

Competency Is Not Enough: Integrating Identity Formation Into the Medical Education Discourse

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Abstract

Despite the widespread implementation of competency-based medical education, there are growing concerns that generally focus on the translation of physician roles into “measurable competencies.” By breaking medical training into small, discrete, measurable tasks, it is argued, the medical education community may have emphasized too heavily questions of assessment, thereby missing the underlying meaning and

interconnectedness of how physician roles shape future physicians. To address these concerns, the authors argue that an expanded approach be taken that includes a focus on professional identity development. The authors provide a conceptual analysis of the issues and language related to a broader focus on understanding the relationship between the development of competency and the formation of identities during medical

training. Including identity alongside competency allows a reframing of approaches to medical education away from an exclusive focus on “doing the work of a physician” toward a broader focus that also includes “being a physician.” The authors consider the salient literature on identity that can inform this expanded perspective about medical education and training.

Competency-based education has become prominent in undergraduate and postgraduate medical training.¹⁻³ In North America, for example, both the Royal College of Physicians and Surgeons of Canada⁴ and the Accreditation Council for Graduate Medical Education (ACGME)⁵ in the United States have been leaders in this process. The resulting frameworks, known as the CanMEDS roles in Canada and the ACGME competencies in the United States, collectively guide the structure of every medical residency program in those two countries and have influenced medical training in many others. The movement toward competency-based education has been seen as a mechanism to (1) analyze physicians’ many professional roles, (2) translate these roles into measurable competencies, and (3) assess the progress of medical students and residents toward attaining these competencies.^{2,3}

Despite its widespread implementation, a growing number of concerns are being leveled at this training movement.⁶⁻¹⁰ Generally, these concerns focus on the dangers associated with translating physician roles into “measurable competencies.” As Ginsburg et al⁹ have suggested, for example, “It may be that medical educators have blurred the distinction between using competencies as an educational framework to organize and guide learning, and attempting to translate them directly into evaluation tools.” By breaking roles into small, discrete, and ultimately measurable tasks, competency-based approaches may be emphasizing (almost exclusively) questions of assessment and missing the underlying meaning and interconnectedness of these roles in shaping physician development. These concerns about excessive reductionism have been particularly salient in discussions of professionalism.¹¹⁻¹⁴

It may be helpful, therefore, to draw back momentarily from the effort to break down roles into a set of measurable competencies and, instead, take seriously CanMEDS’s initial construction of “the physician” as a set of roles. In doing so, we can begin to explore the interrelated identities that form the basis of what it means to be a physician. Such a reframing would allow us to supplement questions of how to assess the minimum level of performance necessary for a trainee to

be competent, with an understanding of how trainees become physicians ready for independent practice. As Cooke et al¹⁵ have suggested, in thinking about what makes an excellent physician, it is important to ask, “What are the hallmarks of the physician that society wants a student or resident to become? What processes support and promote this transformation of identity?”

In this article, we provide a conceptual analysis, based on a review of the salient literature, of the issues and language related to shifting the discourse from an exclusive focus on defining and assessing competencies to include a broader focus on understanding the relationship between the development of competence and the formation of identities during the educational process. Our intention is not to replace competency-based approaches in medical training but, instead, to add a new dimension to the discourse and work of training the next generation of physicians. Including *identity* alongside *competency* allows us to reframe our inquiries toward questions that include a focus on *being* rather than exclusively a focus on *doing*.

We will begin our discussion with the recognition that as roles and responsibilities evolve throughout training, a trainee’s “practice” takes on many different forms. Thus, we will be describing the formation of identities as an adaptive, developmental process that

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happens simultaneously at two levels: (1) at the level of the individual, which involves the psychological development of the person and (2) at the collective level, which involves a socialization of the person into appropriate roles and forms of participation in the community's work. The following sections explore each of these developmental processes and their relationship to physician training. We address the implications of these premises throughout this article, with respect to both education and research in medical training.

We would note that we use the terms *competency* and *competencies* to represent the cluster of skills, abilities, behaviors, and performances that are currently the emphasis of the competency movement. This is intentional, as we acknowledge that the definition of *competency* is admittedly complex and continues to be in transition. Similarly, for the purposes of this discussion, *role* is defined as the "social title" of an individual (e.g., pediatric oncologist). This is separate from, but related to, *identity*, which represents the process by which people seek to integrate their various statuses and roles, as well as their diverse experiences, into a coherent image of self.

The Individual: Identity Formation as Qualitatively Distinct and Discontinuous Stages

Within the field of identity theory is the assertion that the formation of any given individual's identity involves a movement through a series of conceptually distinct developmental stages.¹⁶⁻¹⁹ These stages are characterized by qualitatively different ways of understanding (and being able to understand) both one's environment and one's place in that environment. In this sense, medical students and junior residents are not just immature versions of expert physicians; rather, they think qualitatively differently from expert physicians about the world around them and about who they are in that world. As a lay example, four-year-olds will not understand sarcasm no matter how many times they are exposed to it. This failure to understand is not "fixable" with better teaching. Given their stage of development, four-year-olds are simply not ready to appreciate this form of subtle social discourse. Similarly, as Lingard et al²⁰ have described, medical students

may be literally unable understand what is "relevant" in the eyes of the attending physician, because they have no ability to distinguish the salient clinical feature of a patient's case. Unlike an expert in the same scenario, medical students are not developmentally ready to use the complex clinical reasoning required to appreciate the subtleties of "relevant" as the expert understands this concept. Thus, educators can expose them to the concept of "relevance" but must understand that they may not be at a developmental stage where they can effectively accommodate this concept (one that seems obvious to experts) in their conversations with colleagues and dealings with patients.

Many developmental theorists have argued that there is a developmental inevitability to the stages of identity formation, with each stage characterized by unique features.¹⁷⁻¹⁹ Kegan,²¹ for example, has suggested a five-stage model of identity formation, with Stages 2 through 4 of his model being particularly relevant to understanding how individuals might make sense of their evolving sense of identity as physicians. Stage 2 is characterized by a process of "acting the role." For medical training, this would imply that trainees are characterized by their lack of a broader understanding of what it means to be a physician. Their motivation and performance is based on a narrowly defined, superficial understanding. They may begin to act like physicians and adopt the "cloak" of a physician, but they lack the deeper, more internalized aspects of "being a physician." Manifestations of this stage would include the pride of wearing the white coat, the self-conscious display of the stethoscope, and the excitement of carrying a pager. As they move to Stage 3, trainees have entered what Kegan calls the "socialized mind" and begin to internalize the social expectations, behaviors, and values of the profession. At this stage, they are very sensitive to how others perceive them and whether they are doing things right. They are likely to want to know the rules of appropriate action and will look to authority figures for direction and for reassurance that they are doing well and fitting in. At Stage 4, individuals build a personal system of values and internal processes that they use to evaluate external messages about their role and competence within a community. As

they do so, they gain an ability to think about themselves in relation to the larger systems in which they work. Professional relationships and collegial interactions have become a natural part of their world. As a consequence, they see themselves, and are seen by others, as embodying their profession. They no longer "act" like physicians; they have become physicians. They have consolidated who they are in relation to their community of practice.

Importantly, the transition from stage to stage is not a process of gradual change but, rather, is marked by abrupt discontinuities²² and is precipitated by emerging "crises."²² These crises arise because of discrepancies that become apparent to the individual between her understanding of herself in her professional role and her understanding of the experiences and challenges she is facing. For example, she may define a physician identity in terms of a metaphor such as "physician as healer," but when faced with the death of a patient, it may challenge her notions of *physician*. When faced with such a crisis, an individual will reevaluate the situation, begin to incorporate the new information, and, if all goes well, develop a new understanding of the world and a new understanding of him- or herself (representing a new identity stage).^{18,23} These crises serve as a turning point and represent a crucial period of increased vulnerability and heightened potential,^{17,22} a time of upheaval where old values, perspectives, or choices are reexamined.¹⁸ Given the prominence of these crisis moments in developmental identity theory, the study of identity development in medical education would focus our attention toward these critical incidences or dilemmas. And there are many such experiences in medical training: the first time one touches a cadaver, faces the death of a patient, cuts living flesh, or leads a trauma team. Importantly, however, the focus of attention would not be on the level of competence with which the individual accomplishes the task but, rather, on how each of these crisis moments profoundly influences the aspiring physician's understanding of what it means to "be" a doctor.

A caution must be noted about extrapolating this stage theory of identity formation to the context of medical

training. One potential interpretation of this model might be to assume that the developmental stages in the formation of identity map easily onto the learner's formal levels of training (i.e., to assume that Stages 2, 3, and 4 are equivalent to medical student, resident, and physician). However, we believe that the reality is more complex than simply equating stages to training levels. That is, although each successive training level may, in certain ways, be an increasing approximation of the physician identity, each level of training also has its own identity. Thus, medical clerks are not just learning what it is to *become* a doctor; they are, at the same time, learning what it is to *be* a clerk. Then, abruptly and regardless of where they are in the development of their identity as clerks, they are expected to abandon this identity and learn what it is to *be* a resident.

Recognizing the enterprise of medical education as this succession of adopted identities has several implications for our understanding of trainees' experience of medical training. First, it is important to note that each of these successively adopted identities must go through its own process of identity formation. Thus, we would anticipate that each developmental stage described earlier will be seen *within* each successive level of training. Novice clerks will first try to adopt the behaviors of a clerk, then eventually internalize this role and come to feel like clerks, even if they do not yet feel like doctors.

Second, this focus on multiple successive identities raises questions about the assumption that each role transition (e.g., from medical student to resident) simply moves an individual a step closer to being a fully formed physician. Rather, applying an identity formation approach highlights that the transition from medical student to resident involves both construction of a new identity (i.e., resident) and deconstruction of the old identity (i.e., student). Whereas the resident role may seem to be a closer approximation of a physician, the transition from medical student to clerk, from clerk to resident, or even from junior resident to senior resident may impart feelings of taking a step backward as trainees struggle to incorporate the new expectations associated with a new identity. Abruptly (literally overnight), the community ceases to see them as

effective, well-seasoned clerks and, instead, sees them as untested, novice residents with limited ability and the potential to be dangerous.

Third, defining each successive trainee role as a new, discontinuous identity that must be constructed also allows us to attend to the different place of learning within each identity. For preclinical medical students (and for those who teach them), learning occupies a high priority in that the entire preclinical medical education structure is organized to address trainees' needs as learners. However, as students move into their clerkship rotations, one of the discontinuities that emerges is the discovery that they are no longer the "center of the institutional universe." Instead, they become the most junior people on the clinical team, and learning takes on an unfamiliar structure. In this new context, they must come to understand their place in the community of practice and must reposition their learning relative to the provision of safe care. Although their primary role is still to learn, teaching them is not the institution's primary purpose, and it often takes some time before students cease to suggest that the preceptor prepare teaching notes on the cases they will be seeing that day. This changes again as they move into their residencies, where their role as learner is still a dominant aspect of their identity but is now more secondary to, and more immediately in service of, their responsibilities for ensuring the provision of safe care. This leads to a more acute tension between service and learning,^{24,25} and finding the right balance, in their own minds and in the eyes of the institution, may be difficult. It is not unusual to hear a resident say, "That is not in the best interest of my education," although residents are likely to do so with less frequency and greater discretion than they might have done as clerks. And, of course, such a comment would make no sense to a physician in practice, who has once again repositioned the place of learning to be largely incidental to the enactment of high-quality patient care. As trainees embrace each successive identity, therefore, the importance of learning seems to change sufficiently as to raise doubts about conceptualizing the progression from student to physician as a "continuum of learning."

Overall, then, the developmental theories of identity formation can serve to focus our attention on, and help us to understand the implications of, the striking number of discontinuities that embody the journey from medical student to physician. Although from a distance the process of physician training may appear to be a smooth, linear trajectory toward an end goal, it is in reality a process of constructing and abandoning a series of successive identities, each with its own set of roles, perspectives, rights, and responsibilities. And the adoption of each of these identities is experienced as its own set of developmental stages, each precipitated by its own set of crises and marked by its own experience of discontinuity. Thus, within this framework, discontinuity and crisis are natural and necessary aspects of the developmental process, and understanding them is essential if educators are to help learners manage these discontinuities well and effectively navigate the transition from one form of identity to another on the route to becoming physicians.

The Collective: Influences of the Social Context on Identity Formation

A second core concept found in the identity literature is the understanding that social interaction is fundamental to the process of identity development.^{23,26-31} In a very real sense, one can know one's "self" only in relation to specific social groups (e.g., family, neighborhood, workplace, church, clubs) and the roles one occupies within those groups. It is these social affiliations, described by Wenger³¹ as "communities of practice," that decide when and if an individual can claim a legitimate identity, and it is the connection to these specific communities of practice that gives meaning to the formation and expression of identities. In this sense, social constructions of identity formation foreground and offer additional insights into the place of context, community, and relationships in the process of identity formation. For example, as a critical aspect of identity formation, novices have to *negotiate* their way into socially enduring and complex roles and relationships within a given profession.³² Identity formation begins when newcomers join a community with the prospect of becoming full participants. Even

though their initial participation may be peripheral, focusing on simple, low-risk tasks, their identity is forming and is defined by the community through the various roles they are expected to assume. Through this participation in the work of the community, trainees gradually become more proficient with the tasks, vocabulary, and organizing principles of their professional community. In this way, competence becomes more aligned with role in a process of identity formation. The long period of residency training, for example, provides opportunity for a strong socialization into the professional community of practice, its ways of being as well as its ways of acting. This, in turn, fosters the development of a strong sense of “common identity.”³³ From this perspective, there is a strong link between the process of socialization and identity formation.^{27,34} Identity formation, in this framework, is best characterized as an ongoing process of interpreting and reinterpreting oneself as a certain kind of person in a given context,²³ a process that, in the continuum of medical education, will be repeated in the shift from studenthood to clerkship to residency and beyond. Indeed, the process of identity formation will continue throughout one’s medical career.

The social constructions of identity formation also enable us to explore exactly how the social context influences identity formation. Context, in this sense, involves the socializing agents that have a direct influence on an individual’s identity formation. The concept of socializing agents has a strong research foundation in adolescent development.^{35–38} In that literature, socializing agents are the people and groups (e.g., peers, family, school, media) that influence an individual’s self-concept, emotions, attitudes, and behavior. Within medical education, there are similar socializing agents that affect an individual’s identity formation. Of course, physicians are a critically important socializing agent^{39,40} because medical students and residents continually watch their role models’ work habits, listen to their philosophies, and note their competencies and incompetencies.³³ However, Shuval⁴¹ and Ryynanen³³ remind us that medical students’ and residents’ peer groups also play an important role in regulating the speed with which it is considered legitimate for individuals to take on

any professional identity. Further, other health professionals, such as nurses, play a key role as socializing agents in the settings where medical students and residents learn.³³ Although nurses do not possess any direct formal authority, their interactions with the medical students, residents, and practicing physicians provide unique opportunities to see how “physician identity” (and, separately, how “student identity” or “resident identity”) is defined in relation to others (colleagues as well as patients). Indirect observational interactions, such as seeing nurses interact with physicians, also provide external messages about what it means to be a physician. These external messages become internalized scripts that help trainees form their own identities—as medical student, clerk, resident, and then physician—in relation to others in the workplace. The impact of such messages on trainees’ ability to function as team members and to allow, for example, nonphysicians to lead when appropriate, will directly influence their evolving identity and subsequent behavior as physicians.

Attending to the influence of social context in identity formation, then, is potentially powerful in a number of ways. Professional identities, for example, are understood to be shaped by the discourse and practices of one’s profession. Some of this is at a conscious level of awareness, but much of it is at the unconscious level of socialization into regulative and normative ways of being and participating in the community’s work. Lingard et al,²⁰ for example, describe the central role of discourse in case presentations, because participants at every level position themselves—in relation to the work and in relation to each other—through language. Through “talking the work,” the professional self is negotiated and shaped according to expected roles and responsibilities. In this process, emerging identities and competencies are enacted in relation to who else is “in the room.”

In all aspects of individuals’ lives, roles are thrust on them and identity is formed in relation to these social forces. But a person becomes a physician in relation to others—his or her patients, colleagues, and other members of society. Roles are the external characterizations, defined by others and assigned to trainees. Behaviors are the visible actions others see, but

identity is the internal consolidation of experience as an individual tries to answer Beijaard and colleagues’²³ recurrent question: “Who am I at this moment?” The powerful confluence of external influences, social agents, and role shifts provides opportunities for crises that are the necessary precursors to identity development. As such, “immersion” in the clinical environment is paramount to the process of socialization and to understanding how competence and identity emerge as complementary processes of becoming a physician.

Coordinating Competencies and Identities

In the preceding sections, we have offered a brief description of some key concepts central to a number of theories of identity formation. In addition, we have offered some implications for training and areas of potential focus for medical educators that are not likely to be well captured in the current constructions and discussions of competency-based education. However, we would like to reemphasize that we do not see identity theory as a replacement for the competency discourse but, rather, as an important complement to that discourse. Seeing the complementary nature of competency and identity allows for a reframing of the way we might think about the development of physicians-in-training and about the assessment of this development over time.

That is, early in the adoption of any new role (whether it is the role of clerk, resident, fellow, or physician in practice), the developmental models of identity suggest that there will be a strong focus on the externally generated expectations and activities of the role—on the *doing*. Thus, it may be very sensible to focus heavily in these early days on the core competencies (i.e., performance) expected of a first-year resident. As an individual progresses through residency, competencies continue to develop, but there is, in addition, a gradual integration of competencies into a more holistic identity as physician. This may be why, for example, the use of competency checklists is more amenable to the assessment of junior residents than senior residents. As the resident progresses, assessment requires an evaluation of the integration of a host of competencies into

something more than the sum of those parts—that is, an evaluation of identity as a resident and a closer approximation to physician. Competencies are not irrelevant but may seem less sufficient.

Across this range of development, competence and identity are both present, but they shift in relation to each other as residents move from primarily demonstrating competence through the performance of particular tasks, to eventually taking on the identity of a resident and ultimately physician, something that can only be seen as identity overtakes competency as the primary indication of growth. Not only are individual core competencies (ACGME/CanMEDS) more holistically rendered, they are also more integrated as residents move from junior levels of *doing* to senior levels of *being* a physician. Additionally, incorporating an identity formation approach moves us away from looking at the developmental trajectory of medical education (e.g., medical school to residency training to clinical practice) as simply linear and additive. Unlike the implicit assumptions of constant (perhaps even linear) progression in competency-based training, **what stage theory in identity formation posits is that development is discontinuous and shifts in qualitatively different ways.** Therefore, as a medical student moves into residency, the resultant shift in role simultaneously begins to deconstruct his or her identity as medical student and construct an identity as resident.

Understanding the interplay between competency and identity allows a fuller appreciation of the complexity with which various overlapping physician roles emerge. It suggests, for example, that trainees are not merely struggling to learn how to be physicians; they are also struggling to learn how to be medical students, clerks, interns, or residents. Again, these identities are often rendered as successive approximations of the physician identity, but each must also be recognized as an identity on its own. It will be important, therefore, to understand when and how each trainee role might be, at any point, either compatible or incompatible with the ultimate physician identity that a person is seeking. In either case, it can be **an important moment for providing trainees with feedback**

about the implications for the trainees' understanding of their own progression toward their goal of becoming a physician in addition to their ability to do the things physicians are supposed to be able to do.

Seeing the complementary nature of competence and identity also allows for a reframing of crisis moments. For identity theorists, **it's how the individual reflects on a crisis that matters most.**

For example, when a junior orthopedic resident struggles as he learns how (and when) to consult with internal medicine faculty to discuss a patient's overall care plan, instead of focusing on the patient as a "sore knee," he begins to change the way he thinks about himself and his future surgeon role in relation to the larger system of health care. **Reframing crises as opportunities for development requires an understanding of disequilibrium as a potential marker of a shift in identity and competence.** Also, it helps explain the development of complex and socially situated core competencies, such as professionalism, and allows us to ask, "What kind of physician will this person be when she is ready for independent practice (when no one is watching)?"

The Crucial Importance of Both Individual and Collective Factors

In this article, we have explored an approach to medical education that complements the focus on physician development as a set of behaviors with an understanding of how individuals internalize what it means to *be* a physician. It is important to remember, for example, that although the educational system thinks of residents as *becoming* physicians, residents themselves are also learning to *be* residents. Thus, considering both individual and collective factors related to identity formation is critical. We do not, therefore, take a position about whether identity is, at its core, internal or external but, rather, that it is the essential interplay between both.

Supplementing the work in developing measurable competencies with a consideration of professional identity formation may ameliorate two problems inherent in competency-based training: first, the tendency to atomize and fix what is essentially a dynamic and evolutionary process of becoming a physician and, second, the tendency to

focus on minimally acceptable levels of "competence" as an indication of readiness to practice. Incorporating an identity formation perspective allows one to ask questions differently about how individuals become physicians. Medical education could begin to reorient itself to not only thinking about making medical students and residents perform competently but to also considering how their professional identities as physicians are evolving.

Identity formation theorists articulate and bring into question issues currently underexplored in medical education. For example, in revisiting CanMEDS roles and ACGME competencies, identity theorists would question the premise on which medical educators have viewed the concepts of "roles" and "competencies" as interchangeable. **They would argue that roles and competencies are not synonymous but, rather, that roles are a social construct (not to be confused with identities), and competencies are a behavioral manifestation.** Therefore, instead of assuming that it is possible to specify a constellation of necessary and sufficient physician behaviors, it might, instead, be worthwhile considering **how institutional roles, behavioral competencies, and emergent identities complement one another in the process of becoming a physician.** In this way, the medical education community moves closer to understanding the development of professionalism and the ability to recognize when graduating residents are ready for "independent practice." In fact, such an approach could allow us to illuminate the very concept of what it means for a resident to be ready for "independent practice" by locating competence not only in the individual but also in the social and environmental contexts in which that individual is situated.

Reflection on the relationship between social roles, professional identity, and individual competence specific to a particular community of practice is, therefore, the critical process linking social structures with individual behavior. Whereas society provides roles that are the basis of identity, the emerging self is the "active creator of social behavior."⁴² Understanding the interplay between the social and personal aspects of identity formation allows a fuller appreciation of the complexity

with which various overlapping physician roles emerge.

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