme, were not being deployed frequently. However, it was the *awareness* of their existence that had offered value. The results manifesting over time, regardless of whether they were applied in practice.

As Kevin explained, the awareness of the skills he developed in learning to teach had enhanced his self-confidence within his clinical role. During his second interview, he presented the example of being approached by medical students during the conduct of his own clinical practice, something he had previously often found uncomfortable because of the diversity of challenges they could present. This was, he suggested, something he now viewed as a positive experience and one that he sought out:

> And, you know, if a medical student asks me to come and show them something then I can do it properly and, you know, in a way that can be beneficial for them much more so that I would have done before. So, it's given me the confidence to be able to do that. And also, there's... you know? Coming from that confidence I suppose is the enthusiasm to keep doing it as well. (Kevin, 21-30, medical doctor of 2 years, #2)

This theme of enhanced self-confidence resulting from attendance on the MHPE programme and resulting experiences, continued in Kevin's third interview. He felt able to take on other more diverse clinical roles because of the skills developed:

> …giving you confidence to do it but then also confidence to take on opportunities that may be beyond the actual… what you were taught or adapt yourself to do in situations and the confidence to take on other roles as well. (Kevin, 21-30, medical doctor of 2 years, #3).

Also in Kevin's final interview, the greater understanding of what could be applied to his own healthcare role as a result of exposure to teaching practice was clear:

> Then more professionally, yes, it does change your understanding of what your profession is, because it takes you away from you're just doing clinical stuff and you just have to do this or research and it actually broadens your horizons. So we can do [inaudible] this is how the [specialty removed] role can adapt… (Kevin, 21-30, medical doctor of 2 years, #3)

As has been consistent with Kevin's examples, the application for use always returned to clinical practice, where the underpinning identity salience of the clinical practitioner is expressed. For Kevin, being able to apply teaching techniques had developed changes to how he had felt about his clinical role. As can also be seen with Esther's examples below, this manifestation of teaching skills supporting personal well-being in clinical practice, emerges also from other participants' perspectives.

For Esther, the focus during her second interview fell upon the structured practices of reflection that she had encountered whilst studying to teach. She explained that it had become a useful tool in her own personal well-being, and one that consequently she had shared widely with others*:*

> I think the ability to reflect upon where… where… things that I had done well, and things that I maybe could have done better. I find that quite helpful now, and I've also found it quite helpful to enable others to realise that as well in terms of the different loops of learning. The single loop, and the double loop learning. Kind of working out when they're going to be most appropriate for the situations at hand. But also, again it's… it's… it's highlighting to them that… to be just a little bit kinder to themselves rather than for the pressure we put on ourselves… (Esther, 31-40, Senior Vet of 16 years, #2)

By Esther's third and final interview, the development of her *clinical* practice as a result of learning to be a teacher was also more explicit:

> I think I'm getting more out of it, and I think I'm being able to… I hope I'm being able to let other people get a bit more out of it as well. Kind of like, to try and make that explanation as to how, yeah, as to, you know, how things happen and why things happen. (Esther, 31-40, Senior Vet of 16 years, #3).

Esther presents that her personal capability to develop within her clinical role had been enhanced, again through practices linked to structured reflection and akin to the two prior examples, focussing on how it had consequently made her feel:

> being more aware of where… where we are learning and… and recognising that, I suppose and recognising that it's different for [me] and the reasons potentially behind that and… and recognising where we use tools to learn and to progress… where we might not necessarily realise they are tools, and if we had realised that they're tools, it might make it easier…(Esther, 31-40, Senior Vet of 16 years, #3)

Esther's explicit identification of teaching techniques (developed from attendance on the programme) as *tools within clinical practice*, is a helpful mechanism for her. This lays bare not a diminution of the worth for teaching in comparison to clinical practice (Sollami et al 2018; Jauregui et al 2019), but instead presents a perceived value when focussed on *integrating* it within healthcare practitioner identities. It supports her clinical practice and consequent outcomes, and also enhances her well-being in delivering them however, still remaining channelled within one single social identity

(Bochatay et al 2022). This may appear as having been chosen with high ‘entitativity’ (Hogg 2023 p.831), where identities have such high levels of salience within their boundaries for membership, that they become ‘safe places’ to entrench oneself in the face of self-uncertainty. This becomes particularly likely where such compelling groups appear as well-defined units with their own clear boundaries and shared attributes. These conditions appear present for the interviewees as the properties of their *clinical* healthcare professions, whilst also emerging for them as the *antithesis* of educators within healthcare. A demonstration of being pulled toward clinician identities, whilst pushed away from those of the educator within healthcare.

Others also expressed the benefits of learning to become a teacher through the MHPE programme, whilst still centring these experiences on *clinical* practice. The opportunities to become more effective in learning to develop as clinical practitioners emerged as previously unexpected outcomes for some.

Like Esther, Amanda offered in her second interview that the reflective practices developed for teaching were helpful to her practice as a clinician:

> I’ve already sort of touched on my reflective practice and also I think there is a way in which I choose to learn, assimilate things and I guess defining learning opportunities, even though they’re not labelled as such, which I think is an incredible skill to kind of have as a doctor. (Amanda, 21-30, medical doctor of 3 years, #2)

However, her greatest benefit appears to come from the ability to identify where her own learning and personal development opportunities might be:

…the kind of service provision role of being a doctor is so predominant, especially in the NHS, but you don’t often recognise there’s learning opportunities for what they are and you need to if you’re going to gain from them. I think I’m much better at doing that now ... So [I] make a mental note, I pick up my phone, put it in my notes and then I can read up on it later or pick up on it later and ask the consultant…I think it kind of really helps you in your practice and makes you more intentional and helps

you kind of see your role as a doctor as more multifaceted. (Amanda, 21-30, medical doctor of 3 years, #2)

In her final interview, Amanda notes how the initially unexpected areas of the curriculum in her MHPE teaching programme had developed usefully in her clinical role:

> I think the course sort of opens you up, not just with regards to teaching and education, but being a better learner, and you know, those ideas that you can't quite quantify, it kind of gives them form and shape. So things like psychological safety, the importance of stability in the work environment in learning, and all these sort of important periphery ideas that you know are there, but you can't quite quantify, I think by giving them shape, it gives them power and allows you to be armed with the tools to work better…(Amanda, 21-30, medical doctor of 3 years, #3)

She concludes that, like that described by Esther, it also had made her more able to develop at a faster rate in her clinical practice. Learning faster than peers:

> I think I'm able to learn better and, you know, maximise on training and teaching opportunities better than my counterparts. (Amanda, 21-30, medical doctor of 3 years, #3)

Amanda's examples offer a picture of teaching practices supporting and developing competence in clinical practice that emerges over time. I present that unlike other studies, the longitudinal nature of this research's engagement with the interviewees, not only allows their responses to be considered as robust and heartfelt, but also presents an opportunity for the interviewees themselves to reflect further on their progress. Notably, Sethi et al's (2018) qualitative investigation of similar postgraduate HPE students, uncovers comparable motivations of studying HPE as, enhancing career prospects, being prompted by recommendations from colleagues and the desire to improve educational competence. However, they note their absence of a longitudinal approach that consequently prevents the observation of

identity *formation* processes. Importantly and unlike this research, their interviewees focus only on benefits to their pedagogical application and offer no suggestion of the positive application of *educational* practice enhancing *clinical* practice.

Many of the interviewees focus on how they benefitted from the application of newly acquired teaching practices as individuals. In the previous chapter I presented the interviewees' espoused motivations to teach as often framed (by them) in supporting their in-groups. In later interviews, respondents were often keen to outline examples of subsequent value to their collective practitioner in-group.

Dennis considers it was about enhancing the quality of being a *link in the chain* of specialist training and development. He suggested it was about improving how those below him, in the occupational hierarchy, were to be developed and in doing so raise the standards for those practitioners:

> …the NHS [has] a system that everyone has to teach the person be… hierarchy below them so the same way, so I'm… I'm now a [specialty removed] trainee, I have to teach maybe the non-[specialty removed] trainees for the… or the foundation doctors, and doing so the same way the… my… the registrars above me have to teach me, and they have to teach… and the foundation doctors have to teach medical students, so there's… so that's definitely, I believe, improved the quality of teaching I deliver to my more junior colleagues. So I ended up with [inaudible] approach to teaching which definitely will aid, and has aided, my career, and I believe will continue to help, because even consultants have to teach their registrars. So, the teaching aspect of the NHS never stops. (Dennis, 21-30, medical doctor of 3.5 years, #2)

Dennis' perspective, like the others, is suggestive of *in-group favouritism* through allocating perceived value of teaching to that social identity most salient. However, the tacit implication of positive distinctiveness of these social identities (both own healthcare specialty and the wider NHS) is evident by denoting *virtue* in their subsequent application of teaching mechanisms to enhance their in-group (Sollami

et al 2018), whilst also locating the interviewee's perceived position within society (Gecas and Burke 1995). This is not necessarily demonstrative of the in-group *status enhancement* as outlined by Cote (1996). It can however be seen as an expression of *where I fit in* (Tajfel 1974; Fearon 1999; Hogg 2007), and as a broader reassurance for the individual themselves as to how they should behave and be treated by others consequently. This appears aligned in-part to Goffman's (1959) view of identities as projections of *self*, although arguably more relevant to both Brown (2000) and Hogg (2007), in that it determines *expected* behaviours of self *and others* within social identities specifically.

In seeking to address RQ2 and explicitly it's second component, this section offers further examples of the *influences* on social identification for these interviewees. It presents how their applied levels of engagement with the programme, alongside their acquired skills of teaching, are explicitly framed by them in their clinical practitioner contexts. For Odette it develops clinical practice competence, Andrea suggests enhanced access to research opportunities in her healthcare specialty, Kevin developing self-confidence in clinical practice, Esther supports her own and other's personal well-being, Amanda observes greater capability in studying her specialty, whilst Dennis suggests delivery of quality enhancement within his clinical specialty and the NHS alike. All examples centre their use on their social identities most salient, those of the *clinical* practitioner. Notably, none of the interviewees held explicitly educational roles, instead offering clinical settings as justifications for benefitting from the practices of teaching.

The next section considers both components of RQ2 in unpacking *what consequently happens to identities* and *why*. It presents the notion of *change* in that these interviewees unveil a developing understanding over time of the teacher within

healthcare. However, this is tempered by an understanding of the constraints that teaching faces in this context.

5.7 Teaching Challenges

The previous section considered the interviewees' conceptualisation of teaching as enhancing their *clinical* career and demonstrated this focus as influencing their social categorisation and identification processes. This section develops further to consider the interviewees' often ambivalent or negative views of how teaching manifests within their own profession initially, whilst it then notes changes in their perspectives prompted by reflections over the three years of the study.

For Odette, during her second interview she presented a new awareness that the teaching from her own vocational education had been more intentional than she previously realised:

> …I think my trainer knew about it because when I did my educational supervisor's training he was delivering the training, my trainer from when he trained me 20 years ago, so he's retired but he still delivers the training for GP educational supervisors and he delivered that and I thought to myself I don't remember him explicitly going through this with me so was he kind of doing it subtly and should I have absorbed that more? (Odette, 41-50, GP of 25 years, #2)

However, during her final interview, she balances this greater awareness of teaching's presence alongside heightened constraints of service provision, thus reducing opportunities for effective teaching. She warned that such a lack of focus toward educators would cause further issues:

> …I think unless you can teach, then you're always going to be overwhelmed by your service provision role. You have to teach the new blood, as it were,

> coming through, otherwise, the service provision becomes increasingly more difficult. (Odette, 41-50, GP of 25 years, #3)

The limited level of focus placed upon teaching within healthcare was also a concern for other interviewees. Odette had blamed the pressure of service provision, Heidi however considered the focus on teaching in healthcare was more broadly and systemically constrained. It was present, but this was not enough:

> …there needs to be more of a culture shift towards the medical profession as a whole towards teaching and training being a very important part of a job. I don't know exactly what that looks like, and that's not to say that there aren't lots of really good people who love teaching and are really passionate about it, and there are loads of really good things, and I don't want to diminish that, but do I think it is sufficient? No. (Heidi, 21-30, medical doctor of 2 years, #2)

The limitations placed upon teaching in healthcare were also expressed by Esther. During her second interview, she recalled her own experience of learning as being originally didactic in nature. However, she conceded that some progress had since been made, delivering a much clearer focus on the role of the student in learning, albeit often without understanding the educational theory needed to develop this fully:

> We're asking them [teachers] to be much more reflective, and having to look at people's [students'] reflections, and… and without particularly knowing why we're doing it, or the purpose, and it made it really difficult to support them with that. Whereas actually knowing the purpose is useful. (Esther, 31-40, Senior Vet of 16 years, #2)

She further notes, the expectation to teach is present. However, the capability is often taken for granted in her profession and particularly when one is seen as an experienced practitioner:

> For a lot of people, it's not innate. It's something that you have to learn. But I think there's almost an assumption that you do know how to teach if you're in a position where teaching, or facilitating occurs because why wouldn't you be? You know? Why would you be in that position if you didn't know how to teach? (Esther, 31-40, Senior Vet of 16 years, #2)

This expectation to teach was apparent for Kevin also, where the use of peer teaching was prevalent on his recently joined healthcare specialty training programme. Whilst considering that this could at times be helpful, it was often felt to be variable in quality. Frequently resulting from limited knowledge of educational theory and practice:

> But I think one of the particular things about the… the [specialty removed] training course in this area is that it's… a lot of it is peer teaching. So, yeah, I think you get… you get an afternoon every month which is… that's all the teaching you get, and it's all peer teaching…But I think you can very much tell people who've had no teacher training at all, and then, it's a bit more of a… you know? It's less useful perhaps when the peer teaching isn't done in a way where people are supported to do the stuff [that we need], if that makes sense? (Kevin, 21-30, medical doctor of 2 years, #2)

Like Odette, Heidi and Andrea, Kevin noted that this lack of understanding around teaching could be addressed, but the support to do so appeared to be missing:

> And so, I think, you know, in that instance if… in a programme where … peer teaching is what is expected of you then you should be supported to do it in a way that makes it useful for everybody else. (Kevin, 21-30, medical doctor of 2 years, #2)

These interviewees present a landscape of education being intrinsic to healthcare, which as Bastable et al (2019) suggest is longstanding. It appears despite these participants often appearing constrained under pressure of service provision, institutional barriers and feelings of isolation as educators from the wider community (Lee et al 2022). This and an awareness that teaching structures had often been

present, although *implicitly* in the interviewees' own vocational education, it becomes especially evident when Amanda addresses these points in her final two interviews:

> I don't think you can run away from education. There are always students around, nursing students, physiotherapy students, medical students and I think whether you like it or not they are going to learn from you, so you can either be intentional about it or not…I think that it's something that's sort of almost taken for granted... (Amanda, 21-30, medical doctor of 3 years, #2)

Amanda further suggests that the focus on teaching by practitioners can often be missing if the pressure of their workload within the clinical setting is too demanding:

> I think you have some individuals that are really passionate and put the spotlight on it and help people get excited about it but I think sometimes, just because of the nature of the job and how busy things are, it doesn't get the recognition it deserves…I think there is an overarching awareness that teaching is a part of what we do as doctors. I just don't know if that's recognised all the time. (Amanda, 21-30, medical doctor of 3 years, #2)

Like Odette, Amanda had noted during her third interview that the presence of teaching within her profession was more nuanced than she had previously understood. The process of learning to become a teacher unlocking the realisation of its structure and presence within healthcare:

> I'm sure you're taught as F1s and F2s in various ways that it didn't register because we didn't recognise that. We weren't skilled to understand that that's what it was. So I think there's an element of that, absolutely. So not feeling as if, you know, you're equipped to, you are in a position to, or qualified to, and then that changes and that evolves as you progress, and I think doing the course helps you see. (Amanda, 21-30, medical doctor of 3 years, #3)

These perspectives of teaching in the interviewees' own clinical contexts, build upon the previous sections highlighting a lack of clarity around its practice generally and aligns explicitly to *what does teaching look like in my profession?* It seemed that this became clearer to the interviewees only after some time had elapsed from their initial

HPE studies. Odette and Amanda had offered their realisation that the structured delivery of teaching had indeed been present, albeit unknowingly, in their own initial healthcare practitioner education. Odette, Heidi and Amanda had all highlighted the constraints on the focus or willingness to teach in healthcare, citing pressures of service provision, systemic policies and not only those arising from the pandemic, as has been shown elsewhere (Mian and Khan 2020; TMS Collaborative 2021). This observation of teaching moments within healthcare as omnipresent yet often *unseen*, aligns to Attenborough et al's (2019 p.137) assertions that for many clinical practitioners this will be the case. However, here they (Attenborough et al 2019) also place emphasis on collaborating with the learner to develop these opportunities alongside highlighting the 'culture of busyness'. Somewhere that productivity and efficiency can take precedence over learning. My research appears in contrast to Attenborough et al (2019). I offer that these interviewees find an improved practice of teaching results from their HPE studies, enabling them to enhance learning for others rather than just allowing a greater *signposting* of learning moments.

However, for Esther and Kevin there was a determination that teaching in their healthcare professions had progressed since their time as students, moving beyond the traditionally didactic and towards Mohanna et al's (2023) vision of engaging with healthcare students in a collaborative approach that matches the healthcare learner's individual needs whilst developing initiative, creativity and self-direction. Although both interviewees also suggested that this observed progression and consequent capability had not yet gone far enough.

This section offers examples of how teaching within these healthcare practitioners' own clinical contexts is perceived. It aligns with the earlier section, in that teaching appears more prevalent than initially considered, and for some appears more

effective. Many of the interviewees maintain troubled characterisations of the role of the teacher in their own settings. Limited training often resulted in poor delivery, and threadbare support mechanisms, alongside significant constraints often developed from well-publicised service provision pressures. These can appear more challenging when combined with what interviewees often suggest to be unsupported professional and systemic expectations to teach. It can therefore appear problematic to reconcile concepts of esteem-enhancement through teaching, when existing social identities provide less confusion (Hogg 2023).

5.8 Teaching as a Resource for the Future

The previous section focussed upon *change* in considering how the interviewees' conceptualisations of teaching in their healthcare specialities developed over the three years of research to encompass its much broader applications. In this section I return for the last time to the second component of RQ2, *what are the influences that contribute to the interviewees' resulting identities?* I argue that whilst teaching appears subjugated to clinical practice, by enhancing both *clinical* careers and *clinical* capabilities, this may not be the intention of some of the interviewees for later stages of their careers. It is my contention that for these participants, the processes of social categorisation and consequent social identification are *paused*. They sit within a *liminal space*, ready for the time most suitable for their future investment on education within healthcare to be considered. Teaching consequently appearing for some as a helpful resource for the future.

For several of the interviewees, the potential for a transition to formal and explicitly separate roles in education was still being considered. However, the time frame for this was often much later in their clinical career.

Andrea was one of a few who identified this longer-term plan to integrate education in the later stages of their career explicitly within their first interview in 2019:

> I'm hoping in five years I'll be a [specialty removed] registrar so that will be a time when I can I think maybe develop my teaching skills further, the aim to then become a consultant, which will probably be the biggest challenge at that stage, and then once I'm a consultant to then get into a… getting involved in teaching at high levels. (Andrea, 21-30, medical doctor of 2 years, #1)

In Andrea's third interview three years later, this plan became more manifest and again saw education as a resource. Whilst she now had developed her teaching experience, it was important for her to focus on the clinical requirements of her healthcare specialty in order to progress. However, the intention to incorporate teaching within a later and more senior role was still present:

> I do want to do teaching longer-term anyway, but I'd have to then refocus to get to my ultimate goal [which] would be the [specialty removed], you know, registrar, and then consultant, I'd have to then [address] sort of other aspects of my CV essentially to achieve that, so now I… I'm just starting to reintroduce teaching. (Andrea, 21-30, medical doctor of 2 years, #3)

Andrea was also confident that the later career stage would be when teaching developed for many of her fellow cohort:

> I suspect if you did do a follow up interview in five or six years when people were consultants, you would find a lot of them are doing teaching. You know, one or two days a week. (Andrea, 21-30, medical doctor of 2 years, #3)

Andrea presents that her (and others') ability to develop teaching beyond the integration of its usefulness to clinical practice, is dependent on access to more

senior clinical roles. Success in one social identity may appear to lead to access to another (Serpe and Stryker 1987; Stryker and Burke 2000).

For most others, it was the second series of interviews, 18-months after their first, where the potential for education within the mid to longer-term began to appear within their responses.

Odette, already an experienced clinical practitioner, had begun to consider some more significant and senior roles with a teaching remit:

> Moving forward I don't see myself being a GP for the next ten years at the number of hours I'm currently doing. So part of this is about creating and crafting another role for myself, I suppose, that either will sit alongside or perhaps in time might become the predominant role. So I guess it's creating a niche to step away from that clinical patient management role into something more strategic…maybe become a training programme director. Probably I still think I might want to do that at some point…I think in the long term I probably will apply in a year or two when it comes up next. (Odette, 41-50, GP of 25 years, #2)

Odette's third interview revealed an uneasiness with the way her teaching within the workplace had been supported. Workload allocation and funding benefitted clinical but not educational practice. She outlined that a new role was consequently likely for her, and with the intention that it be able to incorporate education within it:

> But I have got a new post…and I will probably be building a role teaching within that, but… but it will be more peer teaching. (Odette, 41-50, GP of 25 years, #3)

She was however very clear on the counter-intuitive nature[10] of developing a teaching role in healthcare once a practitioner had become more experienced:

[10] This may appear resonant with perspectives on Human Capital Theory, and yet also prove one of Tan's suggested flaws of this theory in offering evidence that individual reward may not always motivate in areas such as educational ambitions (Tan 2014).

> Obviously teaching, in general, is paid less, but within our profession, you're expected to be more qualified to be teaching, but then to do the teaching, you take a pay cut…Yeah. Work harder, be more experienced, get paid less…It's bonkers. Yeah. So, that's really disappointing. (Odette, 41-50, GP of 25 years, #3)

Like Andrea, for Odette the access to social identification processes appears dependent also on obtaining appropriate healthcare roles offering a gateway to other choices. However, here the context also draws upon the limited consideration of esteem for educators within healthcare (Sabel and Archer 2014; Jauregui et al 2019). Despite suggesting that differing healthcare professions can view HPE roles differently in terms of status, Church et al (2024) additionally observe the presence of a *liminal space* for HPE teachers, although in contrast to this research, they studied full-time HPE teachers who no longer practised clinically. They present *their* liminal state as involuntary and often driven by the physical or organisational changes of an occupational setting.

Odette believes the role of education offers value and yet feels that this was not seen by clinical colleagues and thus influenced the decisions she made. In Van den Broek et al (2020) there appears some support, as whilst not rejecting notions of esteem enhancement in identification within healthcare, they place emphasis on the importance of responsibility, successful performance and positive interactions (with colleagues, patients and potentially students) as contributing to a sense of belonging or identification in contexts such as Odette's. However, and in contrast to this research, they (Van den Broek et al 2020) focus only upon the positive aspects of social identification, rather than as here, I directly investigate where such as the lack of esteem that Odette suggests, inhibits in-group identification as teachers.

For Heidi, similarly to Andrea earlier, the clinical focus appears central to future ambition, although her second interview began to reveal the inclusion of education within her longer-term plans.

> I haven't ruled out doing another teaching assigned job, down the line as a more senior doctor. I haven't made any sort of active, current plans to do anything formal, such as a diploma, just because my… my focus is elsewhere at the moment, but I am very keen to kind of keep doing education as and when I can, and I have been trying to actively seek out opportunities for it, with a view to that being part of my career ongoing. (Heidi, 21-30, medical doctor of 2 years, #2)

Heidi's further consideration of teaching at a later point in her career reappears in her third interview. It becomes framed as the opportunity of diversity of experience, but only once she had established seniority within her clinical specialty:

> I kind of sort of see that as not… not the finished product. So, like I… you know, as you said, wanting to have more variety in various roles. As time goes on, actually maybe doing a bit less clinical, a bit more teaching, is something that I'd be really interested in. And I know there are roles including that, so I'd hope to maybe apply to one of those in the future. (Heidi, 21-30, medical doctor of 2 years, #3)

For Odette and Andrea, other roles become the catalyst to allow consideration of education as a distinct entity. However, for Heidi, whilst it is senior roles which may offer access, she presents this more as the manifestation of conquering her own clinically-focussed challenges, before a willingness to engage with education more explicitly could be considered.

Like Odette, Andrea and Heidi, Amanda also makes the connection between seniority within clinical roles and the inclusion of education within future roles. These appear within her second interview:

> I'd love to have a consultant place with some allotted time to teach medical students or help in the curriculum in some sense, perhaps even lecture

> formally. So that's something I definitely want to strive towards, and doctors are a bit more complicated by the fact that you're kind of expected to do research and other things, but yeah, I think it's definitely something I want to aim towards. (Amanda, 21-30, medical doctor of 3 years, #2)

By Amanda's third interview, there was reflection upon why teaching would take a greater place in the explicitly more senior part of her healthcare career:

> …early on in our careers, it's not something that maybe you feel well equipped to do. You feel like you should be getting taught, you know, quite often, and I don't think it's necessarily something that, you know, stands out to you so you don't really reflect on what that means or what that entails in your role. But I think the more you progress, the more exposure you have to teaching, the more you see it, you know, and maybe I think it manifested in ways that weren't so overt. (Amanda, 21-30, medical doctor of 3 years, #3)

In contrast to Heidi who sought to engage with the challenges of a clinical specialty before progressing to education, Amanda suggests that teaching as a distinct practice, benefits from aligning the knowledge that seniority and clinical experience can bring. It is expertise in healthcare that provides the contingent factor (Turner and Reynolds 2012; Turner and Oakes 1986).

Within this section, the notion of *contingent* future actions is introduced. I return to my assertion of the presence of a *liminal space* where amongst these interviewees there is a delaying of an identification process. There is no immediacy to make significant choices toward new social identities, because as Brewer (1999) notes of the social identification process, it is a *deliberate* rather than instinctive choice. The varied factors considered by these interviewees appear as contingent for progression to social categorisation and identification mechanisms. Specific *clinical* roles are chosen as marker points that will trigger potential decisions based on where they may position the interviewee consequently. However, it remains that contexts such as resources available, personal challenge and clinical experience sit as the

underlying rationales for these interviewees' pauses in action. Their future identities can be varied dependent on the context and in allowing for multiple social identities to co-exist (Turner and Reynolds 2012; Turner and Oakes 1986). This is therefore perhaps *delaying* and not explicitly preventing new social identities from emerging.

Whilst there are some early interview examples of dissatisfaction with clinical practice in this research (4.6), I find a lack of explicit examples amongst these interviewees of Church et al's (2024) suggestion, that those who choose to become HPE educators as a replacement of their clinical work, very frequently do so to use their clinical expertise to develop future clinicians. As will be seen from the final section below (5.9), the motivations to teach uncovered within this research appear through the lens of social identities.

The following final section seeks to draw together the components presented within this chapter in addressing both parts one and two of RQ2. It discusses what has changed in terms of the interviewees' social identities and specifically how this was influenced. This will consequently explicitly seek to highlight the distinctive contributions of this work in adding to the relevant body of knowledge.

5.9 Conclusion

This chapter has sought to discuss RQ2's two components of *What happens to healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare?* and *What are the influences that contribute to the subsequent identities displayed?*

From initially considering the explicit and implicit motivations of the interviewees to join a programme of study for educators within healthcare, there appears over time a transformation in these interviewees' perspectives. Many initially present their desires to serve or support their healthcare communities or in-groups. Yet over more than three years, the presentation of their *espoused* motivations change. These motivations emerged as increasing similarity to UK colleagues, demonstrating capability to experienced peers, reducing pressures of clinical practice, and explicit healthcare career advancement.

The projection of the self to in-groups remains, yet it is the apparent motivation that changes. In this way, my work contrasts with Van Schaik et al's (2016) determination that within healthcare, identities harden with time and experience. I find it is instead with these interviewees that *re-considerations* are observed. My argument is that whilst social identities remain embedded *within healthcare* for these practitioners, their perceptions of those social identities, and their own place within them appears to *refine* over time.

Goffman's (1959) presentation of the self as an explicitly considered outward identity, yet again resonates here. Whilst pre-dating SIT concepts, and at times considered inappropriate in applying to widely disparate contexts, it nonetheless remains a foundation of many identities theories today (Jenkins 2008). Indeed, SIT's own deliberation of the extent to which the individual will adjust behaviours dependent on relative values placed upon in-groups is considered both longstanding and current (Reimer et al 2022). Yet this draws criticisms in SIT's apparent ignorance of agency and its diminution of personal identity (Brown 2022). However, I find within this research, that there are just such portrayals of interviewees *adjusting* themselves to toward the expectations of their chosen healthcare group.

In several interviews, there was also the presentation of explicitly chosen *points of distinctiveness* (Burford 2012). These were used to contrast themselves favourably with those who sought teaching solely for their own explicit healthcare career advancement or those who sought to escape the pressure of clinical practice. This may appear as disdain by those who are teaching to *repay the value of their own healthcare education* received (Steinert and Macdonald 2015). It can also present as those who wish to enhance future practitioner competence (Macleod 2011) or shape *appropriate* future healthcare identities (Kerrins 2020; Simpson et al 2018), although neither was offered by interviewees explicitly. Within this research however, it sits more as a *positioning* (Cote 1996) within explicitly the same social identity in-group, in doing so using their close compliance with in-group expectations to denote a status within it (Brown 2000). There is the application of specific well-chosen points of comparison to denote points of difference to others (van den Broek 2020). This supports those that suggest clinical practitioners are unlikely to explicitly seize the identities of educators within healthcare, when they are often perceived as lesser valued (Browne et al 2018; Bartle and Thistlethwaite 2014; Sabel and Archer 2014).

I highlight that the later series of interviews in this research provide examples of in-group *positioning* that offers intra-group status. Here, I sit in contrast to Burford (2012a), who suggest such comparisons amongst the in-group are the need for a *reassurance* of own suitability and place within the in-group identified.

There emerges a change in these interviewees' notions of *good teaching*. It narrows toward the clinical context and the practitioner in-situ, whilst simplistically disregarding potential complexities or intersections (Bochatay et al 2022). This supports those that suggest many entrant practitioners (to teaching) are unaware of what being an educator within the healthcare context entails (Bartle and

Thistlethwaite 2014). Additionally, there develops over time an often-common view amongst the interviewees of the teacher as *indistinct* from the clinical practitioner (Steinert 2012). The view that teaching is *just expected* of those in healthcare (Bastable et al 2019). Because of attendance on a programme to become teachers within healthcare, I present that the *liminal space* between teacher and clinician becomes visible, albeit with the quality of practice of one being seen as dependent on the quality of practice of the other. They are interdependent, but often indistinguishable through the interviewees' initial opacity in educator identities.

As these interviewees change their views on teaching specifically within their own profession, their realisations over time appear to uncloak a clearer perception supportive of those that suggest role-modelling on-going learning and behaviours for students is the future of the educator within healthcare (Simpson et al 2018; Kerrins et al 2022). Settings appear where the intentional application of teaching concepts had gone previously unnoticed. These are now unveiled because of the insights formed through learning to teach more broadly i.e. participation in the MHPE programme *and* the consequent experiences upon which they reflect. This latter point appearing as observations that are what Eraut (1994) describes as *non-formal* learning. These interviewees determined their own path toward such a notion using the 'social contextual perspectives' that their own teaching experience offered (Mount et al 2022 p.102).

It is changes such as these, that appear at odds with the proposition of *increasing* rigidity of identities over time. I do not observe the *hardening* that Bochatay et al (2022) suggest emerges within healthcare as clinical specialties are pursued and invested in. Indeed, it is the displayed commonality I find across these interviewees in their later perceptions of teaching within healthcare, that I propose appears equally

contrary to those who suggest that difficulties in defining *the educator within healthcare,* emerge from the explicitly varied influences of its diverse specialties (Cantillon et al 2016; Mount et al 2022).

Perceptions run throughout the chapter. The perceptions these interviewees sought in presenting themselves to others, to maintain or enhance in-group acceptance (Tajfel 1974; Fearon 1999; Hogg 2007). There are also those unclear initial perceptions of what teachers *are* and *do* within healthcare. Finally, the perceptions of where teaching has been located within their healthcare contexts, at times suggesting educational practice appears as reductive of their self-concepts amongst wider healthcare practitioners (Sabel and Archer 2014; Jauregui et al 2019). These additionally developed over time toward ideas that positioned education as the *useful tool* of the clinician (Bastable et al 2019), enhancing their practice in numerous ways (Sabel and Archer 2014). Yet these emerge as perceptions that combined initially entrench these new teaching practitioners to social identities where they feel most secure, whilst avoiding those (such as teaching), that are laden with confusion (Hogg 2023). It appears with the additional realisation of contemporary constraints on these interviewees. Constraints such as the systemic assumptions that practitioners have *both* available resources *and* inherent capabilities to teach, regardless of the pandemic's practical implications upon their workplace (Gawne et al 2020). This then feeds the considerations from such as Andrea, Odette, Heidi and Amanda, that more *formal* teaching roles would only be desirable once a level of clinical seniority and control had been obtained. But equally I present this work as rejecting Pecukonis et al's (2014) determination that such clinical identities are impermeable to the absorption of the components of others. In this research, there appear examples of

interviewees' seemingly intuitively integrating these within those previously identified liminal spaces (5.6).

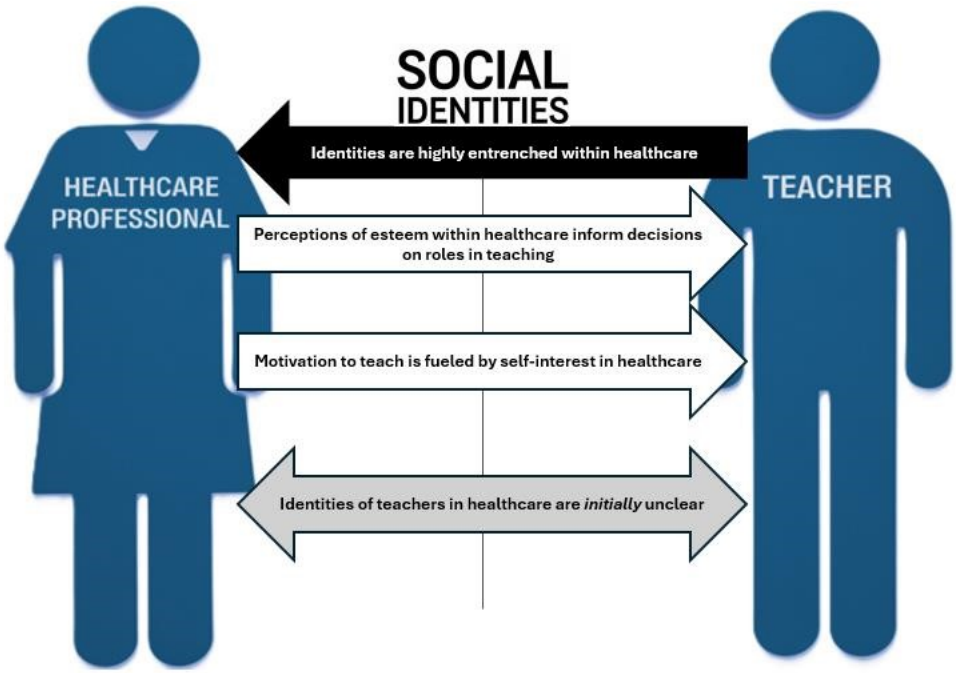
These revelations support my assertion that the interviewees had not fully understood the scope of *the teacher* or *teaching within healthcare*. Their awareness of broader examples emerged only after experiences and their prompted reflections upon them. The initially espoused and then subsequently *differing* unveiled motivations demonstrate a focus on the clinical and not the educational. This is unsurprising now, given the embedded nature of healthcare identities identified in the previous chapter. Additionally, when allied to the expressed challenges in attitudes of peers, systemic or situational constraints, and the expectation of all practitioners to teach, little evidence appears of initial or subsequent intentions to traverse social identities. Consequently, I no longer offer a consideration of the *changes* in identities, but instead present a demonstration of how these interviewees wished to be perceived, albeit within those identities that they arrived with.

Chapter Six – Conclusion

In this chapter I connect the aims of the research and its research questions to significant themes drawn from the data, consequently presenting conclusions for their implications for both HPE and MHPE context and practice and discussing my contributions to the field. The development of the research design is unpacked, exploring the limitations it presents. The chapter concludes with the implications for future research.

As can be seen in *Figure 4*, the significant outcomes in addressing the research are highlighted and these will be unpacked further within the following sections.

Figure 4 **-** Key outcomes addressing the research questions



6.1 Considering the Aims of the Research

In Section 1.1 when introducing the wider context of this research, I stated that 'this study is about those who seek the ability to advance education within healthcare'. It is upon them and for them that this focus remains. I sought to understand the motivations of healthcare practitioners in learning to teach within their profession. Identifying the purposes of these students' learning and their likely applications subsequently. That this may inform improvements to *student*-teacher recruitment, curricula, delivery and assessment within the burgeoning landscape of MHPE programmes.

Notably, this research's contribution also became explicitly atypical, with the interruption by a pandemic unforeseen at its initiation. COVID-19 was an on-going event affecting all disciplines within the healthcare landscape that this study spans.

The first research question is set as: *What are the perceptions of teaching identities amongst healthcare professionals on an award-bearing course in teacher education in healthcare?* This sought to explore how teaching and teachers were perceived and specifically within healthcare by these initiates to educational practice. I considered their motivating factors for entering healthcare, with those they *espoused* for learning to teach within it.

In addressing this, it is helpful to recall that I previously presented HPE as having enjoyed over 70 years of expansion globally, whilst becoming a singular discipline of study from which master's-level programmes (for its educators) have grown twenty-fold in just two decades. It is despite such longstanding heritage, that this research initially contributes to the previously identified and contemporary challenge of *educator roles within healthcare still remaining poorly defined* (see 1.1 and *Figures 1,*

2 and *4*). It does so in revealing the difficulties this initially presents for these entrants to an MHPE programme. I highlight the resulting struggle for participants to robustly form a teaching identity, instead this opacity leaves them to integrate teaching as *within* their clinical work. Consequently, I present that this brought a focus to teaching as one of Eraut's (1994) *non-formal* skills and as such drew the interviewees further away from teaching as a distinct identity

It is unsurprising that Chapter Four unveiled the entrenched nature of original identities within healthcare (see *Figure 4*), formed for these interviewees in adolescence, often with support from family role models (4.2). Their identification processes rooted them amongst healthcare in-groups exhibiting shared-purpose and similarity (4.3). This contrasted with initial difficulties amongst interviewees in defining the teacher within healthcare (4.4, 5.5), albeit with some clarity subsequently and pellucidly emerging from epistemologically constructivist 'meaning-making process[es]' (Krahenbuhl 2016 p.100). Here their context of healthcare joined with the development of acquired teaching and learning concepts and consequent experiences. The resulting determinations of the teacher within healthcare often appeared as the role-model offered by a *clinical* practitioner (4.5, 4.6, 5.5).

These outcomes underline the extent to which healthcare concepts inform these interviewees' perceptions of teaching identities. However, I propose this develops upon the previously noted impact of unclear teaching identities within this explicit context, by offering an example of why this lack of clarity can exist. I present their *entrenchment* within healthcare as explaining *why* they predominantly appeared not to hold explicit perceptions of the teacher. The concept was neither considered sufficiently important (e.g. to expect a level of study higher than most had previously undertaken in healthcare), nor was it considered sufficiently different to investigate

the professional expectations it may hold. That nine of the initial sample of ten presented clinical practitioners as *teacher exemplars*, identifies where and perhaps when such perceptions are formed.

The notions of care that were embedded amongst the healthcare professions identified within Chapter Two, aligned with the participants' expressed concepts of *good teaching*. A key finding here is offered as the interviewees' replacement of their patients for their students. Similarly, the expected process of becoming a teacher replicates the functional *structure and process* model interviewees had always experienced within healthcare. However, for several, the expectations of teaching practice appeared attractively distanced from their demanding clinical practitioner roles, albeit offset against an expected diminished status amongst peers.

In developing the above, as Mount et al (2022) would suggest, these interviewees had *formed their own paths* in defining good teaching practice and the role of the teacher within healthcare. At this initial stage, Van den Broek's (2020) *points of comparison* as markers for in-group determination are as yet only minimally informed, thus encouraging the interviewees' reliance on their longstanding healthcare experiences. It is therefore unsurprising that as Hogg (2023) determines, with such a greater the level of uncertainty, the more deeply one retreats into those single social identities that appear to offer safety. These healthcare practitioners were unable to perceive beyond that which they knew upon entering their programme of study.

The second research question discussed below, considers in what way becoming informed through experiences of study in education adjusts these perspectives.

There are two components of the second research question: (a.) *What happens to these healthcare professionals' identities as a result of participation in a programme of study to become educators within healthcare?* (b.) *What are the influences that contribute to the subsequent identities presented?* Both questions steer toward an observation of change, seeking expressions of movement within espoused identification, whilst also pursuing causation. I offer that a significant contribution of this investigation is its *longitudinal* approach . This allows both the examination of *change* in identities over time and presents a unique aspect of this research within its context. Whilst consideration of identities within HPE exists and presents outcomes in similar settings, explicit observations of identities' *transitions* in this context is both challenging to locate and highly nuanced.

I propose that whilst much is offered on SIT as it relates to *inter-group* behaviours, an inquiry such as this research, within *intra-group* positioning and particularly in the context of HPE is sadly solitary. I follow the notions of esteem, foundational within Social Identity Theory, and note as they appear to manoeuvre newly acquired capabilities in teaching to support in-group positionality within expressly *clinical* practitioner in-groups (5.2, 5.3). The distinctiveness of the teacher held in subjugation to the clinical role, constrained by systemic expectations that *all should teach* mixes with realities of some that do not (5.2, 5.3). This forms a marker for difference, but *within* the in-group membership.

Interestingly, but perhaps less remarkably, it is shown here that for those that can teach, clinical opportunities can also arise through a broader range of future roles available. Where individuals emerge favourably by contrasting with non-teaching peers in a crowded clinical career landscape (5.4). Additionally, whilst the stressors

of clinical practice may appear reduced when substituted with education (4.7), the opportunities of more senior clinical roles with *protected time* for education additionally unveil as considerations for the future (5.4).

In returning to the unexamined *within* healthcare in-groups, I propose that positions within them of my interviewees can appear strengthened and emboldened by the experiential unveiling of the role of teacher and how well it integrates within that of the clinician (5.5). This symbiosis aids concepts of self-esteem and distinctiveness, through enhanced clinical practice (5.6). See *Figure 4* that identifies this self-interest within healthcare as a motivation to teach and the effect of esteem concepts determining how teaching is applied.

There is awareness too of the challenges facing those that teach within healthcare. These manifest for some in a structural scarceness of time allocated to education, amidst workplaces already stretched before the pandemic. For others it remains healthcare's often unfulfilled expectation that *everyone can and will teach* (5.7) or the perceived status diminution of those taking educational roles (4.7). Despite these perspectives, and with no interviewee subsequently holding a *formalised* role within education three years after completing their teaching qualification, education still remains within the *future* field of view for some albeit this too appears contingent upon seniority within healthcare (5.8). I consequently propose that these interviewees demonstrate a previously unobserved *conditionality* in their approach to the social identities that may be taken explicitly as healthcare practitioners or educators within healthcare.

In addressing RQ2's needs to identify and attribute change, I begin by applying the concept of liminality[11], which Turner (1987 p.4) helpfully positions with the perspective that 'If our basic model of society is that of a 'structure of positions', we must regard the period of margin or 'liminality' as an inter-structural situation. It is this *inter-structural* situation that can be observed amongst many of the interviewees. The expectation of change between social identities I have previously dismissed, and yet movement has occurred. The experiences founded by acquired capabilities to teach within healthcare have developed notions of esteem and self, in-group positionality and opportunities for self-protection, alongside an awareness amongst interviewees of transmutation. Yet, Turner's (1987 p.4) application of the concept of 'state' as being a *fixed* condition offering stability cannot yet apply. These interviewees' processes of individuation remain undone, despite a progression of three years, their plans for the future are not yet complete and experiences in the contemporary setting of the healthcare workplace are still to emerge. Their work is unfinished and whilst seeking to avoid the perceived *Point A to Point B* binary constraints of some liminal views (Banfield 2022), more is yet to come. I therefore present my assertion of *liminality* in this context as that space where participants are not immediate in their transition of identities within this setting. That there is an as yet undiscussed process within it of *deliberation* rather than *instinct*. Considerations by the interviewees of formal educational roles within healthcare appear to balance with conditions of clinical advancement.

However, the second component of RQ2 encourages a *what makes it happen?* resolution. The data clearly presents examples of change. This key finding emerges

[11] For an extensive and helpful discussion of the evolution of the concept from van Gennep to Turner and beyond see Babcock (2001).

in interviewees' presenting themselves as the *clinical practitioners* that can and do teach. It offers a *positive distinctiveness* amongst those within their most salient in-group. However, there is balance applied here, as the concept of educator that is *also a clinician* can suggest risk to self-concepts of status. This more formalised role of educator can still become acceptable, but only once a *clinical* seniority is attained. I return to Goffman (1959) in seeing these as considered identities being presented to their world. Brown (2000) is also supportive in presenting SIT as founded upon our human need for meaning and consequent reduction of uncertainty, whilst enhancing our self-esteem. Interviewees had initially made their own meaning within teaching and teacher concepts but doing so from the safety of a standpoint of healthcare. As their experiences develop and new meanings emerge, satisfactory images of the self are still determined by others (Brewer 1991; Deaux 1993; Fearon 1999; Brown 2000), but now there appears control upon how they may find position amongst them (Cote 1996).

In finally drawing together the components of this work, I can present my explicit contribution here. This research offers initially a novel insight into the established challenge for HPE students of the *poorly-defined* roles for the educator. That this uncertainty consequently draws them toward a view of the educator as a subsummation of the clinician's role appears clear. However, I argue that the HPE teacher role can lack this definition because of the entrenchment of clinicians within long-held healthcare identities and their consequent dismissal of the *otherness* of the educator in this context.

Peculiarly, the removal of a sense of difference between educator and healthcare practitioner in this setting appears, in part at least, to also be a consequence of the quest for *sameness* (to clinical practice) that entrants to HPE can seek. The

replacement of *the patient*, upon which most healthcare vocations pivot their identities (see 2.5), with *the student*. This appears alongside the expectation of their own development as HPE students in following an identical path to that observed in healthcare generally (*theory and structure* as identified in 4.6).

In contrast to much that has been offered on the diminution of status of the educator within healthcare when compared to their practitioner colleagues (see 2.6.2). I offer that this research presents a perspective where education, or more specifically the ability to educate, enables the clinician to *enhance* their status within their healthcare in-group (see 5.2 and 5.4), albeit whilst ensuring an avoidance of the distinction of being *primarily* an educator.

Finally, I present an application of the concept of *liminality* in the context of social identities within HPE. Unlike others, I remove the often-binary expectation of *yes* or *no* in terms of social identities. Instead finding the *liminal* space where such decisions on identities are deliberative, conditional and may span several years before their outcomes manifest.

6.2 Implications for Health Professions Education

The research and its questions centre upon identities, it is here that its application emerges most strongly. For many, the concept of an educator and particularly one within healthcare appear unclear from the outset. Over time, the value of experiences within and consequent to their MHPE programme encouraged unexpected reflections on the resulting enhancement to their clinical practice and careers.

As outlined in 1.1, HPE faces challenges reflective of its healthcare context, with increased demand and complexity whilst seeking to recover from the impact of the global pandemic. A greater focus upon diversity amongst the health professions workforce is now incumbent upon MHPE programmes. As Woolf et al (2023) may suggest, they need to ensure cognisance of the considerable diversity amongst those that seek to become health professions educators. Equally, that their curricula give greater emphasis toward the broad spectrum of those that their students will themselves teach. This must include those 1 in 6 from overseas (Kmietowicz 2023), for whom teaching and learning within healthcare may have significantly different connotations, and for whom English is perhaps not a first language.

In the populous discipline of medicine, the expectation of a doubling of UK student numbers by 2031 (NHS 2024) appears an exemplar challenge. The recruitment here of greater numbers of educators, alongside changes in the approaches taken to teaching what will soon be double the current number of medical students, within already crowded teaching hospitals, demands action for this reason alone. The perceptions of the educator must therefore be managed positively to attract more of those who are willing to commit to education within healthcare.

An enunciation with greater clarity of the role of the educator within healthcare must be developed. The constraints of formal ‘teaching’ need to be unwound to address expectations of more practical and theoretically-informed role-modelling in clinical settings. This offers an application that will extract greater value and efficacy within workplace-based learning environments. MHPE programmes may themselves now consider clearer segmentation of their student offer. A policy implication that suggests the insertion of the category of healthcare professional *desirous* of the ability to teach but *loathe* to advance beyond it supporting their clinical practice. Do

MHPE programmes wish to support educators *who are also clinicians* or predominantly focus upon clinicians *who also educate*? This may also include earlier awareness and recruitment for HPE amongst undergraduate health professions students. Therefore, a greater and more explicit visibility of MHPE practitioners within the undergraduate curricula, to develop the notion of *clinician as teacher* appears relevant and supportive.

It is here that the contribution of this work, in terms of informing practice, becomes clearest. MHPE programmes must now develop a focus on the explicit *application* of their students' acquired knowledge and ability within healthcare. This can consequently inform specific programmes that address the needs of workplace-based learning within clinical contexts and do so separately to the differing needs of the more *formalised* settings often found within tertiary education. This must lead to the removal of a seemingly *one-sized* approach to HPE qualifications, that despite broad variations amongst MHPE programmes, still rarely differentiate on the context and use of their qualifications' outcomes. Of the final six participants in this study, not one held a formal teaching role over two years *after completion* of their teaching qualification. However, all were able to describe on-going opportunities to enhance their own clinical practice and in developing learning amongst others that they encountered in the healthcare workplace. It is upon this that forward-looking programmes of study must capitalise. The notion of education feeding into healthcare identities and enhancing clinical practice, may appear in new and importantly *homogenous* HPE qualifications, ones that are clearly understood by both employers and students alike. With a greater understanding as to how such qualifications are used, their focus can become centred toward the contexts of teaching to be undertaken e.g. primary or secondary care settings within the NHS,

rural veterinary or dental surgery. Thus, recognising that the specific ambitions of many HPE students may remain primarily within clinical practice, but that this may not always be the case.

6.3 Reflections on the Research Approach and its Limitations

I remain amongst those whom Crotty (2015) describes as *constructionist,* in that I neither sought nor acquired an objective truth from within this study. I was however fortunate to engage with these research subjects over three tumultuous and unprecedented years within healthcare. These interviewees consequently present Bryman's (2012) created social phenomena writ large, in that they appear to build and present their landscape of education as it has evolved over the three years of the study. Although the concerns around such bounded case-studies' inability to offer generalisation can be overcome, it must be through seeing this work as a contribution amongst multiple sources of evidence (Yin 2009). These are yet to emerge for HPE practice (Newman 2024), acknowledging that this was turbulent time for researchers (Sala-Bubaré 2024). However, when considering the unanticipated changes to the lives and workplaces of these healthcare practitioners resulting from Covid-19, a subsequent replication of the study (Merken 2004) seems unlikely. Yet through the application of SIT, broad contexts can be observed and aligned to those of other MHPE programmes where similarity appears within in-groups chosen, esteem concepts considered, and in-group positioning observed. Using homogenous frameworks to identify in-groups, whilst presenting standardised approaches in calculating levels of salience with identities, are just two examples where the broad church of MHPE providers can seek to calibrate common

approaches in identifying and delivering support that addresses their students' needs.

My concerns of insider research led to an abundance of documentation to demonstrate both rigour and impartiality (Brannick and Couglan 2007). Yet interviewees expressed at times their appreciation of discussing and perhaps *sense-making* with someone sufficiently distant (from healthcare), yet also sufficiently informed (on their studies). This epitomised a suggested balance of strangeness and familiarity (Flick 2014) and more explicitly my challenge of 'making the familiar strange rather than the strange familiar' (Van Maanen 1995 p.20).

The research design's evolution offered an unexpected advantage. I initially only planned pre-entry and post-exit interviews, the inclusion of an unsuccessful online questionnaire (n=5) followed an initially lower-than-anticipated first interview sample (n=10). This, alongside a reduced participation in the planned second interviews (n=7), encouraged the execution of third and final interviews (n=6), these completing three years and five months after the first. This became representative of Seidman's (1991) suggested exploration of interviewees' explicit reflections on their several prior interviews' development, but also notably occurring when Covid-19 adjustments in healthcare environments had reduced significantly. It provided opportunity to address a gap within existing literature (Sethi et al 2018), through exploring more extensively the development of social identities of educators within healthcare *over time*, amidst realisations that are only now emerging post-pandemic.

The initial interview sample of nine from medicine and one from veterinary disciplines whilst only anecdotally reflective of the overall composition of the programme's student intake that year (n=120), was however reflective of both gender and ethnicity ratios amongst that year's postgraduate taught student landscape (HESA 2023).

This case study, as Yin (2009) suggested, is intentionally bounded within time (2019 to 2023). As already noted within 6.3, the appearance of a global pandemic some six months after the initial interviews presents the challenges of both generalisability and replication. As considered in Chapter 3, the initial sample, whilst consistent, is small and reduces over time. Being 90% from medicine, the sample lacks diversity within the broad spectrum of healthcare professions.

This limitation suggests the requirement for further reflection upon the challenges in recruiting participants from the healthcare professions, even before Covid-19. The difficulties of attracting participants to research conducted *by* healthcare professionals is acknowledged and addressed by supportive researcher frameworks such as *The Cochrane Protocol* (Preston et al 2012). However, reviews of research *within* the healthcare professions note frequent difficulties in attracting participants also. Those reasons cited are a lack of time, overly long surveys or a discomfort or disinterest in the topics being addressed (Suhonen et al 2015; Browne et al 2022). Bruneau et al (2021) suggest a fundamental shift is required in the recruitment of healthcare professionals. They suggest being clearer in presenting expectations, whilst doing so in an enticing way. Additionally, offering greater support in such as participant training, amidst finding ways to make *joining in* logistically simpler. These recommendations appear in much the same way as the already-noted Cochrane Protocol for non-healthcare professionals. However, Bruneau et al (2021) further present the importance of reaching out to potential candidates both physically and emotionally. Similarly, a greater use of healthcare professionals' own specific discipline's networks, has been considered by others as an opportunity to address the malaise toward engagement (Browne et al 2022).

Therefore, this sits in accordance with my assertion that the interviewees had initially only limited perspectives on education within the health professions, often struggling to see its presence within the workplace. My seeking to attract participants at the outset of their studies with an appeal around the value of such research in HPE, would then of course be challenging. As I could not rely on any specific profession's networks at this stage, an enhancement may have been to become not just even more explicit about why such research is important, but also engage in the personal benefits their participation may offer them, expanding upon how limited the requirements upon them should be.

The lack of diversity in age of the participants is also of note, seventy percent of the initial sample are aged 30 or younger. In healthcare one can find age and seniority acutely intertwined, thus career considerations may appear quite differently amongst older interviewees.

Indeed, the connection between age and seniority in healthcare is often taken as uncontested (Ravishankar Rao et al 2018). In some settings, such as online healthcare platforms, it has been proposed that the seniority of healthcare practitioners is perceived by patients predominantly in relation to a clinician's engagement frequency and their presentation of certainty (Jin et al 2025). Yet in the more common physical environments, there are longstanding connections between age and status, with older practitioners consequently holding more senior healthcare roles (Snashall 1997). Indeed, in some clinical settings, seniority is explicitly perceived as the length of service held (Lewaherilla et al 2024). Similarly, the appropriation of senior healthcare roles have previously and commonly been determined by qualifications that are earned over time, rather than through required competences being displayed (Decker 1999).

Eckhaus et al (2022), in employing *Upper Echelon Theory*, suggest that when clinical practitioners such as these interviewees become more senior, examples may become apparent of a movement to risk aversion in considering change or innovation. This often manifests with a focus on addressing the immediate need for treatment, rather than developing broader preventative measures. This may of course be balanced, in the context of education, with senior practitioners seeking to mentor those coming behind them and thus leaving a legacy (Thorpe and Loo 2003). However, as Rice et al (2022) suggest, attitudes of healthcare professionals toward their roles change over time. The latter often resulting in a greater need for stability and control within their environment, which may preclude the late-stage career divergences suggested by some of the interviewees. This may appear as what they say they *would* do in the future, and yet we have no certainty about this.

It must also be considered that these interviewees had joined only the certificate component (60 x L7 credits) of a MHPE. Those that commit to the entire Master's programme (180 credits) from the outset, may espouse differing motivations, expectations and applications of their qualification. This will manifest also in the students' consideration of teaching within healthcare as a full or part-time role. This is a contrast that Snook et al (2019) present as often overlooked, with their respective identities (full or part-time educators) being formed and managed by different social groups.

6.4 Recommendations for Future Research

Bochatay et al (2022) suggest that social identities within HPE are often viewed through the lens of just one identity at a time, arguably matching individual

healthcare professions' noted fixation with their own social identities (Roopnarine and Boeren 2020). Much may therefore be embraced with further study that clearly enunciates specificity through a more tightly matched interviewee sample. Sample cohorts might then offer comparisons between, for example, nurses in the NHS, dentistry and those in veterinary practice. Conversely, it may also consider the broad brush of generalisability by recruiting a greater breadth and number across the health professions and their demographics.

The previously noted scarcity of longitudinal research, particularly in HPE identities (1.1, 1.3, 2.6), encourages consideration of similar research being undertaken with student in-takes over several consecutive years. This offers investigation of change on a much broader scale. This may indicate adjustment amongst those that seek to enter MHPE programmes, alongside developments in their responses to that which they find when they get there. Clearly, and hopefully, these may also not include the *anomaly* of a global pandemic. However as 1.1 offers, the process of change for these interviewees is as yet unfinished, so we may find value in further inquiry amongst this specific sample.

Finally, we can seek a bridge across the idiosyncrasies of MHPE programmes (1.1), by undertaking similar comparative studies across many institutions, nations and regions. Such an opportunity may forge homogeneity positively, through greater and more structured dissemination of perspectives in this rapidly developing landscape.

References List

Aaltonen, S., 2016. ‘My mother thought upper secondary school was OK, but then my sibling said no’-Young People's Perceptions of the Involvement of Parents and Siblings in their Future Choices. *Sociological Research Online*, *21*(1), pp.65-76.

Albert, M., Laberge, S., Hodges, B.D., Regehr, G. and Lingard, L., 2008. Biomedical scientists' perception of the social sciences in health research. *Social Science & Medicine*, *66*(12), pp.2520-2531.

Alderwick, H., 2022. New government’s plan for health and social care in England. *BMJ*, *378*.

Alvesson, M., 2003. Methodology for close up studies: struggling with closeness and closure. *Higher Education*, pp.167-193.

Alvesson, M. and Willmott, H., 2002. Identity regulation as organizational control: Producing the appropriate individual. *Journal of Management Studies*, *39*(5), pp.619-644.

AMEE (2019). *Membership*. [online] Available at: https://amee.org/membership [Accessed: 18/7/19].

Amin, A. and Roberts, J., 2008. Knowing in action: Beyond communities of practice. *Research Policy*, *37*(2), pp.353-369.

Anderson, M., O'Neill, C., Clark, J.M., Street, A., Woods, M., Johnston-Webber, C., Charlesworth, A., Whyte, M., Foster, M., Majeed, A. and Pitchforth, E., 2021. Securing a sustainable and fit-for-purpose UK health and care workforce. *The Lancet*, *397*(10288), pp.1992-2011.

Anderson, M., Pitchforth, E., Asaria, M., Brayne, C., Casadei, B., Charlesworth, A., Coulter, A., Franklin, B.D., Donaldson, C., Drummond, M. and Dunnell, K., 2021(b). LSE–Lancet Commission on the future of the NHS: re-laying the foundations for an equitable and efficient health and care service after COVID-19. *The Lancet*, *397*(10288), pp.1915-1978.

Angen, MJ., 2000. Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*. 10(3) pp. 378-39.

AoME, 2024. About us. [online]. Available at https://medicaleducators.org/About-AoME [Accessed 9/2/24).

Apker, J., 2001. Role development in the managed care era: A case of hospital-based nursing. *Journal of Applied Communication Research*, 29, 117–136.

Apker, J., Propp, K.M. and Zabava Ford, W.S., 2005. Negotiating status and identity tensions in healthcare team interactions: An exploration of nurse role dialectics. *Journal of Applied Communication Research*, *33*(2), pp.93-115.

Archer E, van Schalkwyk S, Volschenk M, Schmutz A. 2022. Planned or emergent? An evaluation of a master’s in health professions education programme. *BMC Med Educ*. 22(1):242.

Armitage-Chan, E., 2020. ‘I wish I was someone else’: complexities in identity formation and professional wellbeing in veterinary surgeons. *Veterinary Record*, *187*(3), pp.113-113.

Arroyave, C.A. and Téllez, M., 2019. Patient-Physicians: Identities and Expertise Brought Into the Light of Diagnosis and Treatment. *Journal of Patient Experience, 7*, 245 - 250.

Artino AR Jr, Cervero RM, DeZee KJ, *et al.*: 2018. Graduate Programs in Health Professions Education: Preparing Academic Leaders for Future Challenges. *J Grad Med Educ.*10(2): 119–122.

Attenborough, J., Abbott, S., Brook, J. and Knight, R.A., 2019. Everywhere and nowhere: work-based learning in healthcare education. *Nurse Education in Practice*, *36*, pp.132-138.

Babcock, B.A. 2001. in Eds: Smelser, E and Baltes, P. *International Encyclopedia of the Social & Behavioral Sciences*: Pergamon, pp. 8862-8864.

Bailey, C., 1996. *A guide to field research*. London: Sage

Baker, L., Egan-Lee, E., Martimianakis, M.A. and Reeves, S., 2011. Relationships of power: implications for interprofessional education. *Journal of Interprofessional Care*, *25*(2), pp.98104.

Ball, S.J., Davies, J., David, M. and Reay, D., 2002. 'Classification'and'Judgement': social class and the 'cognitive structures' of choice of Higher Education. *British Journal of Sociology of Education*, *23*(1), pp.51-72.

Banfield, J., 2022. From liminal spaces to the spatialities of liminality. *Area*, *54*(4), pp.610617.

Barab, S. and Duffy, T., 2000. From practice fields to communities of practice. *Theoretical Foundations of Learning Environments*. 1. 25-55.

Bartle, E. and Thistlethwaite, J., 2014. Becoming a medical educator: motivation, socialisation and navigation. *BMC Medical Education*, *14*(1), p.110.

Bastable, S.B., Sopczyk, D., Gramet, P. and Jacobs, K., 2019. *Health professional as educator: principles of teaching and learning.* Sudbury: Jones & Bartlett Learning.

Baume, D., 2006. Towards the end of the last non-professions?. *International Journal for Academic Development*, *11*(1), pp.57-60.

Beauchamp, C. and Thomas, L. 2009. Understanding teacher identity: an overview of the issues in the literature and implications for teacher education. *Camb. J. Educ*. 39(2), pp.175189.

Bebeau, M.J. and Monson, V.E., 2012. Professional Identity Formation and Transformation Across the Life Span. In McKee, A. and Eraut, M. (Eds.) *Professional Learning Over the Life Span: Innovation and Change*. New York: Springer Publishing.

Bligh, J. and Brice, J., 2009. Further insights into the roles of the medical educator: the importance of scholarly management. *Academic Medicine*, *84*(8), pp.1161-1165.

Bochatay, N., Bajwa, N.M., Ju, M., Appelbaum, N.P. and van Schaik, S.M., 2022. Towards equitable learning environments for medical education: bias and the intersection of social identities. *Medical Mducation*, *56*(1), pp.82-90.

Bodey, D., 2024. Fostering belongingness: strategies to enhance learner retention in NHS healthcare education. *British Journal of Nursing*, *33*(6).

Bolt, D.M., Witte, T.H. and Lygo-Baker, S., 2010. The complex role of veterinary clinical teachers: how is their role perceived and what is expected of them?. *Journal of Veterinary Medical Education*, *37*(4), pp.388-394.

Bonetti, D., Young, L., Rennie, J. and Clarkson, J., 2008. Evaluating dental vocational training: how does Scotland compare to the rest of the UK?. *British Dental Journal*, *204*(4), p.195.

Boone, S., and Van Houtte, M., 2013. In Search of the Mechanisms Conducive to Class Differentials in Educational Choice: A Mixed Method Research. *The Sociological Review*, 61(3), pp.549–572.

Boulton, D. and Hammersley, M. in Sapsford, R. and Jupp, V. eds., 2011. *Data collection and analysis*. London: Sage, pp. 243-271

Bourdieu, P. and Richardson, J.G., 1986. Handbook of Theory and Research for the Sociology of Education. *The Forms of Capital*, *241*, p.258.

Braithwaite, J., Clay-Williams, R., Vecellio, E., Marks, D., Hooper, T., Westbrook, M., Westbrook, J., Blakely, B. and Ludlow, K. 2016. The basis of clinical tribalism, hierarchy and stereotyping: a laboratory-controlled teamwork experiment. *BMJ Open*, *6*(7).

Brante, T. 1988. Sociological approaches to the professions. *Acta Sociologica*, 31(2), pp.119142.

Brannick, T. and Coghlan, D., 2007. In defense of being “native”: The case for insider academic research. *Organizational Research Methods*, *10*(1), pp.59-74.

Brante, T. 1988. Sociological approaches to the professions. *Acta Sociologica*, 31(2), pp.119142.

Braun, V. and Clarke, V., 2013. *Successful qualitative research: A practical guide for beginners*. London: Sage.

Braun, V. and Clarke, V., 2014. What can “thematic analysis” offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*, 9:1, 26152.

Braun, V. and Clarke, V., 2022. Thematic analysis: A practical guide. London: Sage.

Breen, L., 2007. The researcher 'in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist*, *19*(1), pp.163-174.

Brewer, M.B. and Gardner, W., 1996. Who is this" We"? Levels of collective identity and self-representations. *Journal of Personality and Social Psychology*, *71*(1), p.83.

Brewer, M.B., 1991. The social self: On being the same and different at the same time. *Personality and Social Psychology Bulletin*, *17*(5), pp.475-482.

Brown, A.D., 2022. Identities in and around organizations: Towards an identity work perspective. *Human Relations*, *75*(7), pp.1205-1237.

Brown, A. and Dowling, P., 2001. *Doing research, reading research*. London: Routledge Falmer.

Brown, R., 2000. Social identity theory: Past achievements, current problems and future challenges. *European Journal of Social Psychology*, *30*(6), pp.745-778.

Brown, C. and Jones, L., 2004. The gender structure of the nursing hierarchy: the role of human capital. *Gender, Work & Organization*, *11*(1), pp.1-25.

Brown, R., 2000. Social identity theory: Past achievements, current problems and future challenges. *European Journal of Social Psychology*, *30*(6), pp.745-778.

Brown, R., 2020. The social identity approach: Appraising the Tajfellian legacy. *British Journal of Social Psychology*, *59*(1), pp.5-25.

Browne, S., Dooley, S., Geraghty, A., Castro, P.D., Reynolds, C., Perrotta, C., Kelly, L., McCallum, K., Clyne, B., Bradley, C. and Bury, G., 2022. Reflections on recruiting healthcare professionals as research participants: learning from the ONSPres Study. HRB Open Research, 5, p.47.

Brown, T. and Sorrell, J., 2017. Challenges of novice nurse educator's transition from practice to classroom. *Teaching and Learning in Nursing*, *12*(3), pp.207-211.

Browne, J., Cooper, N. and Bligh, J., 2011. Become recognised for your teaching. *Education for Primary Care*, *22*(2), pp.124-126.

Browne, J., Webb, K. and Bullock, A., 2018. Making the leap to medical education: a qualitative study of medical educators' experiences. *Medical Education*, *52*(2), pp.216-226.

Brubaker, R. and Cooper, F., 2000. Beyond “identity”. *Theory and Society*, *29*(1), pp.1-47.

Bryman, A., 2004. Social research methods, Oxon: Oxford University Press.

Bryman, A., 2012. *Social research methods* 4th ed. Oxon: Oxford University Press.

Bryman, A., 2016. *Social research methods*. Oxon: Oxford University Press.

Bucher, R. and Strauss, A., 1961. Professions in process. *American Journal of Sociology*, *66*(4), pp.325-334.

Buis, B.C., Ferguson, A.J. and Briscoe, J.P., 2019. Finding the “I” in “Team”: The role of groups in an individual's pursuit of calling. *Journal of Vocational Behavior*, *114*, pp.88-99.

Bulmer, M. 1979. Concepts in the Analysis of Qualitative Data. *The Sociological Review*, *27*(4), 651–677.

Bunniss, S. and Kelly, D.R., 2010. Research paradigms in medical education research. *Medical Education*, *44*(4), pp.358-366.

Burford B. 2012(a). Group processes in medical education: learning from social identity theory. *Medical Education*, 46, pp.143–152.

Burford, B., 2012. Conflict and power as intergroup processes: not below the surface, but part of the fabric. *Medical Education*, 46, Issue 9, pp.830-832.

Burford, B. and Rosenthal-Stott, H.E., 2017. First and second year medical students identify and self-stereotype more as doctors than as students: a questionnaire study. *BMC Medical Education*, *17*, pp.1-9.

Burke, P.J., 1980. The self: Measurement requirements from an interactionist perspective. *Social Psychology Quarterly*. Mar., pp.18-29.

Byrnes, M.K., 2022. Professional skills teaching within veterinary education and possible future directions. *Journal of Veterinary Medical Education*, *49*(6), pp.686-692.

Cabot, L.B., Patel, H.M. and Kinchin, I.M., 2007. Dental vocational training: identifying and developing trainer expertise. *British Dental Journal*, 203(6), pp.339-345.

Cake, M.A., Mansfield, C.F., McArthur, M.L., Zaki, S. and Matthew, S.M., 2019. An exploration of the career motivations stated by early-career veterinarians in Australia. *Journal of Veterinary Medical Education*, *46*(4), pp.545-554.

Campbell, C. 1993. Identity and Difference. *Agenda: Empowering Women for Gender Equity*, *19*, pp.45–63.

Campbell, C. M. 1995. The social identity of township youth: Social Identity Theory and gender (Part 2), *South African Journal of Psychology*, 25(3), pp.160–167.

Cantillon P., D'Eath M., De Grave W. and Dornan T., 2016. How do clinicians become teachers? A communities of practice perspective. *Advances in Health Sciences Education: Theory and Practice*. 5, pp. 911–1008.

Cantillon, P., Dornan, T. and De Grave, W., 2019. Becoming a clinical teacher: identity formation in context. *Academic Medicine*, *94*(10), pp.1610-1618.

Carr-Saunders, A.M. and Wilson, P.A., 1933. *Professions (The)*. Oxford: Clarenden Press.

Charmaz, K., 2008. *The SAGE Handbook of Social Research Methods*. London: SAGE.

Chen, H.C., Wamsley, M.A., Azzam, A., Julian, K., Irby, D.M. and O'Sullivan, P.S., 2017. The health professions education pathway: preparing students, residents, and fellows to become future educators. *Teaching and Learning in Medicine*, *29*(2), pp.216-227.

Chuenjitwongsa, S., Bullock, A. and Oliver, R.G., 2018. Roles and competences for educators of undergraduate dental students: a discussion paper. *European Journal of Dental Education, 22*, pp.47–56.

Chung, G.H. and Armitage-Chan, E., 2022. Student experience and ethnic diversity: the experiences of underrepresented minority students at a veterinary university in the United Kingdom. *Journal of Veterinary Medical Education*, *49*(3), pp.363-371.

Church, H.R., Brown, M.E., Govender, L. and Clark, D., 2024. Beyond the bedside: A scoping review of the experiences of non-practising health care professionals in Health Professions Education. *Medical Education*. 2024, pp.1-20.

Clark, N.J., Alcala-Van Houten, L. and Perea-Ryan, M., 2010. Transitioning from clinical practice to academia: University expectations on the tenure track. *Nurse Educator*, *35*(3), pp.105-109.

Clarke, C.A., Brown, A.D. and Hailey, V.H., 2009. Working identities? Antagonistic discursive resources and managerial identity. *Human Relations*, *62*(3), pp.323-352.

Clough, P. and Nutbrown, C., 2012. Justifying Enquiry: a students' guide to methodology (3rd edition), London: Sage.

Cockburn, C., 1981. The material of male power. *Feminist Review*, *9*(1), pp.41-58.

Coffman, J.R., 2002. Veterinary medical education and a changing culture. *Journal of Veterinary Medical Education*, *29*(2), pp.66-70.

Collins, C.S. and Cooper, J.E., 2014. Emotional intelligence and the qualitative researcher. *International Journal of Qualitative Methods*, *13*(1), pp.88-103.

Conklin, T.A. 2012. Work Worth Doing. *Journal of Management Inquiry* 21(3), pp. 298–317.

Cope, A.L. and Chestnutt, I.G., 2023. The implications of a cost-of-living crisis for oral health and dental care. *British Dental Journal*, *234*(7), pp.501-504.

Côté, J.E., 1996. Sociological perspectives on identity formation: The culture-identity link and identity capital. *Journal of Adolescence*, *19*, pp.417-428.

Coventry, J., Hampton, J.M., Muddiman, E. and Bullock, A., 2022. Medical student and trainee doctor views on the ‘good’ doctor: Deriving implications for training from a Qmethods study. *Medical Teacher*, *44*(9), pp.1007-1014.

Crane, M.F., Kho, M., Thomas, E.F., Decety, J., Molenberghs, P., Amiot, C.E., Lizzio Wilson, M., Wibisono, S., Allan, F. and Louis, W., 2023. The moderating role of different forms of empathy on the association between performing animal euthanasia and career sustainability. *Journal of Applied Social Psychology*, *53*(11), pp.1088-1107.

Crane, M.F., Louis, W.R., Phillips, J.K., Amiot, C.E. and Steffens, N.K., 2018. Identity centrality moderates the relationship between acceptance of group-based stressors and wellbeing. *European Journal of Social Psychology*, *48*(6), pp.866-882.

Creswell, J.W., 2013. *Qualitative inquiry and research design: Choosing among five approaches*. London: Sage.

Crocker, J. and Major, B., 1989. Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review*, *96*(4), p.608.

Croghan, I.T., Chesak, S.S., Adusumalli, J., Fischer, K.M., Beck, E.W., Patel, S.R., Ghosh, K., Schroeder, D.R. and Bhagra, A., 2021. Stress, resilience, and coping of healthcare workers during the COVID-19 pandemic. *Journal of Primary Care & Community Health*, *12*, p.21501327211008448.

Crompton, R., 2006. Class and family. *The Sociological Review*, *54*(4), pp.658-677.

Crossley, J. and Vivekananda-Schmidt, P., 2009. The development and evaluation of a Professional Self Identity Questionnaire to measure evolving professional self-identity in health and social care students. *Medical Teacher*, *31*(12), pp.e603-e607.

Crotty, M., 2015. *The foundations of social research*. London: Sage.

Cruess, R.L., Cruess, S.R., Boudreau, J.D., Snell, L. and Steinert, Y., 2014. Reframing medical education to support professional identity formation. *Academic Medicine*, *89*(11), pp.1446-1451.

Cryer, P., 2006. *The research student's guide to success* (3rd Edn.). Maidenhead: Open University Press.

Cuff, P.A., 2016. *Envisioning the future of health professional education: Workshop summary.* Washington DC: National Academies Press.

da Silva, C.R., Gomes, A.A.D., dos Santos-Doni, T.R., Antonelli, A.C., da Costa Vieira, R.F. and da Silva, A.R.S., 2023. Suicide in veterinary medicine: A literature review. *Veterinary World*, *16*(6), p.1266.

Davies B, Leung A, Dunne S. 2013. Why do general dental practitioners become involved in clinical teaching? A pilot study exploring the views of part-time practitioner teachers, King's College London. *British Dental Journal*; 214, pp.461–465

Deaux, K., 1993. Reconstructing social identity. *Personality and Social Psychology bulletin*, *19*(1), pp.4-12.

De Camargo, C.R. and Whiley, L.A., 2020. The mythologisation of key workers: occupational prestige gained, sustained... and lost? *International Journal of Sociology and social policy*, *40*(9/10), pp.849-859.

Decker, P.J., 1999. The hidden competencies of healthcare: Why self-esteem, accountability, and professionalism may affect hospital customer satisfaction scores. *Hospital Topics*, *77*(1), pp.14-26.

Delamont, S. and Atkinson, P., 1995. *Fighting familiarity: Essays on education and ethnography*. Cresskill, NJ: Hampton.

Delamont, S. and Atkinson, P., 2018. *The ethics of ethnography*. *The Sage Handbook of Qualitative Research Ethics*, pp.119-132.

Denscombe, M., 2003. Methods of social research. *The good research guide*. Maidenhead: OU Press.

Denzin, N.K. and Lincoln, Y.S., 1995. Transforming qualitative research methods: Is it a revolution?. *Journal of Contemporary Ethnography*, *24*(3), pp.349-358.

Derks, B., Van Laar, C. and Ellemers, N., 2006. Striving for success in outgroup settings: Effects of contextually emphasizing ingroup dimensions on stigmatized group members' social identity and performance styles. *Personality and Social Psychology Bulletin*, *32*(5), pp.576-588.

Dharamsi, S., Pratt, D.D. and MacEntee, M.I., 2007. How dentists account for social responsibility: economic imperatives and professional obligations. *Journal of Dental Education*, *71*(12), pp.1583-1592.

Dolby, N. and Litster, A., 2015. Understanding veterinarians as educators: an exploratory study. *Teaching in Higher Education*, *20*(3), pp.272-284.

Dombeck, M.T., 2003. Work narratives: Gender and race in professional personhood. *Research in Nursing & Health*, *26*(5), pp.351-365.

Dornan, T., Roy Bentley, S. and Kelly, M.A., 2020. Medical teachers' discursive positioning of doctors in relation to patients. *Medical Education, 54*, pp.628 - 636.

Duffy, R., 2013. Nurse to educator? Academic roles and the formation of personal academic identities. *Nurse Education Today*, *33*(6), pp.620-624.

Dunne, J. 2011. Professional wisdom in practice. In: Bondi et al. eds. *Towards professional wisdom: practical deliberation in the people professions*. Farnham: Ashgate pp.13-26.

Eckhaus, E., Iholkina, V. and Shkolnik, E., 2022. The impact of healthcare executive seniority on implementation of innovative methods of diagnosis and prevention. *Health Policy*, *126*(10), pp.996-1001.

Ellemers, N. and Haslam, S.A., 2012. Social identity theory. *Handbook of Theories of Social Psychology*, *2*, pp.379-398.

Ellemers, N., Spears, R. and Doosje, B., 2002. Self and social identity. *Annual Review of Psychology*, *53*(1), pp.161-186.

Enoch, J., Subramanian, A. and Willig, C., 2023. "If I don't like it, I'll just pop the phone down!": Reflecting on participant and researcher experiences of telephone interviews conducted during the COVID-19 pandemic. *SSM-Qualitative Research in Health*, *4*, p.100351.

Evans, C., 2020. A multi-dimensional perspective on young people's decisions not to go to university. *British Journal of Sociology of Education*, *41*(8), pp.1235-1250.

Evetts, J. 2003. The sociological analysis of professionalism. *International Sociology*, 18(2), pp.395-415.

Evetts, J. 2012. Professionalism in turbulent times: changes, challenges and opportunities. In: *Propel International Conference*. Stirling 9-11 May, 2012. [online]: https://journals.openedition.org/spp/4955. [accessed 19/11/24].

Eraut, M. 1994. *Developing professional knowledge and competence.* Abingdon: Routledge.

Erikson, E.H., 1959. Identity and the life cycle: Selected papers. [online]: https://books.google.co.uk/books?id=mNTECQAAQBAJ&printsec=frontcover&source=gbs_ ge_summary_r&cad=0#v=onepage&q&f=false [accessed 2/5/19].

Fagermoen, M.S., 1997. Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing*, *25*(3), pp.434-441.

Fearon, J.D., 1999. What is identity (as we now use the word). *Unpublished manuscript, Stanford University, Stanford, Calif*.

Field, J., Spencer, R., Johnson, I. and Cure, R., 2020. Professional standards in dental education. *British Dental Journal*, *228*(11), pp.875-881.

Finstad, G.L., Giorgi, G., Lulli, L.G., Pandolfi, C., Foti, G., León-Perez, J.M., Cantero-Sánchez, F.J. and Mucci, N., 2021. Resilience, coping strategies and posttraumatic growth in the workplace following COVID-19: A narrative review on the positive aspects of trauma. *International Journal of Environmental Research and Public Health*, *18*(18), p.9453.

Fish, D. and Coles, C. 2000. Seeing anew: understanding professional practice as artistry. In Davies et al. eds. 2000. *Changing practice in health and social care*. London: Sage, pp. 290299.

Flick, U. 2014. *An introduction to qualitative research* 5th Ed. London: SAGE.

Fossey, E., Harvey, C., McDermott, F. and Davidson, L., 2002. Understanding and evaluating qualitative research. *Australian & New Zealand Journal of Psychiatry*, *36*(6), pp.717-732.

Fox, C. 1992. What do we mean when we say professionalism? A language usage analysis for public administration. *The American Review of Public Administration*, vol. 22, no. 1, pp. 1-17.

Friedman, A. and Phillips, M., 2004. Continuing professional development: Developing a vision. *Journal of Education and Work*, *17*(3), pp.361-376.

Freidson, E., 1984. The changing nature of professional control. *Annual Review of Sociology*, *10*(1), pp.1-20.

Friedson, E. 1994. *Professionalism reborn: theory, prophecy and policy*. Cambridge: Polity Press.

Gates, M.C., McLachlan, I., Butler, S. and Weston, J.F., 2021. Building veterinarians beyond veterinary school: challenges and opportunities for continuing professional development in veterinary medicine. *Journal of Veterinary Medical Education*, *48*(4), pp.383-400.

Gawne, S., Fish, R. and Machin, L., 2020. Developing a workplace-based learning culture in the NHS: Aspirations and challenges. *Journal of Medical Education and Curricular Development*, *7*, p.2382120520947063.

Gecas, V. and Burke, P., 1995. "Self and Identity." Pp. 41-67 in Sociological Perspectives on Social Psychology, edited by Cook, K., Fine, G. and House, J. Boston: Allyn and Bacon

Get into Teaching., 2024. [online] https://getintoteaching.education.gov.uk/train-to-be-ateacher/initial-teacher-training. (accessed 17/11/2024).

Giddens, A., 1991. *Modernity and self-identity: Self and society in the late modern age*. Stanford: Stanford university press.

Giddon, D.B. and Assael, L.A., 2004. Should dentists become ‘oral physicians'?: Yes, dentists should become ‘oral physicians.'. *The Journal of the American Dental Association*, *135*(4), pp.438-447.

Giusti, E.M., Veronesi, G., Callegari, C., Borchini, R., Castelnuovo, G., Gianfagna, F., Iacoviello, L. and Ferrario, M.M., 2023. Pre-pandemic burnout and its changes during the COVID-19 outbreak as predictors of mental health of healthcare workers: A lesson to be learned. *Psychiatry Research*, *326*, p.115305.

Glaser, B.G. and Strauss, A.L. 1965. *Awareness of dying*. Chicago: Aldine.

Goffman, E., 1959. The Presentation of Self in Everyday Life. New York, NY: Doubleday.

Goffman, E., 1970. *Strategic interaction* (Vol. 1). Philadelphia, Penn.:University of Pennsylvania Press.

Goffman, E. 1983. The interaction order: American sociological association, 1982 presidential address. *American Sociological Review*, 48 (1), pp.1-17.

Goldsmith, L. J. 2021. Using Framework Analysis in Applied Qualitative Research. *The Qualitative Report*, 26(6), pp.2061-2076.

Gordon, S., Parkinson, T., Byers, S., Nigito, K., Rodriguez, A., Werners-Butler, C., Haynes, J. and Guttin, T., 2023. The changing face of veterinary professionalism—implications for veterinary education. *Education Sciences*, *13*(2), p.182.

Gostoli, S., D’Oronzo, A., Malaguti, C., Guolo, F., Balducci, C., Subach, R., Lodi, V., Petio, C. and Rafanelli, C., 2023. Psychopathological Burden among Healthcare Workers during the COVID-19 Pandemic Compared to the Pre-Pandemic Period. *International Journal of Environmental Research and Public Health*, *20*(24), p.7153.

Greco, J., 2017. Introduction: What is epistemology?. *The Blackwell guide to epistemology*, pp.1-31. Chichester: Wiley.

Grey, C., 1994. Career as a project of the self and labour process discipline. *Sociology*, *28*(2), pp.479-497.

Grinyer, A., 2009. The Anonymity of Research Participants: Assumptions, Ethics, and Practicalities. *Pan-Pacific Management Review*, *12*(1), pp.49-58.

Grix, J., 2002. Introducing students to the generic terminology of social research. *Politics*, *22*(3), pp.175-186.

Gunderson, R., 2020. *Making the familiar strange: Sociology contra reification*. Abingdon: Routledge.

Hafferty, F.W. and Castellani, B., 2009. The hidden curriculum: a theory of medical education. In *Handbook of the sociology of medical education* (pp. 29-49). Abingdon: Routledge.

Hafferty F.W. and Franks R., 1994. The hidden curriculum, ethics teaching, and the structure of medical eduation. *Acad Med*. 69, pp. 861–71.

Hafferty, F.W. and O'Donnell, J.F., 2015. In Hafferty, F.W. and O'Donnell, J.F., (ed). *The hidden curriculum in health professional education*, pp1-21. Hanover, New Hampshire: Dartmouth College Press.

Hakim, C., 2012. *Research design: Successful designs for social economics research*. London: Routledge.

Hall D.T., 1987. Careers and socialization. *Journal of Management* 13(2), pp.301–322.

Hall, P., 2005. Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional care*, *19*(sup1), pp.188-196.

Hallett, G., Witton, R. and Mills, I., 2023. A survey of mental wellbeing and stress among dental therapists and hygienists in South West England. *BDJ Team*, *10*(4), pp.30-35.

Hammersley, M., 1996. The relationship between qualitative and quantitative research: Paradigm loyalty versus methodological eclecticism. In Richardson, J.T.E., (ed.) *Handbook of Research Methods for Psychology and the Social Sciences*, p. 159 - 174. Leicester: PBS Books.

Hansen, M.E. and Pickering, S.D., 2024. From plaster casts to picket lines: Public support for industrial action in the National Health Service in England. *Nursing Inquiry*, *31*(3), p.e12637.

Harden, R.M. and Crosby, J., 2000. AMEE Guide No 20: The good teacher is more than a lecturer: the twelve roles of the teacher. *Medical Teacher*, *22*(4), pp.334-347.

Hart, L.A., Wood, M.W. and Weng, H.Y., 2005. Mainstreaming alternatives in veterinary medical education: resource development and curricular reform. *Journal of Veterinary Medical Education*, *32*(4), pp.473-480.

Haslam, S.A., Adarves-Yorno, I., Postmes, T. and Jans, L., 2013. The collective origins of valued originality: A social identity approach to creativity. *Personality and Social Psychology Review*, *17*(4), pp.384-401.

Hearn, J., 1982. Notes on patriarchy, professionalization and the semi professions. *Sociology*, *16*(2), pp.184-202.

Heath, H. and Cowley, S., 2004. Developing a grounded theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies*, *41*(2), pp.141-150.

Hemmings, N., Buckingham, H. and Palmer, W., 2021. *Attracting, supporting and retaining a diverse NHS workforce*. London: Nuffield Trust.

Hicks, C. and Hennessy, D., 1998. A triangulation approach to the identification of acute sector nurses' training needs for formal nurse practitioner status. *Journal of Advanced Nursing*, *27*(1), pp.117-131.

Hilal, A.H. and Alabri, S.S., 2013. Using NVivo for data analysis in qualitative research. *International Interdisciplinary Journal of Education*, *2*(2), pp.181-186.

Hill, B., 2023. Nursing applications in decline. *British Journal of Nursing*, *32*(16).

Hodkinson, P., 2009. Understanding career decision-making and progression: Careership revisited: The fifth John Killeen memorial lecture, October 2008. *Journal of the national Institute for Career Education and Counselling*, *21*(1), pp.4-17.

Hodkinson, P. and Sparkes, A.C., 1997. Careership: a sociological theory of career decision making. *British Journal of Sociology of Education*, *18*(1), pp.29-44.

Hoeve, Y.T., Jansen, G. and Roodbol, P., 2014. The nursing profession: public image, selfconcept and professional identity. A discussion paper. *Journal of Advanced Nursing*, *70*(2), pp.295-309.

Hogg, M.A., 2023. Walls between groups: Self-uncertainty, social identity, and intergroup leadership. *Journal of Social Issues*, *79*(2), pp.825-840.

Hogg, M.A., 2007. Uncertainty–identity theory. *Advances in Experimental Social Psychology*, *39*, pp.69-126.

Holden, A., 2018. Cosmetic dentistry: A socio-ethical evaluation. *Bioethics*. 32: 602–610.

Holden, A.C. and Quiñonez, C.R., 2021. Is there a social justice to dentistry's social contract? *Bioethics*, *35*(7), pp.646-651.

Holmes, A.G.D., 2020. Researcher Positionality--A Consideration of Its Influence and Place in Qualitative Research--A New Researcher Guide. *Shanlax International Journal of Education*, *8*(4), pp.1-10.

Hopf, C. 2004 in Flick, U., von Kardoff, E. and Steinke, I., eds. *A companion to qualitative research*. Sage: London.

Hopkins, L., Hampton, B.S., Abbott, J.F., Buery-Joyner, S.D., Craig, L.B., Dalrymple, J.L., Forstein, D.A., Graziano, S.C., McKenzie, M.L., Pradham, A. and Wolf, A., 2018. To the point: medical education, technology, and the millennial learner. *American Journal of Obstetrics and Gynaecology*, *218*(2), pp.188-192.

Holt, A. 2010. Using the telephone for narrative interviewing: A research note. *Qualitative Research,* 10 (1). pp. 113-121.

Hurley, J. and Lakeman, R., 2011. Becoming a psychiatric/mental health nurse in the UK: a qualitative study exploring processes of identity formation. *Issues in Mental Health Nursing*, *32*(12), pp.745-751.

Iacobucci, G., 2022. Government has overseen “years of decline” in cancer and elective care, say MPs. *British medical journal*, Vol.376, p.o682.

Ibarra, H. 1999. Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly*, 44 (4), pp. 764-791.

Inghilleri, M., 2003. Habitus, field and discourse: Interpreting as a socially situated activity. *Target. International Journal of Translation Studies*, *15*(2), pp.243-268.

Jacobs, C. and Van Schalkwyk, S., 2022. What knowledge matters in health professions education? *Teaching in Higher Education*, *27*(8), pp.1068-1083.

Jacobson, D. and Mustafa, N., 2019. Social identity map: A reflexivity tool for practicing explicit positionality in critical qualitative research. *International Journal of Qualitative Methods*, *18*, p.1609406919870075.

Jans, L., Postmes, T. and Van der Zee, K.I., 2011. The Induction of Shared Identity: The Positive Role of Individual Distinctiveness for Groups. *Personality and Social Psychology Bulletin* 37(8), pp. 1130–1141.

Jans, L., Postmes, T. and Van der Zee, K.I., 2012. Sharing differences: The inductive route to social identity formation. *Journal of Experimental Social Psychology*, *48*(5), pp.1145-1149.

Jarvis-Selinger, S., Pratt, D.D. and Regehr, G., 2012. Competency is not enough: integrating identity formation into the medical education discourse. *Academic Medicine*, *87*(9), pp.11851190.

Jauregui, J., O’Sullivan, P., Kalishman, S., Nishimura, H. and Robins, L., 2019. Removing: A Qualitative Focus Group Exploration of How Educators Maintain Identity in a Sea of Competing Demands. *Academic Medicine, 94* (1), 122-128.

Jenkins, R., 2004. *Social identity*. 2nd Ed. London: Routledge.

Jenkins, R. 2008. Erving Goffman: A major theorist of power? *Journal of Power,* 1:2, pp.157-168.

Jin, J., Chen, Q. and Yan, X., 2025. Do the certainty tone and seniority of physicians matter in patients' information adoption in online health communities?. *Information Technology & People*, *38*(1), pp.442-471.

Johnson, M., Cowin, L.S., Wilson, I. and Young, H., 2012. Professional identity and nursing: contemporary theoretical developments and future research challenges. *International nursing review*, *59*(4), pp.562-569.

Johnson, M. D., Morgeson, F. P., Ilgen, D. R., Meyer, C. J., and Lloyd, J. W., 2006. Multiple professional identities: Examining differences in identification across work-related targets. *Journal of Applied Psychology, 91*(2), 498–506.

Kelly, M., 2011. Preceptorship in public health nursing. *Journal of Community Nursing*, *25*(5), p.10.

Kerasidou, A. and Kerasidou, C., 2023. Data-driven research and healthcare: public trust, data governance and the NHS. *BMC Medical Ethics*, *24*(1), p.51.

Kerins, J., Smith, S. E., and Tallentire, V. R. 2022. 'Us versus them': A social identity perspective of internal medicine trainees. *Perspectives on Medical Education*, *11*(6), 341–349.

Khalili, H., Orchard, C., Laschinger, H.K.S. and Farah, R., 2013. An interprofessional socialization framework for developing an interprofessional identity among health professions students. *Journal of Interprofessional Care*, *27*(6), pp.448-453.

Kidder, L.H. and Fine, M., 1987. Qualitative and quantitative methods: When stories converge. *New Directions for Program Evaluation*, (35), pp.57-75.

Kiger, M.E. and Varpio, L., 2020. Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical Teacher*, *42*(8), pp.846-854.

King, A., 2000. Thinking with Bourdieu against Bourdieu: A 'practical 'critique of the habitus. *Sociological Theory*, *18*(3), pp.417-433.

Kings Fund, 2024. NHS Workforce Nutshell | The King's Fund. [online]. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell (accessed 19/03/25)

Kinkaid, E., 2022. Positionality, post-phenomenology, and the politics of theory. *Gender, Place & Culture*, *29*(7), pp.923-945.

Kline, C.C., Park, S.E., Godolphin, W., and Towle, A., 2020. Professional Identity Formation: A Role for Patients as Mentors. *Academic Medicine, 95*, pp.1578 - 1586.

Kmietowicz, Z., 2023. Halt plans to restrict foreign workers joining the NHS and care services, say leaders.[online] https://www.bmj.com/content/383/bmj.p2803.full (Accessed 19/03/25).

Knifsend, C.A. and Juvonen, J. 2014. Social Identity Complexity, Cross-Ethnic Friendships, and Intergroup Attitudes in Urban Middle Schools. *Child Development* 85(2), pp. 709–721.

Knights, D. and Clarke, C., 2018. Living on the edge? Professional anxieties at work in academia and veterinary practice. *Culture and Organization*, *24*(2), pp.134-153.

Krahenbuhl, K. S., 2016. 'Student-centered Education and Constructivism: Challenges, Concerns, and Clarity for Teachers', *The Clearing House: A Journal of Educational Strategies, Issues and Ideas*, 89(3), pp. 97–105.

Kulich, K.R., Rydén, O. and Bengtsson, H., 1998. A descriptive study of how dentists view their profession and the doctor-patient relationship. *Acta Odontologica Scandinavica*, *56*(4), pp.206-209.

Laberge, Y., 2010. Review essay: Habitus and social capital: From Pierre Bourdieu and beyond. *Sociology*, *44*(4), pp.770-777.

LaTendresse, D., 2000. Social identity and intergroup relations within the hospital. *Journal of Social Distress and the Homeless*, *9*(1), pp.51-69.

Lea, S.J. and Callaghan, L., 2008. Lecturers on teaching within the 'supercomplexity'of Higher Education. *Higher Education*, *55*(2), p.171.

Lee, C.A., Wilkinson, T.J., Timmermans, J.A., Ali, A.N. and Anakin, M.G., 2023. Revealing the impact of the hidden curriculum on faculty teaching: A qualitative study. *Medical Education*, *57*(8), pp.761-769.

Lee, S.L., Rees, C.E., O'Brien, B.C. and Palermo, C., 2022. Identities and roles through clinician-educator transitions: A systematic narrative review. *Nurse Education Today*, *118*, p.105512.

Lemke, J.L., 1998. From Positivism to Interpretivism and Beyond: Tales of Transformation in Educational and Social Research: From Positivism to Interpretivism and Beyond: Tales of Transformation in Educational and Social Research. *Anthropology & Education Quarterly*, 29, pp.255–257.

Leonardelli, G.J., Pickett, C.L. and Brewer, M.B., 2010. Optimal distinctiveness theory: A framework for social identity, social cognition, and intergroup relations. In *Advances in Experimental Social Psychology*, Vol. 43, pp. 63-113).

Lesser, C S, Lucey, C R, Egener, B, Braddock, C H, Linas, S L and Levinson, W A. 2010. Behavioral and systems view of professionalism. *Journal of the American Medical Association*, 304, pp.2732–2737.

Lewin, L.O., McManamon, A., Stein, M.T. and Chen, D.T., 2019. Minding the form that transforms: using Kegan's model of adult development to understand personal and professional identity formation in medicine. *Academic Medicine*, *94*(9), pp.1299-1304.

Liljegren, A., 2012. Key metaphors in the sociology of professions: Occupations as hierarchies and landscapes. *Comparative Sociology*, *11*(1), pp.88-112.

Lingard, L., Garwood, K., Schryer, C.F. and Spafford, M.M., 2003. A certain art of uncertainty: case presentation and the development of professional identity. *Social science & medicine*, *56*(3), pp.603-616.

Littlewood, S., Ypinazar, V., Margolis, S.A., Scherpbier, A., Spencer, J. and Dornan, T., 2005. Early practical experience and the social responsiveness of clinical education: systematic review. *BMJ, 331*(7513), pp.387-391.

Lizardo, O., 2004. The cognitive origins of Bourdieu's habitus. *Journal for the theory of social behaviour*, *34*(4), pp.375-401.

Loseke, D. R., Cahill, S. E. (1986). Actors in search of a character: Student social workers' quest for professional identity. *Symbolic Interactions*. 9, 245 – 268.

Lygo-Baker, S., Kokotailo, P.K. and Young, K.M., 2015. Developing confidence in uncertainty: Conflicting roles of trainees as they become educators in veterinary and human medicine. *Journal of Veterinary Medical Education*, *42*(4), pp.364-372.

Lynch, C.D., Blum, I.R. and Wilson, N.H., 2019. Leadership in dental education. *Journal of Dentistry*, *87*, pp.7-9.

Lyon, L. J., Hoover, T. E., Giusti, L., Booth, M. T. and Mahdavi, E., 2016. Teaching Skill Acquisition and Development in Dental Education. *Journal of Dental Education*, *80*(8), 983– 993.

MacIntosh, J., 2003. Reworking professional nursing identity. *Western Journal of Nursing Research*, *25*(6), pp.725-741.

MacLeod, A., 2011. Caring, competence and professional identities in medical education. *Advances in Health Sciences Education*, *16*(3), pp.375-394.

Madill, A. and Latchford, G., 2005. Identity change and the human dissection experience over the first year of medical training. *Social Science & Medicine*, *60*(7), pp.1637-1647.

Mandy A, Milton C, Mandy P., 2005. The basis of clinical tribalism, hierarchy and stereotyping: a laboratory-controlled teamwork experiment. *Learn Heal Soc Care.* 6, pp.154– 170.

Mann, K. and Macleod, A., 2015. In (eds.) Cleland, J. and Durning, S.J., *Researching Medical Education*. Oxford: John Wiley & Sons, pp.51-64.

Maragha, T., Donnelly, L., Schuetz, C., von Bergmann, H. and Brondani, M., 2023. Students' resilience and mental health in the dental curriculum. *European Journal of Dental Education*, *27*(1), pp.174-180.

Martiny, S.E. and Rubin, M., 2016. Towards a clearer understanding of social identity theory's self-esteem hypothesis. *Understanding peace and conflict through social identity theory: Contemporary global perspectives*, pp.19-32. New York, NY: Springer.

Maseide, P., 1990. The social construction of research information. *Acta Sociologica* 33(3): 3–13.

Masella, R.S., 2006. The hidden curriculum: value added in dental education. *Journal of Dental Education*, *70*(3), pp.279-283.

Masella, R.S., 2007. Renewing professionalism in dental education: overcoming the market environment. *Journal of Dental Education*, *71*(2), pp.205-216.

May, W. F., 1999. Money and the professions: Medicine and law. *William Mitchell Law Review* 25(1), 75-102.

Maylor M. 2005., Differentiating between a consultant nurse and a clinical nurse specialist. *British Journal of Nursing, 14*(8), 463–468.

McAndrew, M., 2010. Community-based dental education and the importance of faculty development. *Journal of Dental Education, 74 9*, pp.980-985.

McMurray, R. 2010. The struggle to professionalize: an ethnographic account of the occupational position of advanced nurse practitioners. *Human Relations*, 64(6), pp.801-822.

McArthur-Rouse, F.J., 2008. From expert to novice: An exploration of the experiences of new academic staff to a department of adult nursing studies. *Nurse Education Today*, *28*(4), pp.401-408.

Mead, G.H., 1934. Mind, self, and society from the standpoint of a social behaviorist. Chicago: Chicago Univ. Press.

Mercer, J., 2007. The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education*, 33(1), pp.1-17.

McMurray, R. 2010. The struggle to professionalize: an ethnographic account of the occupational position of advanced nurse practitioners. *Human Relations*, 64(6), pp.801-822.

Merkens, H., 2004. Selection procedures, sampling case construction in: Flick, U., von Kardoff, E. and Steinke, I. eds., 2004. A companion to qualitative research, pp165-177. London: Sage.

Meyerhoff, M. and Strycharz, A., 2013. Communities of practice. *The handbook of language variation and change*, pp.428-447.

Mian, A. and Khan, S., 2020. Medical education during pandemics: a UK perspective. *BMC Medicine*, *18*, pp.1-2.

Miles, A., Ginsburg, S., Sibbald, M., Tavares, W., Watling, C. and Stroud, L., 2021. Feedback from health professionals in postgraduate medical education: Influence of interprofessional relationship, identity and power. *Medical Education*, *55*(4), pp.518-529.

Miles, M.B. and Huberman, A.M., 1994. *Qualitative data analysis: An expanded sourcebook*. London: Sage.

Moffatt, F., Martin, P. and Timmons, S., 2014. Constructing notions of healthcare productivity: the call for a new professionalism? *Sociology of Health & Illness*, *36*(5), pp.686-702.

Mohanna, K., Wall, D., Cottrell, E. and Chambers, R., 2023. Healthcare professionals as teachers. In *Teaching Made Easy* (pp. 17-27). New York, NY: CRC Press.

Monrouxe, L., 2010. Identity, identification and medical education: why should we care? *Medical Education*, 44, pp.40-49.

Monrouxe, L.V. and Rees, C.E., 2009. Picking up the gauntlet: constructing medical education as a social science. *Medical education*, *43*(3), pp.196-198.

Morgan, B., 2022. NHS staffing shortages. *Why do politicians struggle to give the NHS the staff it needs*.[online] https://www.kingsfund.org.uk/insight-and-analysis/reports/nhs-staffing-shortages. (Accessed 19/03/25).

Morgan, D.L., 1998. Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research*, 8(3), pp.362-376.

Mossop, L.H. and Cobb, K., 2013. Teaching and assessing veterinary professionalism. *Journal of Veterinary Medical Education*, 40(3), pp.223-232.

Mount, G.R., Kahlke, R., Melton, J. and Varpio, L., 2022. A critical review of professional identity formation interventions in medical education. *Academic Medicine*, *97*(11S), pp. S96S106.

Møystad, A., Lycke, K., Barkvoll, T.A. and Lauvås, P., 2015. Faculty development for clinical teachers in dental education. *European journal of dental education: official journal of the Association for Dental Education in Europe,* 19 (3), pp.149-155 .

Muddiman, E., Bullock, A.D., MacDonald, J., Allery, L., Webb, K.L. and Pugsley, L., 2016. 'It's surprising how differently they treat you': a qualitative analysis of trainee reflections on a new programme for generalist doctors. *BMJ open*, *6*(9), p.e011239.

Murray, C., Stanley, M. and Wright, S., 2014. The transition from clinician to academic in nursing and allied health: A qualitative meta-synthesis. *Nurse Education Today*, *34*(3), pp.389-395.

Murthy, V.H., 2022. Confronting health worker burnout and well-being. *New England Journal of Medicine*, *387*(7), pp.577-579.

Nash, R., 1999. Bourdieu, 'Habitus', and Educational Research: Is it all worth the candle?, *British Journal of Sociology of Education*, 20:2, 175-187

Newman, L.R., Nagler, A., Rudd, M., Blanchard, R.D., Whicker, S.A., Winn, A.S., Cohen, A.P., Parry, G., Leichtner, A.M. and Kesselheim, J.C., 2024. Lost in the pandemic: COVID19's impact on health professions educators. *The Clinical Teacher*, 21(5), p.e13764.

Ng, S.H., 2007. Language-based discrimination: Blatant and subtle forms. *Journal of Language and Social Psychology*, *26*(2), pp.106-122.

NHS. 2024. The long-term work force plan. [online] available at: https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ (accessed 15/08/24).

Niemi, P.M., 1997. Medical students' professional identity: self-reflection during the preclinical years. *Medical Education*, *31*(6), pp.408-415.

Nikendei, C., Ben-David, M.F., Mennin, S. and Huwendiek, S., 2016. Medical educators: How they define themselves–Results of an international web survey. *Medical Teacher*, *38*(7), pp.715-723.

Norris, S., 2005. Habitus, social identity, the perception of male domination–and agency?. In *Discourse in action* (pp. 183-196). London: Routledge.

Nowland, M.H., Haidet, P. and Whitcomb, T.L., 2022. Connection and conflict: influence of the hidden curriculum on veterinary residents' professional identities within the specialty of laboratory animal medicine. *Journal of the American Veterinary Medical Association*, *260*(12), pp.1-10.

Nursing and Midwifery Council, 2023. NMC The Register. https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/may-2023/0110a-annualdata-report-full-uk-web.pdf. Accessed online: 12/06/2024.

O'Brien, F., Mooney, M. and Glacken, M., 2008. Impressions of nursing before exposure to the field. *Journal of Clinical Nursing*, *17*(14), pp.1843-1850.

O'Callaghan, C., Sandars, J., Brown, J. and Sherratt, C., 2024. The Value of Master's Degree Programmes in Health Professions Education: A Scoping Review. *The Clinical Teacher*, p.e13758.

O'Dowd, A., 2022. Growing pressure on NHS threatens frontline services. *British Medical Journal*, Vol.379, p.o2439

Olukotun, O., Mkandawire, E., Antilla, J., Alfaifa, F., Weitzel, J., Scheer, V., Olukotun, M. and Mkandawire-Valhmu, L., 2021. An analysis of reflections on researcher positionality. *The Qualitative Report*, *26*(5), pp.1411-1426.

Onorato, R.S. and Turner, J.C. 2004. Fluidity in the self-concept: the shift from personal to social identity. *European Journal of Social Psychology* 34(3), pp. 257–278.

ONS, 2023. *Coronavirus (COVID-19) Infection Survey technical article: waves and lags of COVID-19 in England, June 2021* [online]: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19infectionsurveytechnicalarticle/wavesandlagsofcovid19ine nglandjune2021#waves-of-covid-19. (accessed: 15/02/23).

Ortiz-Paredes, D., Rodríguez, C., Nugus, P., Carver, T. and Risør, T., 2022. Embedding identity and how clinical teachers reconcile their multiple professional identities to meet overlapping demands at work. *Teaching and Learning in Medicine*, *34*(4), pp.405-417.

Owuamalam, C.K., Rubin, M. and Spears, R., 2019. Revisiting 25 years of system motivation explanation for system justification from the perspective of social identity model of system attitudes. *British Journal of Social Psychology*, *58*(2), pp.362-381.

Page-Jones, S. and Abbey, G., 2015. Career identity in the veterinary profession. *Veterinary Record*, *176*(17), pp.433-433.

Pape, G., Dong, F. and Horváth, Z., 2018. Assessing the Professional Identity of Dental School Faculty: An Exploratory Study. *Journal of Dental Education, 82(11)*, pp.1140-1145.

Pecukonis, E., 2014. Interprofessional education: A theoretical orientation incorporating profession-centrism and social identity theory. *Journal of Law, Medicine & Ethics*, *42*(S2), pp.60-64.

Penn, B.K., Wilson, L.D. and Rosseter, R., 2008. Transitioning from nursing practice to a teaching role. *Online Journal of Issues in Nursing*, *13*(3).

Piore, M.J. and Safford, S., 2006. Changing regimes of workplace governance, shifting axes of social mobilization, and the challenge to industrial relations theory. *Industrial Relations* 45(3), pp.299–325.

Potter, J. and Hepburn, A., 2005. Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, *2*(4), pp.281-307.

Power, S. 2008. The Imaginative professional. In: Cunningham, B. eds. *Exploring professionalism*. London: Institute of Education, Bedford Way Papers, pp.144-160.

Preston, N.J., Farquhar, M.C., Walshe, C.E., Stevinson, C., Ewing, G., Calman, L.A., Burden, S., Brown Wilson, C., Hopkinson, J.B. and Todd, C., 2012. Strategies to increase participant recruitment to research studies by healthcare professionals. *Cochrane Database of Systematic Reviews*, *2012*(9).

Price, S.L., 2009. Becoming a nurse: a meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing*, *65*(1), pp.11-19.

Pring, R., 2006. *Philosophy of Educational Research*. London: Continuum.

Punch, K.F., 2013. *Introduction to social research: Quantitative and qualitative approaches*. London: Sage.

Ramsey, S.M., 2025. Diagnosis: undervalued. A psychoanalytic exploration of doctor strikes in the British National Health Service, 2023–2024. *Medical Humanities*. [online] https://mh.bmj.com/content/early/2025/03/06/medhum-2024-013208.abstract?casa_token=gqbuiSze5XQAAAAA:fU2rZi_3-TvV6y3VZ2itlGGF-7EqNeFgeWJzMkQHiZcLl6-hYereewUK7g5sUq-n3MOJJVCkblw (Accessed 19/03/25).

Ravishankar Rao, A., Clarke, D. and Vargas, M., 2018. Building an open health data analytics platform: A case study examining relationships and trends in seniority and performance in healthcare providers. *Journal of Healthcare Informatics Research*, *2*, pp.44-70.

Ray, M., Milston, A., Doherty, P. and Crean, S., 2017. How prepared are foundation dentists in England and Wales for independent general dental practice? *British Dental Journal*, *223*(5), p.359.

Regehr, G., 2010. It's NOT rocket science: rethinking our metaphors for research in health professions education. *Med Educ*. 44, pp.31–39.

Reimer, N.K., Schmid, K., Hewstone, M. and Al Ramiah, A., 2022. Self-categorization and social identification: Making sense of us and them. *Theories in Social Psychology, Second Edition*, pp.273-295.

Rice, B., Martin, N., Fieger, P. and Hussain, T., 2022. Older healthcare workers' satisfaction: managing the interaction of age, job security expectations and autonomy. *Employee Relations: The International Journal*, *44*(2), pp.319-334.

Riiser, K., Kalleson, R., Holmen, H. and Torbjørnsen, A., 2023. Integrating research in health professions education: a scoping review. *BMC Medical Education*, *23*(1), p.653.

Rizwan, M., Rosson, N.J., Tackett, S. and Hassoun, H.T., 2018. Globalization of medical education: Current trends and opportunities for medical students. *J. Med. Educ. Train*. 2:035.

Roberts, J., 2006. Limits to communities of practice. *Journal of Management studies*, *43*(3), pp.623-639.

Roberts, S.J., 2000. Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science*, *22*(4), pp.71-82.

Robson, C., 2011. *Real world research (3rd Ed.)*. Chichester: Wiley Global Education.

Roccas, S. and Brewer, M. 2002. Social identity complexity. *Personal Psychology Review*, Vol.6, pp. 88106.

Roder, C.A. and May, S.A., 2017. The hidden curriculum of veterinary education: mediators and moderators of its effects. *Journal of Veterinary Medical Education*, *44*(3), pp.542-551.

Roopnarine, R. and Boeren, E., 2020. Applying the Readiness for Interprofessional Learning Scale (RIPLS) to medical, veterinary and dual degree Master of Public Health (MPH) students at a private medical institution. *PLoS One*, *15*(6), p.e0234462.

Rubin, M., Badea, C. and Jetten, J., 2014. Low status groups show in-group favoritism to compensate for their low status and compete for higher status. *Group Processes & Intergroup Relations*, *17*(5), pp.563-576.

Roth, J. and Steffens, M. C., 2014. When I Becomes We. *Social Psychology*, 1(4), pp.1–12.

Sabel, E. and Archer, J. 2014. Medical education is the ugly duckling of the medical world" and other challenges to medical educators' identity construction: a qualitative study. *Academic Medicine*, *89*(11), pp.1474-1480.

Sadh, K., Khadse, P.A. and Murthy, P., 2023. Mental Health Effects of Past and Current Pandemics on Health-Care Professionals: A Narrative Review. *Indian Journal of Social Psychiatry*, *39*(2), pp.100-109.

Sala-Bubaré, A., Castelló, M., Corcelles, M. and Suñé-Soler, N., 2024. Researchers' strategies to cope with the covid-19 impact on their activity. *Current Psychology*, *43*(18), pp.16905-16913.

Sapsford, R. and Jupp, V., 2006. *Data collection and analysis*. London: Sage.

Savage, M., 2015. Introduction to elites from the 'problematic of the proletariat' to a class analysis of 'wealth elites'. *The Sociological Review*, *63*(2), pp.223-239.

Saunders, B., Kitzinger, J. and Kitzinger, C. 2015. Anonymising interview data: challenges and compromise in practice. *Qualitative Research: QR*, *15*(5), pp.616-632.

Scheifele, C., Ehrke, F., Viladot, M.A., Van Laar, C. and Steffens, MC., 2021. Testing the basic socio-structural assumptions of social identity theory in the gender context: Evidence from correlational studies on women's leadership. *European Journal Social Psychologyl*. 51: e1– e16.

Schermerhorn, J., Wilcox, S., Durning, S., Costello, J., Norton, C. and Meyer, H., 2023. Masters in health professions education programs as they choose to represent themselves: A website review. *MedEdPublish*, *13*.

Scholz, E. and Trede, F., 2023. Veterinary professional identity: Conceptual analysis and location in a practice theory framework. *Frontiers in Veterinary Science*, *10*, p.1041475.

Schrewe, B., Bates, J., Pratt, D.D., Ruitenberg, C.W., and McKellin, W., 2017. The Big D(eal): professional identity through discursive constructions of ‘patient’. *Medical Education, 51*.

Schwandt, T. A., 1994. Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118–137). Thousand Oaks, Calif.: Sage.

Schwartz-Shea, P., 2019. Scholarly Reflexivity, Methodological Practice, and Bevir and Blakely's Anti-Naturalism, *Critical Review*, 31:3.

Seghers, M., Boone, S. and Van Avermaet, P., 2019. Social class and educational decision making in a choice-driven education system: a mixed-methods study. *British Journal of Sociology of Education*, *40*(5), pp.696-714.

Serpe, R.T. and Stryker, S., 1987. The construction of self and reconstruction of social relationships. *Advances in Group Processes*, *4*, pp.41-66.

Sethi, A., Ajjawi, R., McAleer, S. and Schofield, S., 2017. Exploring the tensions of being and becoming a medical educator. *BMC Medical Education*, *17*(1), p.62.

Sethi, A., Schofield, S., McAleer, S. and Ajjawi, R., 2018. The influence of postgraduate qualifications on educational identity formation of healthcare professionals. *Advances in Health Sciences Education*, *23*, pp.567-585.

Shapiro, J., Coulehan, J., Wear, D. and Montello, M., 2009. Medical humanities and their discontents: definitions, critiques, and implications. *Academic Medicine*, *84*(2), pp.192-198.

Sheehan, K.A., Schulz-Quach, C., Ruttan, L.A., MacGillivray, L., McKay, M.S., Seto, A., Li, A., Stewart, D.E., Abbey, S.E. and Berkhout, S.G., 2023. “Don't just study our distress, do something”: implementing and evaluating a modified stepped-care model for health care worker mental health during the COVID-19 pandemic. *The Canadian Journal of Psychiatry*, *68*(1), pp.43-53.

Shivley, J.M., 2019. Acquisition of pedagogical knowledge by instructors of veterinary medicine. *Transformation in Higher Education*, *4*(1), pp.1-9.

Siebert, S., Bushfield, S., Martin, G. and Howieson, B., 2018. Eroding ‘respectability’: Deprofessionalization through organizational spaces. *Work, Employment and Society*, *32*(2), pp.330-347.

Simon B. 1992. The perception of in-group and out-group homogeneity: reintroducing the intergroup context. *European Review of Social Psychology*. 3, pp.1–30.

Simpson, D., Marcdante, K., Souza, K.H., Anderson, A. and Holmboe, E., 2018. Job roles of the 2025 medical educator. *Journal of Graduate Medical Education*, *10*(3), pp.243-246.

Slay, H.S. and Smith, D.A., 2011. Professional identity construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities. *Human Relations*, *64*(1), pp.85-107.

Smith, M.L. and Foley, M.R., 2016. Transforming clinical education in obstetrics and gynaecology: gone is the day of the sage on the stage. *Obstetrics & Gynaecology*, *127*(4), pp.763-767.

Snashall, D., 1997. Aging healthcare professionals. *Occupational and Environmental Medicine*, *54*(11), p.770.

Snook, A.G., Schram, A.B., Jones, B.D. and Sveinsson, T., 2019. Factors predicting identity as educators and openness to improve: an exploratory study. *Medical Education*, *53*(8), pp.788-798.

Sollami, A., Caricati, L. and Mancini, T., 2018. Attitudes towards interprofessional education among medical and nursing students: the role of professional identification and intergroup contact. *Current Psychology*, *37*, pp.905-912.

Snow, D. and Morril, C.,1995. Ironies, Puzzles, and Contradictions in Denzin and Lincoln's Vision for Qualitative Research. *Journal of Contemporary Ethnography,* 24:3, pp.358-362.

Spencer-Rodgers, J., Major, B., Forster, D. E. and Peng, K. 2016. The power of affirming group values: Group affirmation buffers the self-esteem of women exposed to blatant sexism. *Self and Identity*, 15(4), pp.413–431.

Spendelow, J., Cripwell, C., Stott, R., Francis, K., Powell, J., Cavanagh, K. and Corbett, R., 2024. Workplace stressor factors, profiles and the relationship to career stage in UK veterinarians, veterinary nurses and students. *Veterinary Medicine and Science*, *10*(4), p.e1547.

Steinert, Y., 2012. Faculty development: on becoming a medical educator. *Medical Teacher*, *34*(1), pp.74-76.

Steinert, Y., Basi, M. and Nugus, P., 2017. How physicians teach in the clinical setting: The embedded roles of teaching and clinical care. *Medical Teacher*, *39*(12), pp.1238-1244.

Steinert, Y. and Macdonald, M.E., 2015. Why physicians teach: Giving back by paying it forward. *Medical Education*, *49*(8), pp.773-782.Stets, J.E. and Burke, P.J., 2000. Identity theory and social identity theory. *Social Psychology Quarterly*, pp.224-237.Stewart, E., Nonhebel, A., Möller, C. and Bassett, K., 2022. Doing ‘our bit’:

Solidarity, inequality, and COVID-19 crowdfunding for the UK National Health Service. *Social Science & Medicine*, *308*, p.115214.

Stewart, F.M.J., Drummond, J.R., Carson, L. and Reddick, G.H., 2004. The future of the profession—a survey of dental school applicants. *British Dental Journal*, *197*(9), p.569.

Stryker, S., 1968. Identity Salience and Role Performance. *Journal of Marriage and the Family*, 4, pp.558-64.

Stryker, S. and Burke, P.J., 2000. The past, present, and future of an identity theory. *Social Psychology Quarterly*, pp.284-297.

Stubbing, E., Helmich, E. and Cleland, J., 2018. Authoring the identity of learner before doctor in the figured world of medical school. *Perspectives on Medical Education*, *7*(1), pp.40-46.

Suhonen, R., Stolt, M., Katajisto, J. and Leino-Kilpi, H., 2015. Review of sampling, sample and data collection procedures in nursing research-An example of research on ethical climate as perceived by nurses. *Scandinavian Journal of Caring Sciences*, *29*(4), pp.843-858.

Swanwick, T., 2013. Understanding medical education. *Understanding medical education: evidence, theory and practice*, pp.1-6.

Tagawa, M., 2016. Effects of undergraduate medical students' individual attributes on perceptions of encounters with positive and negative role models. *BMC medical education*, *16*, pp.1-9.

Tagawa, M. 2020. Scales to evaluate developmental stage and professional identity formation in medical students, residents, and experienced doctors. *BMC Medical Education* 20(1), pp.19.

Tajfel, H., 1974. Social identity and intergroup behaviour. *Information (International Social Science Council)*, 13(2), pp.65-93.

Tajfel, H., 1978. *Differentiation between social groups. Studies in the social psychology of intergroup relations*. London: Academic Press.

Tajfel, H., 1982. Experimental studies of intergroup behaviour. In *Cognitive analysis of social behavior: Proceedings of the NATO advanced study Institute on "The cognitive analysis of socio-psychological processes", Aix-en-Provence, France, July 12–31, 1981* (pp. 227-246). Dordrecht: Springer Netherlands.

Tan, E., 2014. Human capital theory: A holistic criticism. *Review of Educational Research*, *84*(3), pp.411-445.

Taylor-Gooby, P., Sylvester, S., Calnan, M. and Manley, G., 2000. Knights, knaves and gnashers: professional values and private dentistry. *Journal of Social Policy*, *29*(3), pp.375395.

Taylor, C., Grey, N.J.A. and Checkland, K., 2017. Professionalism... it depends where you're standing. *British Dental Journal*, *222*(11), p.889.

Tekian, A., Dekhtyar, M. and Park, Y.S., 2024. The rapid growth and expansion of Master of health professions education (MHPE) programs: A mixed-methods study of international curricular trends and guidelines for programs. *Medical Teacher*, *46*(3), pp.341-348..

Tekian, A. and Harris, I., 2012. Preparing health professions education leaders worldwide: A description of masters-level programs. *Medical Teacher.* 34(1), pp.52–58.

Ten Cate, O., 2021. Health professions education scholarship: The emergence, current status, and future of a discipline in its own right. *Faseb Bioadvances*, *3*(7), pp.510.

Thorpe, K. and Loo, R., 2003. Balancing professional and personal satisfaction of nurse managers: current and future perspectives in a changing health care system. *Journal of Nursing Management*, *11*(5), pp.321-330.

Thupayagale, G. and Dithole, K., 2005, October. What is in a name: the case of nursing. *Nursing Forum*. Vol. 40, No. 4, pp.141-144.

TMS Collaborative, 2021. The perceived impact of the Covid-19 pandemic on medical student education and training–an international survey. *BMC Medical Education* 21, pp.1-8.

Toma, J.D., 2000. How getting close to your subjects makes qualitative data better. *Theory into Practice*, *39*(3), pp.177-184.

Tracy, S.J., 2010. Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), pp.837-851.

Trautwein, C., 2018. Academics' identity development as teachers. *Teaching in Higher Education*, 23(8), pp.995-1010.

Trier-Bieniek, A., 2012. Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion. *Qualitative Research*, *12*(6), pp.630-644.

Tsang, A.K., 2010. The Evolving Professional (EP) Concept as a Framework for the Scholarship of Teaching and Learning. *International Journal for the Scholarship of Teaching & Learning*, *4*(1).

Tsang, A.K., 2011. Students as evolving professionals-turning the hidden curriculum around through the threshold concept pedagogy. *Transformative Dialogues: Teaching and Learning Journal*, *4*(3), pp.1-11.

Tuckett, A.G. 2005. Applying thematic analysis theory to practice: A researcher’s experience, *Contemporary Nurse*, 19:1-2, pp.75-87.

Turner, J.C. and Oakes, P.J., 1986. The significance of the social identity concept for social psychology with reference to individualism, interactionism and social influence. *British Journal of Social Psychology*, *25*(3), pp.237-252.

Turner, J. C., Oakes, P. J., Haslam, S. A. and McGarty, C., 1994. Self and Collective: Cognition and Social Context. Personality and Social Psychology Bulletin, 20(5), pp.454– 463.

Turner, J.C., Reynolds, K.J., 2012. Self-Categorization Theory. In: van Lange, P.A.M., Kruglanski, A.W. and Higgins, E.T., *Handbook of Theories of Social Psychology*. London: Sage.

Turner, V., 1987. Betwixt and between: The liminal period in rites of passage. *Betwixt and between: Patterns of masculine and feminine initiation*, pp.3-19. Open court Publishing

UCAS, 2024. 2024 cycle applicant figures. [online]: https://www.ucas.com/undergraduatestatistics-and-reports/ucas-undergraduate-releases/applicant-releases-2024-cycle/2024-cycleapplicant-figures-31-january-deadline. (accessed 12/08/24).

Vagni, M., Maiorano, T., Giostra, V., Pajardi, D. and Bartone, P., 2022. Emergency stress, hardiness, coping strategies and burnout in health care and emergency response workers during the COVID-19 pandemic. *Frontiers in Psychology*, *13*, p.918788.

Vainio, A., 2013. Beyond research ethics: Anonymity as ‘ontology’,‘analysis’ and ‘independence’. *Qualitative Research*, *13*(6), pp.685-698.

Van De Camp, K., Vernooij-Dassen, M.J., Grol, R.P. and Bottema, B.J., 2004. How to conceptualize professionalism: a qualitative study. *Medical Teacher*, *26*(8), pp.696-702.

van den Berg, J.W. and Lombarts, K.M., 2018. The struggle to support the transition to medical educator. *Medical Education*, *52*(2), pp.145-147.

Van den Broek, S., Querido, S., Wijnen-Meijer, M., van Dijk, M. and Ten Cate, O., 2020. Social identification with the medical profession in the transition from student to practitioner. *Teaching and Learning in Medicine*, *32*(3), pp.271-281.

van Huyssteen, M. and Bheekie, A., 2015. The meaning of being a pharmacist: Considering the professional identity development of first-year pharmacy students. *African Journal of Health Professions Education*, *7*(2), pp.208-211.

van Lankveld, T., Thampy, H., Cantillon, P., Horsburgh, J. and Kluijtmans, M., 2021. Supporting a teacher identity in health professions education: AMEE Guide No. 132. *Medical Teacher*, *43*(2), pp.124-136.

van Lankveld, T., Schoonenboom, J., Kusurkar, R.A., Volman, M., Beishuizen, J. and Croiset, G., 2017. Integrating the teaching role into one’s identity: a qualitative study of beginning undergraduate medical teachers. *Advances in Health Sciences Education*, *22*(3), pp.601-622.

Van Maanen, J., 1995. An end to innocence: The ethnography of ethnography, in J. Van Maanen (ed.), Representation in ethnography, pp1-35. Thousand Oaks, CA: Sage.

van Schaik, S.M., O'Sullivan, P.S., Eva, K.W., Irby, D.M. and Regehr, G., 2016. Does source matter? Nurses' and physicians' perceptions of interprofessional feedback. *Medical Education*, *50*(2), pp.181-188.

van Veelen, R., Otten, S., Cadinu, M. and Hansen, N. 2015. An Integrative Model of Social Identification*. Personality and Social Psychology Review*, 20(1), pp.3–26.

Olmos-Vega, F.M., Stalmeijer, R.E., Varpio, L. and Kahlke, R., 2023. A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, *45*(3), pp.241-251.

Vial, A.C. and Napier, J.L, 2017. High Power Mindsets Reduce Gender Identification and Benevolent Sexism Among Women (But Not Men). *Journal of Experimental Social Psychology*, 68, pp.162–170.

Vivekananda-Schmidt, P., Crossley, J. and Murdoch-Eaton, D., 2015. A model of professional self-identity formation in student doctors and dentists: a mixed method study. *BMC Medical Education*, *15*(1), p.83.

Wald, H.S., Anthony, D., Hutchinson, T.A., Liben, S., Smilovitch, M. and Donato, A.A., 2015. Professional identity formation in medical education for humanistic, resilient physicians: pedagogic strategies for bridging theory to practice. *Academic Medicine*, *90*(6), pp.753-760.

Walliman, N. 2011. *Your research project: Designing and planning your work*. London: Sage.

Warmington, S.G. and McColl, G.J., 2016. Medical student stories of participation in patient care-related activities: the construction of relational identity. *Advances in Health Sciences Education, 22*, pp.147 - 163.

Weatherall, A., Gavey, N. and Potts, A., 2002. So whose words are they anyway? *Feminism & Psychology*, *12*(4), pp.531-539.

Weidman, N.A., 2013. The lived experience of the transition of the clinical nurse expert to the novice nurse educator. *Teaching and Learning in Nursing*, *8*(3), pp.102-109.

Weinberger, S., 2009. The medical educator in the 21st century: a personal perspective. *Transactions of the American Clinical and Climatological Association*, *120*, p.239.

Welie, J. V. M., 1999. “Do you have a healthy smile?” Ugliness as a medical indication for dental and surgical cosmetic treatment. Medicine, Health Care and Philosophy, 2, pp.169– 180.

Welie, J. V. M., 2004. Is dentistry a profession? Part 3. Future challenges. *Journal of the Canadian Dental Association*, 70(10), pp.675–678

Welie, J.V., 2004a. Is dentistry a profession? Part 1. Professionalism defined. *Journal of the Canadian Dental Association*, 70(8), pp.529-532.

Welie, J.V., 2004b. Is dentistry a profession? Part 3. Future challenges. *Journal of the Canadian Dental Association*, *70*(10), pp.675-8.

Wijngaards, I., Pronk, F.R., Bakker, A.B. and Burger, M.J., 2022. Cognitive crafting and work engagement: A study among remote and frontline health care workers during the COVID-19 pandemic. *Health Care Management Review*, *47*(3), pp.227-235.

Wiles, R., Crow, G., Heath, S. and Charles, V., 2008. The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, *11*(5), pp.417-428.

Willetts, G. and Clarke, D., 2014. Constructing nurses' professional identity through social identity theory. *International Journal of Nursing Practice*, *20*(2), pp.164-169.

Williams, M., 2000. Interpretivism and generalisation. *Sociology*, 34(2), pp.209-224.

Wilson, I., Cowin, L.S., Johnson, M. and Young, H., 2013. Professional identity in medical students: pedagogical challenges to medical education. *Teaching and Learning in Medicine*, *25*(4), pp.369-373.

Wilson, A., Pearson, D. and Hassey, A., 2002. Barriers to developing the nurse practitioner role in primary care—the GP perspective. *Family Practice*, *19*(6), pp.641-646.

Wilson, I., Cowin, L.S., Johnson, M. and Young, H., 2013. Professional identity in medical students: pedagogical challenges to medical education. *Teaching and Learning in Medicine*, *25*(4), pp.369-373.

Woods, A., Cashin, A. and Stockhausen, L., 2016. Communities of practice and the construction of the professional identities of nurse educators: A review of the literature. *Nurse Education Today*, *37*, pp.164-169.

Wolff, S., 2004. Ways in the Field and their Variants in Flick, U., von Kardoff, E. and Steinke, I. eds., 2004. *A companion to qualitative research*. pp.195-202. London: Sage. Wu, R. and Shea, C.K., 2020. Examining occupational therapy students' responses to integrative seminars. *The Open Journal of Occupational Therapy*, *8*(2), pp.1-11.

Woolf, K., Papineni, P., Lagrata, S. and Pareek, M., 2023. Retention of ethnic minority staff is critical to resolving the NHS workforce crisis. *BMJ*, *380*.

Yakov, G., Riskin, A. and Flugelman, A.A., 2021. Mechanisms involved in the formation of professional identity by medical students. *Medical Teacher*, *43*(4), pp.428-438.

Yin, R.K., 2009. *Case study research: Design and methods* (Vol. 5). London: Sage.

Young, J.L. and Hegarty, P., 2019. Reasonable men: Sexual harassment and norms of conduct in social psychology. *Feminism & Psycholo*gy. 29 (4), pp.453–474.

Zaidi, S.B., 2022. Situating Sensitizing Concepts in the Constructivist-Critical Grounded Theory Method. *International Journal of Qualitative Methods*, *21*.

Zemljic, B., 2004. Standards of veterinary education for the future: Preparing the profession for the new century. *Journal of Veterinary Medical Education*, *31*(1), pp.13-14.

Zheng, M., Bender, D.J. Nadershahi, N.A., 2017. Faculty professional development in emergent pedagogies for instructional innovation in dental education. *European Journal of Dental Education, 21*, pp.67–78.

Zijlstra-Shaw, S., Robinson, P.G. and Roberts, T., 2012. Assessing professionalism within dental education; the need for a definition. *European Journal of Dental Education*, *16*(1), pp.e128-e136.

Zwanikken, P.A., Dieleman, M., Samaranayake, D., Akwataghibe, N. and Scherpbier, A., 2013. A systematic review of outcome and impact of Master's in health and health care. *BMC Medical Education*, *13*, pp.1-11.

Appendices

Appendix A1 – The Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Research Title: *Do professional identities impact upon how postgraduate trainees in healthcare 'make sense' of learning to become teachers in their workplace?*

You are being invited to take part in a research project. Before you decide whether or not to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with others, if you wish.

Thank you for reading this.

1. What is the purpose of this research project?

The intention is to explore the relationship between the professional identities of the healthcare professionals (doctors, dentists and nurses) and their approach to becoming healthcare educators. It will investigate how teaching identity may develop in relation to different healthcare professions. It centres on the interviewees' experience of a postgraduate teaching and learning programme in healthcare.

2. Why have I been invited to take part?

You have been invited because you are or will shortly become a student on the teaching and learning programme within the study.

3. Do I have to take part?

No, your participation in this research project is entirely voluntary and it is up to you to decide whether or not to take part. If you decide to take part, we will discuss the research project with you [and ask you to sign a consent form]. If you decide not to take part, you do not have to explain your reasons and it will not affect your legal rights. It should be made clear that involvement in this research project will have no effect on the participants' education or progression through any degree course.

You are free to withdraw your consent to participate in the research project at any time, without giving a reason, even after signing the consent form.

4. What will taking part involve?

Participants will be asked to engage in two short Skype or telephone interviews (each lasting approximately 30 minutes). One in the early phase of their study and then one at the end of their period of study (for many this will be approximately 9 months between first and final interview). The interview questions will be on the areas of their teaching and learning perspectives and how these may also relate to their professional background. Audio recordings will be made to create subsequent transcripts for analysis. All participants' identifying details will be anonymised during this process.

5. Will I be paid for taking part?

Participant interviewees should understand that any information offered will be as a gift and they will not benefit financially or via any other reward.

6. What are the possible benefits of taking part?

There will be no direct advantages or benefits to participants from taking part, but their contribution will help us understand more around the process of personal and professional development of educators in the healthcare professions. This may then result in enhanced approaches that could increase the capabilities of these professions.

7. What are the possible risks of taking part?

The risks that have been identified within this process are where participant information presented is not treated or used confidentially or where inappropriate influence is exercised by the researcher or their institutions on any outcomes that may affect the participant e.g. inappropriately adjusting marks of assessed work submitted within the programme of study. In order to ensure mitigation of such risks, all of the participants responses are anonymised and recordings secured digitally by

use of enhanced protection. The participant also may at any time request their work to be assessed independently by faculty who have no relationship with the research being conducted.

8. Will my taking part in this research project be kept confidential?

All information collected from or about participants during the research project will be kept confidential and any personal information provided will be managed in accordance with data protection legislation. Please see 'What will happen to my Personal Data?' (below) for further information.

9. What will happen to my Personal Data?

Personal data, according to the General Data Protection Regulation (GDPR) means any information relating to an identifiable living person who can be directly or indirectly identified in particular by reference to an identifier. This may include information such as an individual's name, address, email address or date of birth. This project is therefore defined as using personal data (any research project involving the use of written consent forms will be using personal data). In addition to participant interview responses, the personal data that will be collected are in the areas of contact details (emails but not addresses or telephone numbers) and professional background (but not employer details). The arrangements for anonymising these involve the use of a research project number.

Cardiff University is the Data Controller and is committed to respecting and protecting the participants' personal data in accordance with their expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/dataprotection
Printed copies of the above-mentioned documentation and privacy notices are available if required.

After 24 months, the research team will anonymise all the personal data it has collected from, or about participants in connection with this research project, with the exception of their consent form. Your consent form will be retained for 5 years after the completion of the research project and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 5 years after the end of the project, but may be published in support of the research

project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

It will not be possible to withdraw any anonymised data that has already been published or in some cases, where identifiers are irreversibly removed during the course of a research project, from the point at which it has been anonymised.

10. What happens to the data at the end of the research project?

The anonymised data may be made publicly available and/or shared within the University and/or shared outside of the University? Future research using the data be limited to areas of health care professional or broader vocational education.

11. What will happen to the results of the research project?

It is our intention to publish the results of this research project in academic journals and present findings at conferences. Participants will not be identified in any report, publication or presentation although verbatim anonymised quotes may be used.

12. What if there is a problem?

[Should participants have any concerns or wish to raise a complaint, they should in the first instance discuss with the researcher, Andrew Burnett. If they feel their complaint has not been handled to their satisfaction, they may contact someone independent from the research team e.g. Chair of the School Research Ethics Committee at SOCSI, Cardiff University.

If participants are harmed by taking part in this research project, there are no special compensation arrangements. If harmed occurs due to someone's negligence, participants may have grounds for legal action, but may have to pay for it.

13. Who is organising and funding this research project?

The research is organised by Andrew Burnett from Cardiff University with supervision from Prof. Alison Bullock and Dr Dean Stroud.

14. Who has reviewed this research project?

This research project has been reviewed and given a favourable opinion by the School of Social Sciences Research Ethics Committee, Cardiff University.

15. Further information and contact details

Should you have any questions relating to this research project, you may contact us during normal working hours:

Andrew Burnett via burnettar@cardiff.ac.uk or andrew.burnett@bristol.ac.uk or telephone 07738 684606.

Thank you for considering to take part in this research project. If you decide to participate, you will be given a copy of the Participant Information Sheet and a signed consent form to keep for your records.

Appendix A2 – The consent form

CONSENT FORM

Title of research project:

Do professional identities impact upon how postgraduate trainees in healthcare 'make sense' of learning to become teachers in their work place?

SREC reference and committee: SREC/3211

Name of Chief/Principal Investigator: Andrew Burnett

	Please initial box
I confirm that I have read the participant information sheet dated [September 2019] version [1.1] for the above research project.	
I confirm that I have understood the information sheet dated [September 2019] version [1.1] for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant).	

I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my data.	
I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify me from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I consent to being audio recorded for the purposes of the research project and I understand how it will be used in the research.	
I understand that anonymised excerpts and/or verbatim quotes from my [INTERVIEW/QUESTIONNAIRE ETC] may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree to take part in this research project.	

Name of participant (print)	Date	Signature
_____		_____
Name of person taking consent (print)	Date	Signature

_____

Role of person taking consent

(print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

Appendix A3 – The final ethics form

School of Social Sciences Ysgol Gwyddorau Cymdeithasol Head of School, Pennaeth yr Ysgol Dr Tom Hall	CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD
SREC Ref No:	

STUDENT PROJECTS - MASTERS PROGRAMMES/ MPhil/PhD &

PROFESSIONAL DOCTORATE RESEARCH PROJECTS

Ethical Approval Application Form

Must be submitted by the due deadline to:
socsi-ethics@cardiff.ac.uk

Note: This form uses check boxes, select the appropriate box, double click and select 'checked' a cross will appear in the box which indicates your response.

SECTION A: PERSONAL INFORMATION [all boxes can be expanded]

Please tick relevant project type:	**Masters** Yes ☐	**MPhil/PHD** Yes ☐	**Professional Doctorate** Yes ☒
Student Name:	Andrew Burnett		Student Number:0744789
Email Address:	burnettar@cardiff.ac.uk		
Supervisors:	**1 Dr Dean Stroud**	**2 Prof. Alison Bullock**	

Supervisors' Signatures:	**1**	**2**
Degree Programme:	EdD – Professional Doctorate	
Title of Project:	*An investigation into whether professional identities impact upon how postgraduate trainees in healthcare 'make sense' of learning to become teachers in their work place?*	
Project Start Date:	2/9/19	**Dissertation/Thesis Submission Date: May 2021**
Student's Signature:	**Andrew Burnett (electronic signature)**	**Date: 15/2/19**

Before completing, please now read the Application Guidance Notes at the end of this form

SECTION B: DISSERTATION SUMMARY

1. Below, please provide a concise general description of your dissertation project

The intention of the proposed thesis is to explore the relationship between the professional identities of the healthcare professionals (doctors, dentists and nurses) and their approach to becoming healthcare educators. I wish to investigate how teaching identity develops in relation to different healthcare professions. I am taking as my focus their experience of a postgraduate teaching and learning programme. Focussing on an interprofessional education programme in healthcare provides opportunity to view the process of different healthcare professions learning together in a frequently collaborative process. During this learning process, I intend to observe the development of "identification" through the basic cognitive and social processes through which they make sense of and organise their human world, and to consider whether "embodied identifications" such as profession (i.e. nurse, dentist or doctor) affect this.

Research Design

I will adopt a case study design focussing upon the education programme. I will interview participants both prior to commencement and after completion of the postgraduate study. This can be done within a 9-month timeframe. I anticipate 15 interviews for each of the two phases of research. I may also observe interaction of trainees within group settings. This will not be conducted without the explicit and recorded consent of those observed.

13/02/2020 - Additional amendment: I wish to conduct a short online questionnaire to be sent to all students attending the TLHP Certificate Programme (not just the interview respondents). The questionnaire will be sent by a third party (the University's TLHP Programme Administration Team). It will make very clear that it is voluntary. The questionnaire will be piloted on the TLHP Certificate Programme student reps (x2) and and two teaching colleagues. These pilot respondents will be able to put comments in open text boxes within it.

A copy of the link to the MS Forms survey is below

https://forms.office.com/Pages/ShareFormPage.aspx?id=MH_ksn3NTkql2rGM8aQVGwAjNZQSNdIlq6pmPMdbNbpUMFg5OVpKRlFJREpDNk1TOTdXRzIzSERTTC4u&sharetoken=1p58woF8i4dZ6b71Hx3n

1/1/22 – Additional amendment. As a result of the impact of Covid 19 on my research timetable (my interview subjects are healthcare professionals and became very busy during some of the pandemic peaks) and also a reduced number of continuing interviewees (down from 10 subjects to 7 in my second 'round' of interviews in March 2021). I would like to receive approval for a third set of interviews (7 interviewees in total) to be conducted in April 2022. Both the interviewees and the questions would be the same as those previously approved but will offer additional longitudinal insight into some emerging themes from earlier interviews.

I would also like to re-run the previously approved online questionnaire with the same approved sample; as when it was issued in early 2021 the response level was 3 out of 132. A second attempt when these healthcare professionals are no longer amidst a surge of infection could provide valuable additional data.

2. What are the research questions?

My overarching question is: Do professional identities impact upon how postgraduate trainees in healthcare 'make sense' of learning to become teachers in their work place?

	My three sub-questions are: 1. What are the self-perceptions of teaching identity amongst trainees following an award bearing course in medical education? 2. Does the preceptor trainee's teaching identity develop during their process of learning? 3. How do professional identities influence teacher identity?
3.	Who are the participants? The research will focus on participants following the certificate-level Teaching and Learning for Health Professionals (TLHP) programme in the University of Bristol's Faculty of Health Sciences. Over 90 Certificate-level students enrol each year, primarily from medicine, dentistry and nursing. The certificate requires attendance over 7 study days and submission of three written formative and three written summative assignments (20 credits each).
4.	How will the participants be recruited? Potentially, I might be a tutor on one of the TLHP taught units. Hence, to alleviate any potential sense of obligation to participate, initial contact will be made by the general administration team. Those registered for the programme will be emailed information on the research by a member of the programme administration/faculty admissions team. Anyone willing to participate will be invited to contact me. As a result of limited responses, I request to also be able to canvas participants by informing of the existence of the research project and the request for participants on their first day of study. The information offered will be identical to that presented by the Administrative team's emails originally. A brief hand out can be issued for students to take away and consider. This will be 'inform' rather than 'sell' as an approach. Should observations of engagement amongst trainees be considered, I will arrange for potential participants to be contacted by the general administration team, informing of the project and offering information and a consent form in advance of any sessions that might be observed. I will not be the tutor in those sessions.
5.	What sort of data will be collected and what methods will you use to do this?

	The data will be audio recorded interviews. The interviews will be offered via Skype or telephone, depending on the preference of the participant. The interview will be subsequently transcribed. Should observations be conducted, these will be in a classroom setting during taught modules and comprise interaction analysis i.e. discursive analysis or 'classroom talk' of trainees. The data will be collected using field notes which will be digitally stored on secure university systems and any hard copies kept in locked cabinets.		
6.	How and where (venue) are you undertaking your research? The interviews will be conducted via Skype/telephone, with the interviewer located in a private office within the University building, in order to ensure privacy/confidentiality. The observations (if conducted) will occur in the seminar room, where trainees attend the taught study modules. It is on the University campus. What is the reason(s) for using this particular location? For interviews - Privacy and convenience. Skype calls allow the researcher access to the trainees before they attend the study days within the University as they may be in diverse/distant locations. It also accommodates their own work and life commitments. For observation (if conducted) – This seminar room is where trainees will engage with each other and the course tutor, and so the primary location for interaction to occur amongst them.		
7.	(a) Will you be analysing secondary data? If YES, does approval already exist for its use in further projects such as yours?	Yes ☐	No ☒
	(b) Will you be using administrative data? If YES, how will you be using these data (e.g. sifting for suitable research participants or analysing the data)?	Yes ☒	No ☐

	From an initial cohort that is expected to exceed 90 students, I wish to include a range of professional backgrounds. I will use the administrative data to give me an overview of the numbers of doctors, nurses, dentists, others on the programme.		
	SECTION C: RECRUITMENT PROCEDURES		
8.	(c) Does your project involve children or young people under the age of 18? If **No**, go to 10	Yes ☐	No ☒
	(d) If so, have you consulted the University's guidance on child protection procedures, and do you know how to respond if you have concerns?	Yes ☐	No ☐
9.	(a) Does your project involve one-to-one or other *unsupervised* research with children and young people under the age of 18 ? If **No** go to 9(b) If **Yes**, go to 9(c)	Yes ☐	No ☐
	(b) If your project involves only *supervised* contact with children and young people under the age of 18, have you consulted the head of the institution where you are undertaking your research to establish if you need a Disclosure and Barring Service (DBS) Check? If **Yes**, and you do need a DBS check, then go to 9(c); if you do not need a DBS check, then go to Question 10.	Yes ☐	No ☐
	(c) Do you have an up-to-date Disclosure and Barring Service (DBS) Check ? If your application is **pending** please state the submission date: __ / __ / __ The SREC Office will require you to notify them when it is approved.	Yes ☐	No ☐
10.	Does your project include people with learning or communication difficulties?	Yes ☐	No ☒
11.	Does your project include people in custody?	Yes ☐	No ☒
12.	Is your project likely to include people involved in illegal activities?	Ye	No ☒

		Yes ☐	
13.	Does your project involve people belonging to a vulnerable group, other than those listed above?	Yes ☐	No ☒
14.	Does your project include people who are, or are likely to become your clients or clients of the department in which you work?	Yes ☒	No ☐

SECTION D: CONSENT PROCEDURES

Please ensure you are familiar with the updated General Protection Data Regulation (GDPR) guidance when considering consent for your participants.

15.	Will you obtain written consent for participation?	Yes ☒	No ☐

16. What procedures will you use to obtain, record and maintain informed consent from participants?

1. The information on the project will be issued by the 'third party' administrator.
2. Anyone interested in taking part will be invited to discuss participation with me.
3. Interested participants will be invited to sign a consent form.
4. If a signed (and potentially scanned) copy has been obtained, the Skype/telephone interview will be arranged, or if consent has been obtained for participation in an observed session, then the process will commence. Observation fieldnotes will not include any information on non-consenting individuals.
5. At the beginning of an interview I will re-affirm the conditions of participation and the consent, ensuring that the participant is aware that participation in the study will have no bearing on their participation in the course and that they have the right to withdraw at any time during or after the interview, without consequence. I will particularly emphasise that the interviews will be with me in my role as doctoral student, not as course tutor. This is something that will be made explicit on the Information Sheet.

17.	If the research is observational, will you ask participants for their consent to being observed?	N/A ☐	Yes ☒	No ☐
18.	Will you tell participants that their participation is voluntary?	N/A ☐	Ye	No ☐

			Yes ☒	
19.	Will you tell participants that they may withdraw from the research at any time and for any reasons?	N/A ☐	Yes ☒	No ☐
20.	Will you give potential participants appropriate time to consider participation?	N/A ☐	Yes ☒	No ☐
21.	Does your project provide for people for whom English / Welsh is not their first language?	N/A ☐	Yes ☐	No ☒
SECTION E: POTENTIAL HARMS ARISING FROM THE PROJECT				
22.	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?		Yes ☐	No ☒
23.	Is there any realistic risk of any participants experiencing a detriment to their interests as a result of participation?		Yes ☐	No ☒
24.	**Below, please identify any potential for harm (to yourself or participants) that might arise from the way the research is conducted** PLEASE DO NOT LEAVE BOX BLANK			
Participants may feel that their participation could have a positive or potentially negative effect on their progress within the teaching programme, as the researcher is a tutor on the course. They may feel discomfort sharing potentially negative opinions about the course or their participation in it (for example, that it has not met their expectations).				
25.	**Below, please set out the measures you will put in place to control possible harms to yourself or participants** PLEASE DO NOT LEAVE BOX BLANK			

Participants will be reminded that participation is voluntary and has no bearing on their participation or progress on the course. That all questions in the interview will be optional and that they should only share opinions they feel comfortable sharing.

That data will be confidential and anonymised so that no extracts/quotes will be assigned to any identifiable individual.

I will ensure that the participants are clear that the interviews will be with me in my role as doctoral student and not as course tutor. Following the initial interview, participants course work will be anonymised(standard) and marked by someone other than the researcher.

The potential for reputational damage is addressed through data protection and anonymisation processes that will be

applied.

SECTION F: SECURITY-SENSITIVE RESEARCH & PREVENT DUTY

Cardiff University has established a Security-sensitive research framework which aims to balance the commitment to academic freedom and scope against the need to safeguard researches from risk of radicalisation and/or risk that their research activity might result in a misinterpretation of intent by external authorities.

26.	Has due regard been given to the 'Prevent duty', in particular to prevent anyone being drawn into terrorism? For further guidance, see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445916/ Prevent_Duty_Guidance_For_Higher_Education__England__Wales_.pdf and http://www.cardiff.ac.uk/public-information/policies-and-procedures/freedom-of-speech	Yes ☒	No ☐
27.	Does your research fall within the Security-Sensitive policy? This includes the following:- • Research concerning terrorist or extremist groups (in particular, those designated by the Home Office as a 'Proscribed Terrorist Organisation'); and • Research involving access to materials that may be considered extremist and/or materials that promote terrorism, extremism or radicalisation.	Yes ☐	No ☒

	For further guidance, see: https://intranet.cardiff.ac.uk/intranet/staff/documents/research-support/integrity-and-governance/Final-V1_Security-Sensitive-Research-Policy.docx If **'Yes'** go to Question 28. If **'No'** go to Question 29.		
28	Have you followed the registration procedure detailed within the policy? Please note this must be done before ethical approval can be given.	Yes ☐	No ☐
SECTION G: RESEARCH SAFETY			
Before completing this section, you should consult the document 'Guidance for Applicants' – and the information under 'Managing the risks associated with SOCSI research'.			
29.	Are there any realistic safety risks associated with your fieldwork?	Yes ☐	No ☒
30.	Have you taken into account the Cardiff University guidance on safety in fieldwork / for lone workers?	Yes ☒	No ☐
SECTION H: DATA COLLECTION			
The SREC appreciates that these questions will not in general relate to research undertaken in SOCSI. However, for further University guidance and information please see the links below.			
31.	Does the study involve the collection or use of human tissue (including, but not limited to, blood, saliva and bodily waste fluids)?	Yes ☐	No ☒
	If **Yes**, a copy of the submitted application form and any supporting documentation must be emailed to the Human Tissue Act Compliance Team (**https://intranet.cardiff.ac.uk/staff/research-support/integrity-and-governance/human-tissue-research**). A decision will only be made once these documents have been received. For guidance on the Human Tissue Act: http://www.cardiff.ac.uk/govrn/cocom/humantissueact/index.html		

32.	Does the study include the use of a drug? If **Yes**, you will need to contact Research Governance before submission (**resgov@cardiff.ac.uk**)	Yes ☐	No ☒
	SECTION I: DATA PROTECTION		
33.	(a) Are you collecting sensitive data? [Defined as: the racial or ethnic origin, political opinions, religious beliefs (or similar), trade union membership, physical or mental health, sexual life, the commission or alleged commission any offence, or any proceedings for any offence committed or alleged to have been committed the disposal of such proceedings or the sentence of any court in such proceedings.]	Yes ☐	No ☒
	If **Yes**, how will you employ a more rigorous consent procedure?		
	(b) Are you collecting identifiable data? [Please note, this includes recordings of interviews/focus groups etc.]	Yes ☒	No ☐
	If **Yes**, how you will anonymise these data? Recordings will be anonymised upon transcription by the use of pseudonyms and the removal of other identifying information (e.g. workplaces). I hope to recruit about 15 participants from a pool of about 90. Although I will want to refer to professional group, I anticipate my participants will be from the major participating groups (doctors, nurse, dentists). However, I will be sensitive to identity disclosure should any participants be from a minority group. In that case, the specific profession will not be reported.		
	(c) Will any non-anonymised and/or personalised data be retained? RESPONSE: Only the consent form, copies of which will be kept separately and in a locked cabinet.	Yes ☒	No ☐
	(d) Data (i.e. actual interview recordings, not just transcripts) should be retained **for no less than 5 years or at least 2 years post-publication and then destroyed in accordance with GDPR.** Have you noted and included this information in your Information Sheet(s) ? [The University may request access to this data at any point in this year to confirm your marks. It is your responsibility to maintain it securely.	Yes ☒	No ☐
34.	**Below,** please detail how you will deal with data security. Please note, personal laptops (even password protected) stored in personal accommodation are not acceptable. Storage on University network, or use of encrypted laptops is required.		

Storage via Cardiff University Systems using password protected one-drive facility. The interview recordings will be removed from the recording device immediately and stored within the secure system noted.

If there are any other potential ethical issues that you think the Committee should consider, please explain them on a separate sheet. It is your obligation to bring to the attention of the Committee any ethical issues not covered on this form

SECTION J: SUPERVISOR DECLARATION

The supervisor(s) must explain in the box below how any potential ethical issue(s) highlighted by the student above and via ticked shaded boxes on this form, will be handled. Please also consider if it is appropriate for the information sheet(s) and consent form(s) to be attached to this form.

PLEASE DO NOT LEAVE THIS BOX BLANK

We have discussed the ethical implications of this research with Andrew and are comfortable that he has given due consideration to how participants will be recruited, how consent will be obtained, how data will be collected and stored. A key point of our discussion has been around his dual role as tutor on the course from which he will be recruiting participants and his role as researcher. We have discussed this particularly in relation to recruitment, consent procedures and potential harms.

As the supervisor for this student project, I believe that all research ethical issues have been dealt with in accordance with University policy and the research ethics guidelines of the relevant professional organisation.

Supervisor(s) Signature:	**1. Dean Stroud**	**2. Alison Bullock**
Date:		

Appendix A4 – The Interview Schedule

Andrew Burnett EdD Interview Schedule (V.3 – post-piloting)

Data Capture – Semi-structured Telephone Interview Questions

Courtesy Questions

- Confirm the timing is still convenient
- Remind of purpose of the interview
- Reassure about confidentiality, anonymity
- Check consent completed
- Confirm permission for interview to be recorded
- Ask what further questions they may have before commencing

Profile Questions

In order to support later analysis, some general information is needed on our research subjects. All information provided is confidential and anonymised. Please leave blank if you do not wish to answer a specific question.

Gender* (with which subject identifies):

Male Female Other

Age range:

21-30 31-40 41-50 51-60 >60

Ethnicity*:

White

White Irish

White – English, Welsh, Scottish, Northern Irish, British

White Scottish

Irish Traveller

Gypsy or Traveller

Other white background

Black or Black British – Caribbean

Black or Black British – African

Other Black background

Asian or Asian British – Indian

Asian or Asian British – Pakistani

Asian or Asian British – Bangladeshi

Chinese

Other Asian background

Mixed – White and Black Caribbean

Prefer not to say

Professional background/Occupation: <free text>

What qualification allows you to practice in your health care profession?:

Highest qualification held (diploma, certificate, undergraduate degree, postgraduate certificate, postgraduate diploma, Master's degree or PhD/Doctorate) :

Time held in current position:

How long has it been since completing your initial professional training enabling you to practice in Healthcare?:

*The categories provided are those currently in use by the Higher Education Statistics Agency (HESA)

Research Question:

My overarching question is: *Do professional identities impact upon how postgraduate students in healthcare 'make sense' of learning to become teachers in their workplace?*

My three sub-questions are:

1. *What are the self-perceptions of teaching identity amongst students following an award bearing course in medical education?*

2. *Does the preceptor student's teaching identity develop during their process of learning?*

3. *How does professional identity influence teacher identity?*

1. **Tell me about you?**
    a. Questions to prompt further may be: Tell me about the 'professional' you. Is this different to the 'normal' you? *What do you do? Where are you in your career at this moment? How do you feel about this? What groups do you identify with/feel part of? (perhaps explain Communities of Practice) Why? Why did you decide to become a doctor, nurse, dentist..? How does education form a part of your current role?*
    b. Here I am looking to bring out statements around origin (profession), associated groups, career stage/status, self-perception and levels of satisfaction.

2. **What brought you here to complete this programme?**

    a. Questions to prompt further may be: How much did you think about attending the programme? *How does this programme interest you personally? What are your experiences of teaching in the workplace (as a teacher or a student)? What drives you to complete this additional study? What are the influences that have placed you on this path?*
    b. Here I am looking to bring out statements around ambition, goals, pre-formed conceptions of the teaching role and perhaps how these have been developed, motivation and the inducements or pressures that may be present to suggest this programme as a course of action.
    I am aware some interviewees will say they attend because the course is funded and expected. It will be helpful to see whether they just considered attendance because it was expected by the funding employer.

3. **What do you consider are the qualities or attributes of a teacher?**
    a. What forms your ideas? What picture do you imagine? Where are the examples of teachers drawn from? (e.g. school, undergraduate teaching, vocational teaching 'on the job'?)
    b. Relates to sub-question 1 on self-perceptions of teaching identity.

4. **What do you think this programme will entail?**
    a. Questions to prompt further may be: *What are your expectations? What excites you about this programme? Do you feel apprehensive about this course, if so in what way? What about this course might disappoint you? Have you considered how you will engage with teaching staff and other students?*

ENSURE these prompts are given as presented otherwise may get a repeat of what is on the TLHP programme website.

b. Here I am looking to bring out how informed the interviewee feels around the forthcoming process (did they know what they were entering, and how was that knowledge gained)? How will they view a scale of satisfaction (excitement to apprehension or even disappointment)? Have they considered the other students on

the course in terms of impact, interaction, and anything else? Similarly, how do they feel about the teaching staff and their part in the process?

5. **Could this Programme enhance the work you already do? ~~Will this make you a better~~ ~~[doctor, nurse, dentist…]?~~**
   a. Questions to prompt further may be: *What do you hope to be able to do once this programme has been completed? Do you expect to see benefits in your professional life? Will others (e.g. colleagues/family) benefit from your successful completion of this programme? Are you aware of the GMC/GDC/NMC guidance on levels of teaching expected within own profession? Are you aware of the standards they expect in delivering teaching?*
   b. Here I am looking to bring out statements around the impact on their original role
   (e.g. will it make them a better nurse, a nurse who teaches or a teacher of nurses)? Their descriptions will be important. Are there rewards to this form of development or do they perceive there to be expectations from others (or consequences)?

6. **Where do you think this might take you?**
   a. Questions to prompt further may be: *What are your professional expectations (perhaps in 5 years from now?)? how could this programme fit into your longer term career pathway? Do you expect to change the way you work? Do you expect to change the work you do? What do you consider is the value of education and teaching to your profession? How involved should your profession be in delivering education? Should it be intrinsic to your profession's practice?*

   b. Here I am looking to bring out their visions of the future. To look for motivators. To consider other ways of understanding their reasons for being on the programme.

7. **Do you feel the programme might change your view/perspective of who you are professionally and your profession generally? And the teaching profession?**
   a. Question to prompt further may be does the respondent think this process may change them?
   b. Relate to research question 2.

Appendix A5 – An example of own notes during familiarisation with interview data

Appendix A5