Transition theory and the emotional journey to medical educator identity: A qualitative interview study

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RESEARCH ARTICLE

PROFESSIONAL IDENTITY

Transition theory and the emotional journey to medical educator identity: A qualitative interview study

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Abstract

Background: Medical academia is in crisis, with fewer people entering and growing concern at numbers leaving. While faculty development is often seen as part of the solution, there are significant issues with faculty not engaging with and resisting development opportunities. Lack of motivation may be linked to what might be called a 'weak' educator identity. We studied medical educators' experiences of career development to gain further insights into: how professional identity may develop; individuals' accompanying emotional responses to perceived identity change; and consideration of the accompanying temporal dimensions. Drawing on new materialist sociology, we explore medical educator identity formation in terms of an affective flow that places the individual within a constantly shifting assemblage of psychological, emotional and social relations.

Method: We interviewed 20 medical educators at various career stages, with differing strengths of medical educator self-identity. Using an adapted transition model as a basis for understanding the emotions experienced by those undergoing identity transitions, we explore the process that, for some medical educators, appears to lead to decreased motivation, ambiguous identity and disengagement, but for others results in renewed energy, a stronger and more stable professional identity and increased interest and engagement.

Results: By more effectively illustrating the emotional impact of the transition process leading to a more stable educator identity, we show that some individuals, especially where the change was not sought or welcomed, express their uncertainty and distress through low mood, resistance and an attempt to minimise the significance of undertaking or increasing teaching duties.

Discussion: Understanding the emotional and developmental phases of the transition to medical educator identity has several key implications for faculty development. Faculty development approaches should be alert to the individual educator's stage of transition since this will affect that individual's readiness to accept and respond to guidance, information and support. A renewed emphasis on early educational approaches that will support the transformational and reflective learning of the

individual is needed, while traditional approaches emphasising skills and knowledge may be more useful in the later stages. Further testing of the transition model and its applicability to identity development in medical education is indicated.

1 | INTRODUCTION

While many healthcare educators enjoy long, happy and successful careers, concern has grown that fewer individuals are entering medical academia[1,2] and still others are leaving to return to clinical practice.[3,4] The systemic reasons behind this attrition have been well rehearsed, including workplace cultures that prioritise clinical service and academic research above teaching,[5] unclear career pathways,[6] workplace inequities,[7] lack of institutional support[8] and faculty development approaches that fail to support educator identity formation.[9]

However, many challenges appear to be personal and individual. For example, Sethi et al argue that constantly negotiating the multiple tensions involved in developing and maintaining an educator career may 'lead to detachment, cynicism and a weak sense of identity among healthcare educators'.[2] It is also suggested that 'navigating and overcoming these tensions' requires a major transition on the part of the individual—a 'leap' towards a more stable educator identity that many find difficult to negotiate.[10,11]

Recent research on educator development has focused on 'identity formation'—the need for individuals to (re)construct and develop a new understanding of their professional identity that incorporates the educator role into their primary clinical identity.[12] Establishing a professional identity as an educator is linked to increased commitment to personal and skills development,[13] greater role satisfaction,[14] increased well-being and a decrease in feelings of impostorism[15] and a positive impact on teacher effectiveness.[16]

Educator identity formation is theorised in different ways, drawing respectively on literature rooted, along Westernised disciplinary lines, in sociological or psychological theory.[17,18] Some scholars view identity formation as fragmentary, multiple and always contingent,[19] others view it as a linear progression towards a specific identity,[20,21] while still others see it as a process of socialisation that is influenced by how an individual experiences their relationship within a professional community.[2,22] Nevertheless, the concept of identity development, however theorised, invariably contains a temporal component: the notion of development necessarily contains within itself a sense of progression or trajectory—the idea that the individual is continuously becoming something other than what they are at present.[23,24]

In this paper, we emphasise the importance of the emotional response to assuming (either fully, or in part) a medical educator 'identity'. In addition, we consider the temporal dimensions of moving in (and out) of a medical educator identity. Our theoretical position draws on new materialist sociology.[25] From an ontological and epistemological perspective, we see identity as describing a process: a way of knowing and being ourselves. Identity is not limited to singular categories (human, woman, doctor, medical educator); rather, identity, or the identities that we occupy, has fluid boundaries that are temporarily constructed through everyday material-discursive practices (through our interactions and exchanges within the real-world contexts that we inhabit). Like other 'identities', medical educator identity is a material (in that it has physical properties and affects) and social construct with which individuals or groups may (or may not) engage. Similarly, with respect to emotions, while we acknowledge the importance of understanding the embodied, lived experience of emotion from the perspective of individuals and groups and the role of emotion 'work',[26] theoretically, in this paper, we unhitch emotions from their corporeal or cultural associations and consider them independently, as 'matter', in terms of their 'affect' within the relationship (or assemblage) of 'things' (actors, social and cultural ideas, rules, artefacts). Our position is that emotions have material effects, and this has implications for perpetuating or disrupting well-trodden 'normalised' ways of 'thinking and doing'. Finally, we regard temporality as an inherent and unproblematised aspect of any 'process', which (like emotions) is underplayed within the medical education literature. Mostly theorised from within the phenomenological school of thought (see, e.g. the work of Sundberg et al[27]) from our new materialist perspective, we consider time in terms of 'affective flow'[28]: in terms of how assemblages of things ('matter'—such as actors, rules and artefacts) are involved in ongoing, relentless, social production. Our position here aligns with and draws on theories discussed elsewhere in medical education, including actor–network theory[29] and cultural historical activity theory.[30]

To describe the relationship between medical educator identity, emotion and time, we draw on ideas associated traditionally with the field of psychology: transition theory. Within the context of this paper, we treat transition theory as a mid-range theory.[31] Unlike broader, more abstract 'grand theory' (e.g. new materialism), mid-range theory is more local and applied: a theory that can be used as a heuristic framework and applied to a particular phenomenon. Additionally, mid-range theories might be tested empirically using (in this case, social science) methodologies. As such, transition theory, in addressing how individuals respond to their social and material contexts, to changing relationships, routines, assumptions and roles, provides useful conceptual insights that can assist the exploration of 'trajectories' in relation to 'taking on' a professional identity.[32]

To illustrate the value of transition theory in highlighting the importance of the emotional aspects of the medical educator journey, we draw on a study undertaken in the United Kingdom in 2018. The aim of the study was to explore the development of the medical educator from the perspective of those at various stages in their medical education career. These included early career medical educators, senior medical educators and those who have opted out of the medical educator role.

2 | METHOD

Ethical permission for the study was granted by the Peninsula Medical School Faculty Research Ethics Committee (ref 17/18-874) and Cardiff University School of Medicine Research Ethics Committee (ref 18/30).

Because we wanted to explore the process of professional identity development among educators, leaving the question of what they understood 'identity' to mean to the participants themselves, a qualitative design was used. Participants were encouraged to discuss their ideas and experiences in their own words. We aimed to recruit UK-based practising educators to exclude, as far as possible, systems-based effects such as different employment conditions.

Initial recruitment was through social media communications containing a link to a short online survey, which was sent out via our own social media networks (personal Twitter accounts @greyliterature and @traceloader) with a request to retweet, and also from the UK-based Academy of Medical Educators account (@medicaleducator, with 14 000 followers) between 26 February and 15 July 2018, giving us a potential reach of tens of thousands of UK medical educators.

The recruitment survey introduced the qualitative study and our request for a sample. The first two questions asked were, 'would you describe yourself as a medical educator' and 'what is your job title'? We wanted to gather the views of a wide range of people actively involved in the education of medical students, trainees and doctors, including those who (i) would not describe themselves as medical educators; (ii) felt that it was a weak or developing part of their professional identity; and (iii) strongly identified as medical educators. We therefore also asked, 'on a scale of 1–10, how far do you identify as a medical educator'? We also asked those who said that they would describe themselves as medical educators to disclose years of involvement in medical education.

One hundred and forty responses to the recruitment survey were received. All respondents indicated that they were actively involved in the education of medical students, trainees and doctors. Of these, 80 expressed willingness to be interviewed. The majority of responses (n = 79/140) came from those who did not describe themselves as medical educators: But of these, only 19/79 left contact details so that interviews could be arranged. The remaining 61/140 all left contact details. These had been asked to indicate how long they had been working in medical education. Using these data, we allocated respondents into groups depending on the degree to which they identified as medical educators with 0 = not at all and 10 = completely. We also divided them according to their career stage: those who had been in the field for up to 5 years (EARLY [EC]); those with 6–12 years' experience (MID CAREER [MC]); and those with more experience including retired (LATE CAREER [LC]). Because we wanted to exclude possible contextual effects of differing healthcare systems, 10 volunteers from

TABLE 1 Characteristics of study participants.

Participant	Gender	Stage of career based on years since first teaching role Early = <5 Mid = 6–12 Late = > 13	Declared self-identity as medical educator (scale of 0–10)
A	M	Late	0
B	F	Late	10
C	M	Mid	0
D	F	Late	10
E	M	Mid	7
F	M	Mid	8
G	M	Mid	7
H	M	Late	8
I	M	Early	0
J	M	Late	10
K	F	Late	8
L	F	Mid	8
M	M	Mid	10
N	F	Early	8
O	F	Mid	8
P	M	Mid	2
Q	F	Late	6–7
R	M	Late	4–6
S	F	Early	8
T	M	Mid	2–3

outside the United Kingdom were excluded, leaving 23 EARLY, 17 MID and 30 LATE. Our final sample was purposively selected and comprised 20 respondents (Table 1).

JB and TC conducted 20 hour-long, semi-structured telephone interviews. The interviews took the form of a 'conversation with a purpose' about each respondent's personal journey within the field of medical education.[33] Our prompt question was: 'Can you tell me about your career as a medical educator?' As participants talked about their careers, comments about medical educator identity were probed.

All interviews were transcribed professionally. We first undertook a thematic analysis, double-coding the interview transcripts and discussing the data and codes in detail. In this way, we familiarised ourselves with the data, developing around 230 themes and codes in a process that Terry et al describe as 'Big Q TA', in which 'analysis becomes a creative rather than technical process, a result of the researcher's engagement with the dataset and the application of their analytic skills and experiences, and personal and conceptual standpoints'.[34] Early in the process, we began to appreciate that each interview represented a coherent and distinct narrative that our coding was not fully able to reflect, so we went on to undertake a detailed analysis of each participant's 'journey', plotting their development, noting temporal factors—significant events, emotions, threshold moments, choices and career trajectories—and comparing these analytically. This iterative approach to exploring affect and 'affective flow' and relating it to development over time gave rise to our interpretation of the data in terms of individual progress between phases of identity transition. (For an insight into the process, see Figure 1.) Because the applicability of the transition model was identified during the process of our working and reworking of the thematic clusters following initial analysis, we present combined findings and discussion in the next section.

3 | TRANSITION THEORY

Transition theory emerged in the 1970s as a new conceptual field that attempted to integrate, explore and develop previous approaches to understanding and assisting psychosocial adjustment to grief and loss.[35,36] However, it has since been shown to have wider applications, including clinical practice, social work, occupational therapy, leadership, education and career development.[37] Adopting a mid-range theoretical approach[31] focusing on the practical application of the ideas rather than the philosophical aspects, recent research into transition theory has shown that it can be usefully applied to the study of the process in which healthcare educators move from a primary professional identity (such as nurse, dentist or doctor) to a new, integrated identity where the educator and clinical/academic identities are held in satisfactory equipoise.[11,38,39] The process of moving from primary professional identity, through a series of changes,
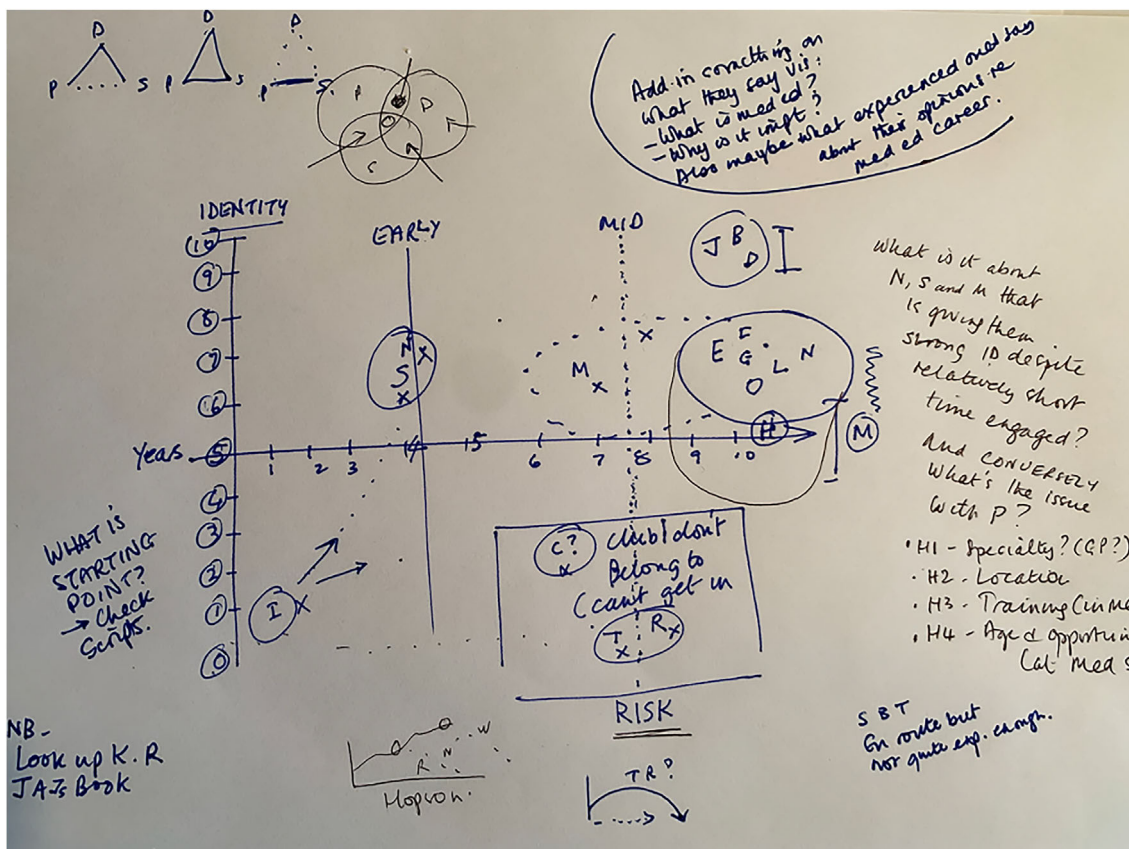
FIGURE 1 Image showing research notes and temporal mapping undertaken by authors (anonymised). [Color figure can be viewed at wileyonlinelibrary.com]

towards a more stable integrated self-identity may not be linear or involve significant stress to the individual; and it is certainly not permanent,[40] but it does involve a temporal progression against which healthcare educator career trajectories can be theorised.[41]

Hopson and Adams,[41] expanding on Kübler–Ross's work,[42] proposed a model representing the emotional effects of the transition phases involved in 'experiencing a disruption, acknowledging its reality, testing oneself, understanding oneself and incorporating changes in one's behaviour'[41] (p. 13). They stressed that it should be seen as cyclical, emphasising that individuals rarely move neatly from phase to phase, with some never getting past the first stages and others hindered in their progression and cast back to earlier phases by sudden setbacks. Subsequently, Williams[43] applied the model to career change. We have adapted this model further to reflect the current state of the literature around the move to a more stable healthcare educator identity (Figure 2).

Most scholars report a dip in mood during transitions; this is to be expected, since all transitions involve some degree of loss, uncertainty and stress, even where the change provoking the transitional process was desired, such as a career promotion. Figure 2 shows this graphically, where the line of transition dips into negative well-being. Our interviewees, describing their career trajectories in medical education, offered substantial support for this interpretation.

3.1 | Phase 1: Excitement or Shock/Denial

Starting at the Y axis, individuals find themselves faced with a significant change or trigger event: in the case of participants, they started a new teaching role or significantly increased their educator responsibilities. If a change is unwelcome (lower dashed line), individuals may feel overwhelmed and even unable to accept their new situation (phase 1). Many of our interviewees reported that they had not initially sought medical education careers, or that where they had, the job-seeking and induction processes had been difficult. While excitement and euphoria often follow a desired change, for most of our respondents, even those with high educator identity scores, their chief reaction appeared to be disappointment and stress:

> I'd got to this stage and I just felt I'd fallen back down the ladder like snakes and ladders, fallen down the snake. Participant D (10, LC)

> I took it because I couldn't afford not to have the money, or not to have the gap on my CV and to be out of it altogether. Participant G (7, MC)

> And so it was an uncomfortable time. Participant B (10, LC)

> Well as I said to them in my interview when they go 'Why this job, why now?' and I was like I can't stand the thought of the wheels coming now after everything everybody's done. And it wasn't a particularly good time for me personally. Participant O (8, MC)

Transition theory suggests that individuals experiencing an unwelcome or difficult change are likely to attempt to deny, minimise or trivialise it in an effort to adapt their new circumstances to their internal mood. Some of our respondents with low educator identity scores were indeed disparaging of medical education, with a linked suggestion that it was not worth the effort:
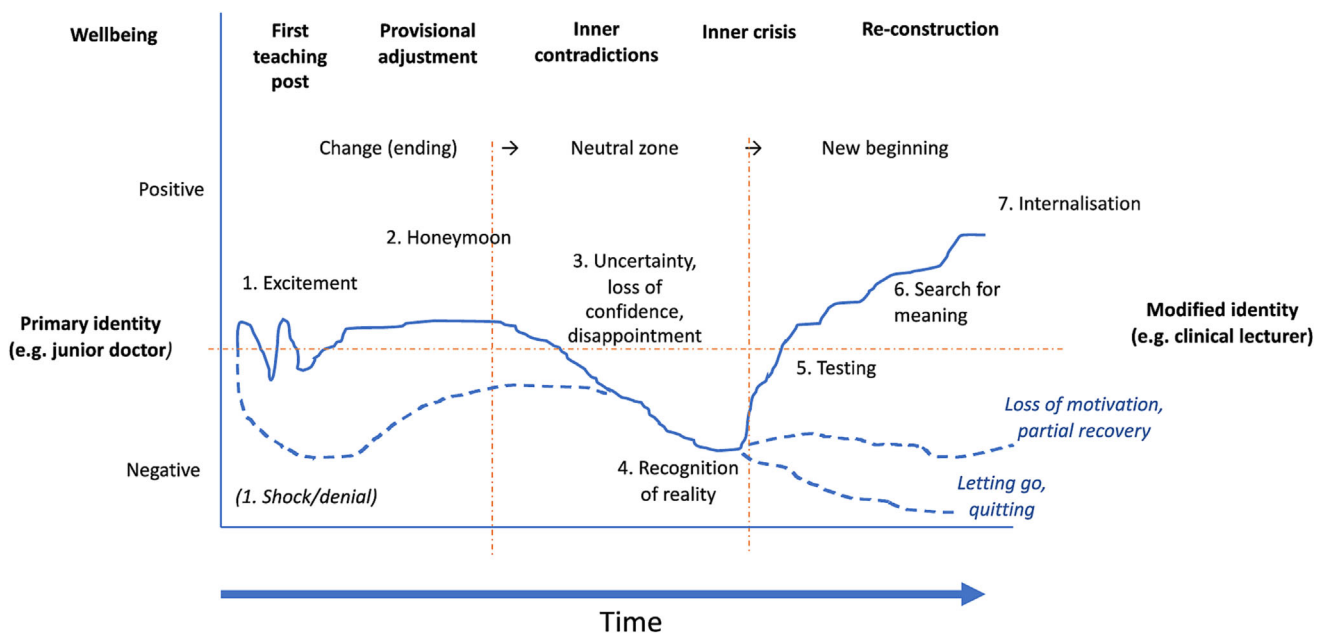
FIGURE 2 Hopson and Adams's seven phases of transition applied to educator identity development[42] (modified). [Color figure can be viewed at wileyonlinelibrary.com]

There's a lot of people within medicine do teaching because it's easy, I don't have to put much effort into it, and I can skive, and I'll get time for it. Participant A (0, LC)

I think teaching is a main part of all medicine. We all do teaching but there's been a few snotty people who're kind of 'I've done a diploma'. Participant A (0, LC)

I think also a lot of the construction (sic) educational theory, so a lot of the stuff is [...] based on pseudoscience. Participant T (2–3, MC)

3.2 | Phase 2: Honeymoon

If the initial change is welcome, a period of euphoria (phase 2—honeymoon) is likely, especially where the individual is happy to leave behind an unwanted situation. As examples of this, two participants described their early-career excitement, one looking forward and one looking back:

I just saw the way other people were doing it and could see myself doing that in a few years' time, it just seemed really such a rewarding thing to do, to be able to train others and pass on your information and your wisdom to other people, I think that's really interesting. Participant P (2-EC)

And I see a lot of the doctors in training coming in and they're keen and they're interested; it's such a shame for them that there isn't a big thing like we had with the GMC and 'Tomorrow's Doctors' because that was just the most fantastic time to be in medical education, ever. It was just so fabulous, and it was life-changing almost Participant D (10, LC)

3.3 | Phase 3: Uncertainty

Over time however, the realities begin to sink in for most (phase 3—uncertainty, loss of confidence, disappointment). They become aware that they need to adapt to new working conditions, relationships and responsibilities. The limitations of their changed situation become evident. They may start to miss aspects of their past situation and social grouping, especially where these were closely linked to their self-identity. A dip in mood is inevitable as the uncertainties and difficulties of their new situation become clearer:

... sometimes if I need to be in several places at once, or I've got a deadline coming up and deadlines always seem to cluster, so there'll be a clinical thing and a PhD thing, and maybe something that I need to get sorted

for a [...] meeting or something like that, and that can be quite stressful, I do have those moments of oh my god why am I doing this to myself. Participant M (10, MC)

3.4 | Phase 4: Recognition of Reality

The theory proposes that phase 4 (recognition of reality) represents a 'crunch point'—the place, we hypothesise, where the previously described 'leap' to medical education happens.[12] Many participants reported a phase where the tension between clinical and educational identities became almost overwhelming:

I'm very much feeling that tension at the moment of people saying well which one do you want to be, you can't just have it all, and actually what I've been saying is well actually I feel like I do want both parts of that world, and that's not me being greedy, but I just don't feel like, I can't give up education cos it feels the most natural thing to me, but yeah you've claimed me for near on 11 years so it would be a shame for me to have to give up (clinical specialty) altogether. Participant P (2, EC)

In this phase, the individual is forced into either making a commitment to the change process, or resisting it, risking loss of motivation or disengagement. Interviewees reported how they began to achieve realistic acceptance of the educator role, leaving behind lingering attachments to their previous (pre-transition) situation. As the new reality was accepted, it became possible to look to the future more optimistically and to see the genuine potential in the new situation.

But yeah it is an interesting one isn't it, trying to strike the balance and I think I've just about got it right at the moment, but I can see how you end up doing 14 hours every day for five or six days a week, but yeah I'm good enough I think at striking a balance there. Participant F (8, MC)

I think just sheer bloody-mindedness meant that I decided therefore I was going to make sure that this was really successful and I was going to prove that medical education was just as valuable as any other direction within medicine. Participant M (9, MC)

3.5 | Phase 5: Testing

Those who successfully navigate phase 4 progress into phase 5 (testing), where they start exploring new behaviours, skills and social situations, metaphorically trying on the role of healthcare educator

to see how well they can make it fit. At this stage, the more experienced educators reported undertaking courses and qualifications in education as a way of exploring the potential of their new situation:

> once I'd got it (PGCert Medical Education) I had this sort of extra feather in my cap that said yes, yes, this person is dedicated and they know a bit more than the other doctors who do not have this. Participant Q (6–7, LC)

> in my first couple of years I just went in, did the session or taught students on the ward and that was that. Whereas this qualification has helped me consider the other aspects of education, for instance evaluation, linking it to assessment, so actually what is the use of this and how do you involve the students in that, and obviously the theory and the different learning styles. So this has branched out my thinking of education. Participant N (8-EC)

During phase 5, individuals may still feel unsettled or irritable as they harness the personal energy involved in the process, but their interest and curiosity to explore their new position continues to fuel their progress.

> You've got to be committed and you've got to be present if you're wanting to change and move things on. ... I learnt to be rather assertive to actually build what I wanted I suppose there. Participant B (10, LC)

> (I) was a good strong classroom teacher, I'd done my Cert Ed, [...] So I felt really that I knew what I was doing educationally, and I'd done my masters as well to sort of stretch it a bit. Participant D (10-LC)

3.6 | Phase 6: Search for Meaning

Phase 6 (search for meaning) is a more reflective phase where individuals begin to make sense of and rationalise their experiences of change.

> So that's a large part of what actually drives me now in education, it's how my effort can be magnified and multiplied to help the most people, even though they don't know that I'm helping them. Participant G (7, LC)

> a sort of incentive to keep myself up-to-date, to keep myself keen, eager, looking for the best, er and to develop myself, and also in order to help support the development of the profession as a whole. I suppose you could describe that as self-interest. Participant R (4–6 LC)

you have to take these sort of things seriously and do these things properly, and that there are ways that are demonstrably better than others, and you need to have robust measures, it's something that's quite difficult to get across, we're doing it this way cos we think it's best, as opposed to why you need to do it this way. Participant K (8 LC)

3.7 | Phase 7: Internalisation

Having been able to understand at a more cognitive level what the change means in their lives, they are able to move to phase 7 (internalisation) in which they incorporate these meanings into their self-identity and behaviour.

> And I think the other thing is about think through why you're in it, why you're in the game; I know now from lots of reflection and sort of find your why sort of thing, I'm in education, and leadership, and all the stuff I want to do, is cos I want to improve the health for patients and communities. Participant D (10, LC)

4 | 'GETTING STUCK'

However, some people become stuck at earlier phases, typically at phase 4 (recognition of reality). These individuals struggle to leave behind their previous clinical identity and status—a significant risk within in healthcare education due to the previously described challenges involved[10]—and they may never succeed in letting go completely. Some risk quitting education entirely (Figure 2, lower dashed line). Others may struggle on with low motivation and continued regrets, but in these cases their adaptation happens so slowly that detachment, cynicism and a weak sense of identity remain problems for them and inhibit their progress into phase 5 and beyond.[2] We found that many of the mid/late career educators with weaker self-identities were able to articulate why they found maintaining the journey towards transition so difficult:

> So would I have liked to have done it if I'd had the chance, I'm sure I would have, my concern is now what you're actually able to do with it, and if you go through the effort of doing it and then can't use it it's an utter waste of time ... And you're going to end up scunnered and feeling I don't want to do anything. Participant A (0, LC)

> I don't really want to be hooked into this, into kind of all those processes that come with it really. Participant T (2–3, MC)

> I find now that I'm that much older the responsibility weighs heavier cos I get all the really complicated stuff,

but also I just can't hack it, I can't. And I'm just thinking I'm too old for this. Participant Q (6–7, LC)

5 | THE SIGNIFICANCE OF THE TRANSITION MODEL FOR FACULTY DEVELOPMENT

Continued attention has been paid to faculty development highlighting the ongoing need for support at the level of the institutions of medicine, education and medical education[10,19] and providing insight into various elements of running courses with respect to their overarching design, their content and processes of implementation.[3,9,43,44]

Relatedly, significant work has explored the myriad ways in which individuals are motivated towards[1,6] or deterred from[2,4,9,11] engaging in faculty development. Yet, while there is increasing acknowledgement of the importance of integrating the educator identity into one's broader identity and attending more closely to the transition that many faculty encounter,[11–13] there is a continued emphasis on using categorical measures against which to benchmark success[45] along with an over-simplification of the process of moving individuals from non-educator to educator (as discussed by Steinert et al[9]). For example, Dana et al,[46] defining two groups of faculty learners, capture some of the frustrations of engaging clinical teachers in faculty development activities:

> **Faculty resisters** did not see any need for changes in the way we teach, did not believe student-centred teaching to be more effective, could not appropriately define student-centred teaching, were motivated by extrinsic factors, and felt unvalued. Conversely, **faculty changers** were excited for changes and saw the need for change and for student-centred teaching, were intrinsically motivated, and felt valued as faculty members.

Recognising that change resistance is a regular challenge for faculty developers, they recommend explaining why educational reform is needed and offering greater rewards and incentives for those who adopt more student-centred methods.[47] However, our adaptation of Hopson's model, by focusing on the individual's emotional journey towards a settled educator identity, provides insights into why such approaches may have limited success with those whose educator identity remains weak, such as new educators, or those who have resisted change for some time. No matter how much someone desires change, regret and nostalgia are invariably involved as individuals leave behind aspects of their previous situation that contributed to their sense of identity.[41] Examples in healthcare education may include the social capital that comes from being a senior clinician, the security of a clear career track or the colleagues and role models who reinforced their professional identity.[11]

The main implication of this is that that an individual educator's development is unlikely to become appropriately self-directed and reflective until they are approaching the fifth phase: active testing against a realistic understanding of the change that has occurred.[42] Early interventions for new educators should therefore focus on assisting learners through the difficult first stages, acknowledging the risk of regression and withdrawal.

The activity of medical education is methodologically complex, yet this is often under-acknowledged initially. The key to working with transformation is not to fall back into labelling: not to categorise individuals as simply having 'a bad attitude', 'resistant to change', or 'unable to cope', but respectfully (and in keeping with the original psychotherapeutic literature) supporting those who wish to be supported when moving on is challenging.

6 | LIMITATIONS

There was a risk of volunteer bias in studying participants who had been recruited via social media; this was mitigated somewhat by the very large potential pool of respondents, and by our use of purposive sampling, in which 20/80 volunteers were carefully selected to ensure the widest possible range of career stages and degrees of educator self-identity.

Our data were gathered prior to COVID-19; while it is almost certain that pandemic pressures affected the workloads and stress levels of educators and might have accelerated or decelerated an individual's progress, the transition literature suggests that it is unlikely that these factors would alter the order in which an individual experienced the transition trajectory.

Finally, as strongly-identifying medical educators ourselves, we acknowledge the risk of study bias. Careful and reflexive discussion and journalling, the support of critical friends and reviewers and scrupulous attention to method have helped us to approach this study as objectively as possible.

7 | CONCLUSION

In this paper, we set out to emphasise the importance of the emotional response to assuming (either fully or in part) a medical educator 'identity' and to consider this with respect to the passing of time. Our methodological position is grounded in new materialism[26] that is, we argue that 'who we perceive ourselves to be' and the lived experience of who we are, are mediated by our interactions with the objects of everyday life (animate and inanimate). Moreover, our emotional responses will affect and at times (re)produce what we become. We have used transition theory as a practical/conceptual way of giving voice to the emotional embodied phenomenon of being a medical educator as it is experienced over time by those of varying career length and with varying degrees of acceptance of the medical educator identity. Furthermore, we have suggested that particular configurations of activity or assemblages give rise to opportunities for transformation and growth, whereas other configurations can hold people back.

Because becoming a self-identifying educator involves significant internal personal change, (and for some this is experienced as a deep ontological/epistemological shift as the everyday taken-for-granted norms come into question) we argue that with respect to faculty development, more attention might be paid to teaching and learning methodologies that have a stronger focus on the transformational aspects of teacher development. Indeed, faculty development interventions that concentrate on teaching knowledge or skills without significant attention to learners' need for support with the personal aspects of the educator role are perhaps less likely to help those still struggling with the change process. Since supporting change in the individual's self-identity until aspects of educator identity are assimilated and stable is essential to aid transition, transformative learning (TL) techniques should be considered.[48] In keeping with social constructionist pedagogies, such techniques should be rooted in mutualistic exchange and might include acknowledging and discussing the social, political and psychological contexts within which change is taking place as well as individual mentoring.[48] In addition to approaches to educator development that focus on transition and identity change, educators themselves need to understand the process in which they are engaged to assist in the reflective and recreative approaches that are so necessary to support individuals and themselves during stressful periods.

AUTHOR CONTRIBUTIONS

Julie Browne and Tracey Collett contributed equally to study design, data collection, analysis and write-up. Both approved the final draft.

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CONFLICT OF INTEREST STATEMENT

None.

ETHICS STATEMENT

Ethical permission for the study was granted by the Peninsula Medical School Faculty Research Ethics Committee (ref 17/18-874) and Cardiff University School of Medicine Research Ethics Committee (ref 18/30).

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