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Understanding healthcare providers' professional identification: The role of interprofessional communication in the vocational socialization of physicians

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ABSTRACT

As physicians' roles continue to change in the US, scholars have called for more research in interprofessional communication—communication between physicians and other healthcare providers to help interprofessional healthcare teams work together to examine, design, and deliver quality medical care to patients. Here, we examine the role of interprofessional communication in fostering professional identification among physicians. Survey results from physicians showed the unique role that mutual support plays in strengthening healthcare providers' professional identities. This study contributes to the current communicative-based identification literature by looking beyond formal socialization practices to show how day-to-day interprofessional interactions influence physicians' identity. In addition to expanding theory, this research also adds to practice by demonstrating the need to train physicians not only on when and how to consult other physicians and medical teams, but also to trust, depend on, and work in concert with other specialties.

During the last decade, the roles and expectations of healthcare providers in the United States healthcare system have changed. Physicians in particular, are now dealing with reduced autonomy, increased organizational control, and greater influence of third-party payers,[1] which may affect physicians' professional identity. In response to these growing issues, [2] recently called for more research in health-related organizational communication to understand physicians' professional identity.

Although some studies have taken a communicative approach to explore physicians' identities, current research focuses solely on early vocational socialization experiences. For example, several studies have focused on socialization during pre-clinical years, such as Harter and Kirby (2004)[3] who investigated how medical students came to understand their professional roles through interactions with standardized and virtual patients. Similarly, Harter and Krone's (2001)[4] study of osteopathic medical students, found that students' identities were embedded in socialization discourses. Other research has looked at medical residents, including Apker and Eggly's (2004)[5] study of how professional identity is constructed during morning report, and Pratt, Rock, and Kaufmann's (2006)[6] study of residents and identity construction. Similar to research that explores how people learn and become part of corporations, most studies of physician identification focus on *newcomers*' experiences.[7]

The identification process, however, is fluid and changes over time.[8,9] Beyond formal socialization, scholars must consider how day-to-day interactions influence physicians' identities. This study explores how experiences beyond early socialization influence physicians' professional identities. Specifically, we examine the role of interprofessional communication—communication between physicians and other healthcare providers in fostering professional identification. Real, Bramson, and Poole's[10] research has demonstrated the importance of environment and context in understanding physicians' identities. Beyond the traditional socialization that physicians receive, we investigate how communication in the medical environment shapes professional identity.

Scholars need to better understand the role of interprofessional communication in fostering physicians' professional identities because their professional identities are being challenged in today's

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environment. Decades ago, sociologists suggested that physician identity was structured around power, autonomy, and prestige (e.g.[11]). Today, increased cost control, administrative rationality, the rising numbers of physicians, and patients' ability to access medical information online are shifting these longstanding beliefs about physicians.[1,10] Physicians' professional identities have implications for how physicians and other healthcare providers make decisions and communicate with patients, so scholars need to better understand the day-to-day experiences and communicative dynamics that shape physicians' connection to their profession.[2,10]

Review of literature

The socialization process

Scholars have defined socialization as the primary process by which people "learn the ropes" of an organization and adapt to new roles within it ([12] p. 211). Through socialization, people adjust to occupational practices and gain the "social knowledge essential for assuming an organizational role and for participating as an organizational member," ([13] p. 229–230). Several theorists have argued that socialization is multidimensional (e.g.[14]). Scholars have explored the dimensions of learning and adapting as well as the communication sources surrounding the socialization process. Kramer[15] has summarized seven socialization studies that presented various dimensions of how newcomers learn and adapt (see Table 1). Primarily, vocational socialization involves 1) meeting people, 2) adopting the professions' values, 3) learning language, and 4) understanding the history of the profession.

First, newcomers engage in relational learning and adapting—getting to know their workgroup and developing relationships with others. Relationships include (but are not limited to) peers, supervisors, and staff members.[16] Second, people must learn the goals and values of their profession. This includes explicit and implicit rules or principles that maintain the integrity of the profession.[17] Third, socialization involves learning the profession's technical language, including "acronyms, slang, and jargon," ([14] p. 732). Fourth, new members must understand the history of the profession and its members, such as traditions, customs, myths, and rituals.[18]

For many vocations, such as police officers[19] and firefighters,[20] newcomers enter a structured socialization process to help them learn and adapt to these four socialization dimensions. We explain this complex socialization process for physicians next.

Physicians' vocational socialization

Physicians' vocational socialization begins with the decision to attend medical school and pursue a career as a healthcare provider. Students who are accepted into medical education programs are highly motivated individuals, who are focused on achieving personal success.[21] Although students' experiences of the education process will differ based on the program they attend, most programs require two years of basic science training followed by two years of clinical training.[22] During the basic science training, students acquire new knowledge and a new set of technical skills to enable them to care for patients.[23] During clinical training, students learn at the bedside of patients and are taught tasks such as how to organize a patient's history and how to examine patients. Attending physicians oversee this process by walking students through a calm and deliberate analysis of clinical information and providing instruction on how to treat various conditions.[22]

Because medical students are highly motivated to achieve personal success, they are often very control-oriented and fear that their team's performance may fall short of what they could achieve as an individual.[21] Medical education then adds a system of rewards based on individual grades, which further creates a competitive versus collaborative environment among students. Through this type of training, medical students learn the culture of a new "in-crowd," which encourages emerging physicians to see specialties they interact with as "other."[24] Even during this early stage in the education process, medical students are socialized to be the "best" even among other physicians.[21] At the conclusion of the four-year education program, students graduate and enter programs of residency, as they are not yet ready to practice in the absence of supervision.[25]

Residency is differentiated from the hands-on training students receive in the last two years of medical school, in that the training becomes more intense.[23] Because residents already graduated medical school and are now junior physicians, they are required to care for an increased number of patients, which bears a greater amount of responsibility related to clinical care and an immense pressure to perform.[23] During residency, residents rotate through different departments under the guidance of supervising physicians and perform additional tasks that are characteristic of the profession, such as being on call and attending report sessions.[22,26,27]

Residency is a difficult time for residents as they must find a balance between what is expected of them and live up to those expectations, all while providing care to patients.[27] Physicians are trained like soldiers[23] in that they are taught to suppress emotions and block natural responses to what they see and what they must do.[22] The goal of medical education is to professionalize physicians so that they are able to function under stress, focus on the task at hand, make the right diagnosis, and perform the appropriate procedures in a high stress environment.[23]

Developing a professional identity

According to social identity theory (Tajfel & Turner, 1986), "people tend to classify themselves and others into various social categories, such as organizational membership, religious affiliation, gender and age" (Ashforth & Mael, 1989, p. 20). For example, people define themselves in terms of their organization—"I am a

Table 1
Dimensions of socialization (adapted from Kramer, 2010[15]).

Chao et al.[14]	Louis (1982)	Miller & Jablin (1991)	Morrison (1995)	Myers & Oetzel (2003)[16]	Nelson & Quick (1991)	Ostroff & Kozlowski (1992)
Performance proficiency	Task/procedures	Referent	Technical/task referent	Job competency	Tasks	Task
Organization goals/values	Image/identity	Relational	Culture/normative	Role negotiation	Roles	Role
Organization history	Workplace frame	Appraisal	Organization information	Organization acculturation	Make sense of experiences	Culture/norms
Politics	Power/players		Political/power	Supervisor familiarity	Relationships	Group
People/relationships	Task/social networks		Relationships	Involvement	Performance	
Language	Local language		Appraisal	Recognition	Isolation	