The Role of Professional Identity Formation in Balancing Residency Service Versus Educational Needs

Mirabelle Sajisevi, MD
Reason Wilken, MD
Walter T. Lee, MD, MHSc

Residency is a unique time in one's medical career. It is a time of intense learning and mentorship, as well as work and service. The aspects of service and education in residency have often been regarded as being on the opposite ends of a spectrum.

As an example, consider the scenario of a resident who has decided, midresidency, to move into another specialty. In order to provide the best preparation for this new career choice, one might assume that freeing up time to participate in research projects and prepare for application into the newly chosen specialty would be the best course of action. After all, once the decision has been made to change specialties, what educational value remains in being part of a specialty that one will never practice? Certainly, various logistical and professional concerns may exist regarding completing clinical duties to minimize disruptions of colleagues' schedules resulting from a resident leaving a program midyear. However, the completion of such obligations would seem to fall squarely in the "service" category, with little to no educational utility.

This underscores the fact that service and education in residency are often considered opposing, and mutually exclusive, considerations. There is a resident survey given by the Accreditation Council for Graduate Medical Education (ACGME), which is conducted to monitor compliance with the accreditation standards, and residents are asked how often their clinical education is comprised of excessive service obligations.[1] The ACGME highlights the emphasis on learning activities and supports the principle that the balance of education and service should be weighted on the side of education. The ACGME's expectation that education should receive a higher priority than service likely is rooted in the exploitation of residents dating back to the 1920s and 1930s, when interns were relegated to paperwork and inserting intravenous lines, while having limited opportunities for didactics or clinical rounds.[2] The ACGME standards emphasize the educational aspects of residency training.

However, who really determines what constitutes "excessive service obligations"? Currently, the arbiter is on the trainee, and this has led to some challenges.[3,4] In addition, neither "education" nor "service" is defined by the ACGME, and trainees responding to the survey may not be aware of the experiential learning that occurs during service provision. As those who have entered or completed medical training are aware, there are essential tasks residents must perform that fall under the heading of "work" or "service," such as administrative duties or scheduling. The work required of the residents and their attending teams to effectively care for patients on an inpatient service and manage busy clinic schedules can be significant. While the educational experience may be the primary factor focused on during residency training, this focus may present a false dichotomy in how service aspects are "balanced," particularly as education and service aspects often are intertwined. In contrast to viewing the relationship of education and service as a "balance" between the 2 dimensions, the educational experience can be understood as a dynamic process. In some instances, the emphasis will be on education, and in other instances, on service.

There arguably is a level in which certain activities become "burdensome nonmedical chores,"[5] and educators must recognize this. At the same time, it is evident that both service and education are valuable aspects of residency. Attempting to assess the benefits of a certain amount of service relative to a certain amount of education is not ultimately helpful, as this may overlook the primary objective of residency programs.

We assert that professional identity formation should be the primary objective of residency. Cruess et al[6] defined professional identity as "a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician." Furthermore, training programs are responsible for providing an environment that enables this identify formation.[7]

DOI: http://dx.doi.org/10.4300/JGME-D-15-00123.1

Let us return to the scenario of the resident who decided to change to a different specialty midway through residency. Conversations focused on service or education limit how this would best be addressed. As mentioned above, having a trainee remain in the program to complete the year appears to be more in the service realm rather than education. However, if we understand this within the context of professional identity formation, answers to the questions of what does one do from both the program and the resident perspectives begin to emerge. First, the reasons for the new specialty choice should be ascertained by the faculty. Once there is mutual agreement on what is best for the resident, faculty should support the resident in pursuing the newly chosen specialty. This may include offering recommendations and assisting with identifying career options, as well as demonstrating that faculty members are committed to doing what they can to help develop the resident's professional identity formation, irrespective of the chosen field of medicine.

The resident also has a role in his or her professional identity formation. For example, the resident still has responsibilities for providing patient care as part of the health care team. Furthermore, expectations that pertain to all residents in the program, such as giving a grand rounds presentation on clinical topics, should be met. While the subject matter may be different, the resident needs to show an understanding that practical skills gained in providing patient care will serve him or her well in the new field, and this should not be overlooked. In other words, the medical and surgical treatment of a thyroid tumor may be different than that of a newly discovered skin cancer, but learning the process of assessing and counseling patients is an essential skill relevant for all physicians. In addition, fulfilling responsibilities and striving for personal excellence is an important part of being a physician, regardless of specialty.

It should be noted at this point that the scenario described earlier actually occurred in all of the authors' residency programs. It was this experience that brought about a deeper understanding of how professional identify formation is experienced and understood within a residency training program. Going beyond our scenario, the concept of professional identify formation can be broadly applied in residency. We believe service is a vital part of professional identity formation and may be expressed in other examples, which are as simple as obtaining a wheelchair for someone who is struggling to walk from the parking garage to the clinic or stopping to offer directions to someone who appears to be lost. The concept also extends to other professions, where it is considered a conceptual apprenticeship that professionals-in-training must traverse.[8]

In summary, the concepts of education and service during residency are integrated, and few tasks in the clinical setting are devoid of opportunities to expand one's fund of knowledge and skills. Together, these elements are valuable in achieving the goal of professional identity formation. This formation, during these critical years of training, involves teaching trainees to have a commitment to professionalism, an adherence to ethical principles, and an engagement in the pursuit of lifelong education and service.

References

1. Accreditation Council for Graduate Medical Education. Resident/fellow and faculty surveys. http://www.acgme.org/acgmeweb/tabid/97/DataCollectionSystems/ResidentFellowSurvey.aspx. Accessed January 15, 2016.
2. Ludmerer KM, Johns MM. Reforming graduate medical education. *JAMA*. 2005;294(9):1083–1087.
3. Sanfey H, Cofer J, Hiatt JR, Hyser M, Jakey C, Markwell S, et al. Service or education: in the eye of the beholder. *Arch Surg*. 2011;146(12):1389–1395.
4. Galvin SL, Buys E. Resident perceptions of service versus clinical education. *J Grad Med Educ*. 2012;4(4):472–478.
5. Wallace EZ. Service vs education in internal medicine residency. Need for a resolution. *Arch Intern Med*. 1988;148(6):1296.
6. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. Reframing medical education to support professional identity formation. *Acad Med*. 2014;89(11):1446–1451.
7. Cruess SR, Cruess RL. Teaching professionalism—why, what and how. *Facts Views Vis Obgyn*. 2012;4(4):259–265.
8. Wegner JW. The Carnegie Foundation's *Educating Lawyers:* four questions for bar examiners. *The Bar Examiner*. June 2011:11–24. https://law.ubalt.edu/academics/pdfs/Carnegie%20Report%20article_final.pdf. Accessed January 15, 2016.

Mirabelle Sajisevi, MD,* is PGY-5 Resident, Division of Head and Neck Surgery & Communication Sciences, Department of Surgery, Duke University Medical Center; **Reason Wilken, MD,*** is Research Fellow, Department of Dermatology, University of California, Davis School of Medicine; and **Walter T. Lee, MD, MHSc,** is Associate Professor, Division of Head and Neck Surgery & Communication Sciences, Department of Surgery, Duke University Medical Center, and Staff Surgeon, Section of Otolaryngology, Durham VA Medical Center.

The views expressed in this article are those of W.T.L. and do not necessarily represent the views of the Department of Veterans Affairs or the US government.

Corresponding author: Walter T. Lee, MD, MHSc, Duke University Medical Center, Division of Otolaryngology–Head and Neck Surgery, Department of Surgery, Room 3532–Blue Zone, DUMC 3805, Durham, NC 27710, 919.681.8449, fax 919.613.6524, walter.lee@dm.duke.edu

* These authors contributed equally to this article.