# "Medical Education Is the Ugly Duckling of the Medical World" and Other Challenges to Medical Educators' Identity Construction: A Qualitative Study

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## Abstract

### Purpose
The authors first aimed to ascertain how the Academy of Medical Educators (AoME) could develop and support early career medical educators. They expanded their study to explore the challenges to defining medical education as a discipline because of a lack of collective identity among educators.

### Method
In 2010, the authors and members of the AoME Early Careers Working Group conducted focus groups with early career medical educators (clinicians and scientists) and interviews with senior medical educators in the United Kingdom. All focus groups and interviews were audio recorded and transcribed verbatim. The authors used an interpretative phenomenological analysis to explore how medical educators described events or phenomena in their careers. They inductively identified overarching theoretical perspectives to understand observed phenomena drawing on social identity theories.

### Results
The authors conducted nine focus groups with 34 participants in total and six interviews. Participants identified fundamental challenges to their identity as a medical educator; they understood their medical education role to be secondary to their primary role as clinician or scientist. Participants noted that they had not developed an emotional attachment to medical education. Their relationship with the field remained at an operational level, revolving around roles and responsibilities.

### Conclusions
Medical educators' social cohesion is threatened by their sense that educators are poor relations compared with scientists and clinicians. While medical educators' identities may be in crisis, they also are changing, a change needed for medical education, medical education research, the practice of medicine, and ultimately patient care.

Over a decade ago, Levinson and Rubenstein[1] lamented the challenges that medical educators in the United States faced. They highlighted the lack of recognition for teachers and medical managers in terms of funding and promotion opportunities. Although some have started to address these issues—for example, the General Medical Council in the United Kingdom now offers formal recognition of named educational and clinical supervisors[2]—many challenges remain as university funding still is driven primarily by research income and academic outputs rather than by measures of teachers and medical education managers and leaders.

One initiative to redress this imbalance and to strengthen medical education was the creation of the Academy of Medical Educators (AoME) in the United Kingdom. The AoME's objectives are (1) developing a curriculum and qualification system, (2) undertaking research for the continuing development of professional medical education, and (3) promoting and disseminating best practices in medical education, all for the public benefit. Established in 2006 as the professional organization for medical educators, the AoME aims to provide leadership, promote standards, and support all those involved in the academic discipline of medical education.

Although getting exact numbers is difficult, we know that medical education is a vast and expensive industry.[3] However, despite the numbers of people involved, currently no structured professional career pathway exists for medical educators. Even the term *medical education* is poorly defined, as are *medical educator* and *medical educationalist.* In addition, sparse research has been conducted to understand career development in medical education. Indeed, it remains unclear if individuals seek a career in medical education or if they instead fall into one.

The literature to date has focused mainly on exploring who medical educators are, highlighting their role and potential importance, and discussing how they might be best supported.[4,5] For example, Gozu and colleagues[6] recognized how few teaching institutions provide curriculum development education, although examples of best practices do exist.[7,8] Levinson and Rubenstein[1] noted that traditional academic environments focus on research-based careers in which teaching excellence is expected but not rewarded. They proposed that institutions recognize clinical educator–researchers, who focus on research that directly

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informs clinical education, and support all clinical educators by developing a cadre of clinician–educators.

Within the AoME, the Early Careers Working Group (ECWG) was interested in exploring how to best develop and support early career medical educators. In this study, we aimed to identify and systematically interview early career medical educators to ascertain how the AoME could practically support them. However, while conducting the study, we realized that we, the ECWG, did not define this group in the same way that they defined themselves. In this article, we describe our qualitative study funded by the AoME to explore the potential challenges to defining medical education as a discipline because of a lack of collective identity.

## Method

We aimed to investigate the current barriers and enablers to developing careers in medical education by discussing with early career medical educators their experiences and triangulating these findings with interview data from senior medical educators, who we hoped would provide a historical perspective and insights into their experiences throughout their careers. Our initial aim was to develop a series of recommendations to the AoME about how to best support the next generation of medical educators.

### Data collection

**Early career medical educator focus groups.** We conducted focus groups with early career medical educators at medical schools and clinical training institutions. We used specific terminology to indicate those individuals who were at any stage in their careers (clinical or academic/scientific) but new to medical education. We refined this terminology to align with that in other career paths in clinical practice and/or academia. For example, we defined *early career clinician–educators* (medically qualified) as clinical teaching fellows or fellows in medical education (i.e., clinically trained physicians working in specifically labeled teaching posts in medical schools and/or clinical environments). We defined *scientist–educators* (those with basic or social science backgrounds working in medical schools and teaching medical students and junior physicians) as being below or at the academic level of a lecturer. Specifically, we wanted to engage those involved in teaching and the delivery of medical education, rather than the smaller subset of clinical education researchers.

In beginning our research, we realized how challenging it was to identify early career medical educators, particularly those with clinical training, within different hospitals and regions who were eligible to participate. We had no defined system or network for identifying suitable participants and no recognized national body to assist us. Ultimately, we recruited early career clinician– and scientist–educators pragmatically and opportunistically via our professional contacts and extended networks. We made no attempt to sample by protected characteristic (e.g., gender) but, rather, invited anyone involved in educating medical students or junior physicians. For example, we contacted current and recent fellows in medical education at the London Deanery via e-mail through one of our networks (E.S.). We used our connections and the ECWG networks to recruit scientist–educators via e-mail.

We conducted focus groups in 2010 at various centers in London, Nottingham, and South West England, until we reached data saturation (no new themes emerged). For the most part, we were able to separate the clinician–educators and scientist–educators into different focus groups, anticipating that the challenges and emerging themes would differ for each. However, some groups were mixed because of logistical difficulties and the need to optimize focus group size.

Participants signed a consent form ensuring confidentiality and informing them about the purpose of the study. A senior manager at the National Research Ethics Service (NRES) confirmed that our study did not require formal NRES approval.

Focus group research is well suited for eliciting participants' attitudes, feelings, beliefs, experiences, and reactions,[9] allowing for the discussion of a wide range of responses and revealing issues of consensus and disagreement. The format of our focus groups was facilitative but not overly directive. Several different facilitators from the ECWG took part; each focus group had one or two facilitators present. We conducted a narrative literature review to develop the focus group guide. Then the ECWG discussed and agreed on a final version (see List 1). We encouraged participants to share personal events and experiences to illustrate their points. All focus groups were recorded and then transcribed verbatim.

**Senior educator interviews.** We compiled a list of senior educators (e.g., undergraduate and postgraduate deans, past leaders of medical institutions,

List 1

**Question Guide for Focus Groups With Early Career Medical Educators to Learn About Identity Construction, 2010**

- What is your understanding of the meaning of "a career in medical education"? Where do you see yourself and your future in relation to that? (What factors are informing the way you view the future?)
- What do you think is current practice in the United Kingdom regarding the training, support, and accreditation of medical educators?
- What do you see as the current strengths and weaknesses of your training experience in medical education in terms of promoting your career progression within medical education? Are there any impeding factors?
- What other interventions are people aware of that could support career development in medical education? Does the Academy have a role? What impact would a more transparent career structure provide?
- What do you think needs to be in place to support careers mapped to the *Professional Standards* framework from the AoME?

  For example:
  - Standard 2.5.2 Demonstrates the ability to interpret and apply the results of educational research.
  - Standard 3.2.2 Demonstrates competency in a broader range of learning and teaching methods and technologies.
  - Standard 4.3.2 Contributes to writing of assessment items.
- Are there other things which might be helpful for us to think about that we haven't already discussed today?

such as the General Medical Council) with the help of the AoME Council. We did not invite council members to participate, to ensure a broader view of medical education outside that of the AoME. Interviews were semistructured and took place throughout 2010. One of us (E.S.) conducted all interviews over the telephone. Participants were asked to give autobiographical accounts of their careers to date, explaining how they came to be involved with medical education. They were asked about the factors that had influenced their career choices and the factors that had supported or impeded the development of their careers. All interviews were recorded and then transcribed verbatim.

### Analysis

Initially, we planned to conduct a basic thematic analysis to explore participants' thoughts on how the AoME might develop and support careers in medical education. However, we quickly realized that the data were much richer and that participants were speaking more to their experiences of belonging (or not) to medical education and of being (or not) medical educators. We therefore proceeded with an interpretative phenomenological analysis (IPA) instead.[10] The hybrid model of using both focus groups and interviews has been employed in IPA before.[11] In using such a model, we had the opportunity to gain insight into how early career medical educators described events or phenomena in their careers, and thus how they understood those events, as opposed to simply what those events were.

We used an iterative and an inductive approach[12] to analyzing our data, using recognized models within IPA. Through an initial line-by-line analysis of the beliefs, concerns, and understanding of each participant,[13] we were able to identify emerging themes. We used NVivo 8.0 software (QSR International, Victoria, Australia) to conduct our analysis, which yielded an organizational framework. Through discussion, we were able to start to interpret the data, while supporting each other through a reflexive account of ourselves in the analysis.[12] During the initial analysis, while exploring possible superordinate themes, we identified a possible overarching theoretical perspective to understand the observed phenomena—social identity theory.[14]

Tajfel's[14] social identity theory has been used to understand the conflict between groups with different social identities. An extensive literature supports its application, including its use in medical education.[15] Yet, the theory has not been used extensively in empirical medical education research.[16] The theory describes a way of understanding group behavior at all levels, from the creation of social groups to the biases and prejudices that often emerge between them. It was later extended to include self-categorization theory,[17] which focuses on maintaining positive differences between one's own group (in group) and other groups (out group) according to a valued domain. Categorization happens when a group is defined as much by how they are different from other groups as by how individuals within the group are similar to each other.[18] We also drew on other theories, including important sociological work by Bourdieu,[19] examining medical education as a competed field and the ideas of boundary work.[20]

During our analysis, we kept in mind the Tajfel framework while iteratively identifying themes, and we have presented our data with the themes that emerged organized around the framework. We felt that the framework offered a deeper understanding of our findings while not detracting from the content of the basic themes.

## Results

We conducted nine focus groups involving 34 participants across the United Kingdom. Ten participants were scientists, and 24 had clinical backgrounds. Each focus group lasted between 60 and 90 minutes, depending on when the discussion came to a natural close. Six senior educators took part in a telephone interview. Interviews lasted about one hour.

Using social identity theory as a framework, we identified the following themes: professional identity, social categorization, in group/out group/intergroup identity, and developing an identity.

### Professional identity

We found many mentions of the challenges to professional identity that participants faced and the conflicts that ensued as a result. Many identified a dual career identity crisis—a tension between their primary identity (as a clinician and/or scientist) and their role as an educator. Without exception, medical education interests took second place. One clinician participant explained: "I fear that when I start my consultant job.… I'm not going to have any time for all these interests I've got really, realistically. That's the way it is" (P3, SE Clin). The scientist participants all noted that they had to prioritize research, their primary identity, over education:

> I'm trained as a scientist, as a bench researcher, and I have a hell of a lot of pressure on my time just to keep my research group afloat and then I do the teaching too, and I see that as part of my job and I know that's recognized by the Research Council as part of my job. But it is just that, it's a chunk of my time. (P3, SW Sci)

Participants experienced an identity conflict when they recognized that their primary identities were fundamental in shaping and supporting their medical education roles. One clinician participant said:

> It's important to have a clinical role in many ways certainly early on. If you're to teach about medicine.… I think it's important to do kind of working on the "coalface" to then be able to teach other people. (P3, SE Clin)

Tajfel[14] suggested that self-identity is shaped by a cognitive understanding of who one is and what shapes one personally and professionally. One possible challenge to an educator's development of self is the unplanned nature of participants' involvement in education. Many "fell into it." For example:

> So obviously I have a very research-based focus because that's my career choice and the medical education side of things … has kind of crept up on me as something that I'm now doing, which I am actually finding I'm really enjoying. (P1, SW Sci)

Participants also noted that medical education as a construct can be unclear. For example, they perceived a tension between managing the opportunities to teach and pursuing educational research.

> From my point of view, to have a career in medical education, I would have to do research in medical education but no one's really touched on that as being a part of your career progression. (F1, Mid Clin/Sci)

Many participants did not see their medical education identity as a separate entity. One

senior clinician participant said: "I didn't see myself as a medical educator specifically. I was a clinical academic doing the three things [clinical, teaching, research]" (SE1). A scientist participant put it as: "I have to be frank, probably not. I mean, to me, a career in medical education is, it's part of a career in science" (P1, SW Sci).

### Social categorization

Participants highlighted their struggle to identify with a medical educator type or ideal. Although some identified with specific roles or qualifications, participants generally could not describe what a medical educator looks like. For example, some described medical educators as those with the right qualifications: "Yeah, I think once I got the masters, I felt that I was a medical educator, you know" (SE2). Another participant noted:

> When I was thinking of doing a career in medical education, it was just speaking to other people and they've said, "Oh we've done this PGCert which you can continue to do, you can get a diploma and then a masters if you're really serious about medical education." (P2, SW Clin)

Qualification attainment, then, may be one route to a possible shared identity or social categorization.

Other participants, however, believed that such qualifications were not the correct currency and often are worthless in terms of judging who is a capable educator and who is not. For example, one participant explained:

> There's a lot of chat as in how valid it is about the fact that training won't be commissioned to people that don't have education qualifications, which I think is actually shooting everybody in the foot because just because you have an educational qualification doesn't make you a good trainer/teacher, and there are [a] huge amount of people out there that have no formal educational qualifications, as we were saying, who are fantastic at what they do. (P2, SE Clin)

The debate about the importance of qualifications as the marker of what makes an individual a medical educator is arguably an important indicator of the current struggle medical education faces in shaping a cohesive identity.

### Social identity theory

Social identity theory posits that groups define themselves both by how they identify themselves (in group) and by how they are defined by outsiders (out group). Although participants spoke about both these categorizations, they more often spoke about the lack of them.

**In group.** While participants struggled to self-identify with medical education, they also struggled to identify with medical educators as a group. One participant described becoming an educator as "going native" (P4, SW Sci). More often, though, participants had trouble identifying the practices and attitudes of medical educators "in the wild." They also noted that they did not develop an emotional attachment to medical education, which is important in allowing individuals to identify and then bond with others in a group.

Participants found the identity of medical educators to be rather nebulous, meaning different things to different people, even to those who described themselves as being heavily involved in the field. Some participants did have a clearer view of their own perceived position and aims but defined their identity by their activities.

> On a practical level, I would say a career in medical education for me would involve a part of my time as a professional dedicated to medical education, be it educating undergraduates or in terms of lecture or whether it would be clinical teaching sessions, but also on a more, I don't know, on a different footing perhaps getting involved in development of the undergraduate curriculum and policy setting and things like that as well. (P4, Mid Clin)

Few were able to define the roles of medical educators. Some declared a lack of general knowledge about the possibility of developing a career in medical education.

> We need clarification of the career's structure.… I think things aren't very clearly defined at the moment. There's been lots said about careers education within medical schools and that's lacking in general, but particularly in medical education. Students aren't aware that they can have a career in medical education. (P3, Mid Clin Sci)

**Out group.** Struggling to identify with and join a group is only one aspect of developing a social identity. Much of a group's identity is defined by those who do not belong to the group; in other words, one's social identity is derived from what one is not. This social comparison can generate self-esteem within a group. Participants expressed that the lack of value (perceived or otherwise) that others place on medical education challenges educators' group identity by decreasing their shared self-esteem. For example, one participant explained that "we don't have a good reputation amongst other medical specialties.… I think medical education is kind of the ugly duckling of the … medical world" (P6, Mid Clin).

In nearly every transcript, both the junior and senior educators made a comment that aligned with the poor relation phenomenon. Participants felt that medical education activities lacked recognition and, without a career structure, were less valued than clinical work or research. The time involved often was not acknowledged and remained unaccounted for in job plans. One participant explained, "When I expressed my interest to one of my consultants about education, the term 'those that do, do, those that don't, teach' was quoted to me, and I can't believe that somebody at this stage, at this present time, would say that" (P2, SE Clin). Another participant expressed a similar experience: "Like 'oh you know most surgeons that go into medical education just can't operate'" (P3, SE Clin).

The lack of self-esteem among medical educators appears to be a core problem. One participant recognized this phenomenon, and her response is both challenging and encouraging for the development of medical education as a discipline in the future:

> I think as a teaching-oriented body of people, I think that we need to make a stand and actually sort of demonstrate that we actually have got an expertise in an area that's crucially important. So I think perhaps as people who teach we could brand ourselves, not a very nice metaphorical use of that term, but we could promote ourselves a little bit better as opposed to, I don't like the idea of the downtrodden teacher with the frayed knapsack which is overloaded with books, who kind of like gets all the crappy jobs and is always standing at the broken photocopier. (P4, SW Sci)

**Intergroup comparison.** According to Tajfel,[14] to be satisfied within a group, one must develop a self-identity and a group identity, and when an individual compares his or her group with other groups, it compares favorably. If not, the individual

will be dissatisfied with his or her social identity. As we have reported, participants described a nebulous identity for medical educators. Poor social or intergroup comparison can undermine group identity. As one participant lamented, "I wouldn't be able to say, 'oh in 10 years' time, I've somehow got something to show for it other than lots of anecdotes about mad students'" (P3, SW Sci).

Participants could see the structure of their clinical and/or academic careers, but when they compared their medical education identity with their primary identities (intergroup comparison), the structure of their medical education career was unclear:

> I've never really had a firm grip on like who becomes a director of medical education in a trust. What, how do they qualify for that role? Have they been college tutor, have they been a program director of something, or have they just done some research? Have they done their masters? Have they done a certificate in education? Or I mean, I'm sure it's different to every trust and I don't think there probably is any clear guidance. And to me a career in medical education, I completely agree, can mean a million different things. (P3, SE Clin)

Some participants did see the advantage of an unfixed career structure, were happy to "venture into unchartered territory" (SE4), and recognized that "it doesn't have the same sort of structure that you would be familiar with perhaps [from] other branches of medicine, which makes it interesting, but you [are] never quite sure what's going to happen next year if you know what I mean?" (P4, SW Clin). Most, however, felt that the unclear career structure was risky to pursue.

> That's the bit that I'm struggling with, I don't know where I'm going, all I know is that you need to collect a set number of things along the way and then you might land up somewhere. I don't know what the pathway is or what you do, you just get as much as you can on the way up. (F3, Mid Sci)

Participants highlighted a number of factors that contributed to this unfavorable comparison. First, they sought guidance: "What opportunities are there, you know, generically or specifically that are available that we could be going for if we wanted? And I don't really know where to go" (P4, SW Clin). They also were keen to reduce the sense of isolation that the lack of structure brought:

> There's nothing actually set down [that] said oh you're interested in medical education, these are the avenues which you can explore, this would enhance your career and your experience this way. These are the careers that are available in medical education, which irritates me a little bit, because in clinical academia, it's very set. You have very clear routes which you can undertake, it's not so in medical education. (P2, SE Sci)

Finally, participants highlighted the financial barriers that they perceived perpetuated an uncertain career structure and nebulous identity.

> You know a few years ago, there was a lot of opportunities for you to get involved in education, both in secondary and primary care, who hadn't previously been there, but I think there's going to be a lot of shedding isn't there 'cos there's no cash around. (P4 SW Clin)

### Developing an identity

Participants also offered suggestions for ways in which educators could develop their sense of identity and group ownership.

Although many participants viewed medical education poorly in comparison with other areas of practice, many acknowledged recent developments in the field.

> The potential is enormous, there are really, really good people in the field, it's raised its status no end, there are highly prestigious journals, conferences, organizations. There's a lot of really, really good things, many of which have happened since I joined, you know, 20 years ago now. Many of which have happened and which I applaud and I'm delighted to see. (SE3)

Senior medical educator participants also described the luxury of a more flexible system, one that provides support for career advancement in education with the freedom to develop research designs, job plans, and other activities.

All participants recognized networking as an enabling factor in their development of a career in medical education. Participants discussed the benefits of networking in enabling specifically educational research collaborations and teaching courses, as well as providing opportunities to discuss and hear about career opportunities. This opportunity was particularly valued in an environment in which educators can hold disparate posts. Working in such relative isolation, sometimes educators may not be aware of other educational positions within their organization. One participant explained, "It's just nice to have contacts with people and contacts with senior … educators who you would never normally meet" (P6, Mid Clin).

Similar to networking, both junior and senior medical educators felt that mentoring was essential to developing a career in medical education. Mentors provided career advice and support and specific guidance with research. Participants also noted that mentors should not be too much further in their careers than their mentees so as to be able to provide useful and up-to-date support. Mentors also should receive mentorship training. As a senior educator explained:

> My latest new thing is coaching and mentoring, and I do think that having a mentor, especially a mentor who knows what they're doing, trained mentor as opposed to a very experienced person who's agreed to be your mentor, they're very very different things I can tell you, is hugely career enhancing. (SE4)

Finally, participants described the joy of teaching. Teaching was a strong motivator for both junior and senior medical educators who valued their personal contribution to the advancement of medical education. Thus, teaching is a career-enabling, in-group factor in terms of sparking and sustaining educators' interest in career development.

> There can be two or three reasons why you're going to go into medical education. One is that after a while you feel that you have learnt something and you want to leave a legacy, you want to pass on something to your juniors or something like that and you want to feel good that having passed it on, maybe it's sort of vicarious gratitude or whatever it is, I don't know if that exists, of being able to teach somebody and seeing them happy and progress. (P7, Mid Sci)

## Discussion

While we found a number of useful, practical recommendations for how the AoME could better support medical educators, we also identified potential challenges to medical educators' identity construction.

A significant body of literature is concerned with professional identity as social identity. While some authors struggle with the concept of identity,[21]

social identity theory brings together two concepts—that of a self, internalized identity and that in which identity is co-constructed through social interactions.[14] Most of the social identity literature in medicine, however, focuses on the identity construction of medical students as they become physicians,[22] rather than the identity construction of medical educators. Yet, medical education as an identity, not just as an area of inquiry, is an important construct. Bleakley and colleagues[23] describe medical educators' identities as "identities in crisis and transformation." They argue that medicine itself will be democratized through a more patient-centered approach to care and the negotiation of this crisis by more collaborative and participative practices.[23] Thus, understanding and negotiating medical educators' identities is important to the field, medical education research, the practice of medicine, and ultimately patient care.

Much of the medical literature focuses on the roles of medical educators as teachers, scholars, and even managers.[24] Our participants, however, did not always understand their roles or what roles might contribute to their identity as educators. Having more than one identity, such as physician, family physician, or mother, is commonplace.[25] However, how these identities are nested or placed in a hierarchy[16] affected how participants understood and valued their identity as medical educators. In other words, if medical educator is seen as an add-on role, rather than nested in one's other identities, and if it's low in one's personal hierarchy of roles, individuals will be unlikely to give it prominence, and others will be unlikely to recognize it as a separate construct.

Because medical educators hold a number of roles—from clinical teacher to education researcher[23]—it is not surprising that they struggle to develop a salient identity.[26] The literature assigns this saliency to two categories—accessibility and fit.[26,27] *Accessibility* refers to the ways in which an identity is open to an individual based on his current roles and context. Thus, scientists should find medical education as an identity more inaccessible than clinically trained physicians. However, we did not find evidence of this in our data. Instead, we found that no participants, including senior educators, sought access to the medical education identity.

*Fit* is defined by the concepts of in and out groups in self-categorization theory.[17] The more an individual fits the profile of the in group and the less he or she fits the profile of the out group, the more that individual will align him- or herself with the in group. Fit often manifests in two main ways. First, normative fit relates to stereotyping when an individual fits a particular group. Our participants expressed their fears for fitting the educator stereotype—"the down-trodden teacher with the frayed knapsack" and the "ugly duckling." We would argue that our participants did not seek out normalization into such stereotypes.

More relevant to our study is comparative fit, when a group's stereotype is less certain. Comparative fit is often seen with social groups that emerge ad hoc, coming together to complete a specific task. We would argue that medical education as a social group has not yet evolved beyond this transient social structure. Individuals from various disciplinary backgrounds simply have come together to complete a task—to educate medical students and physicians—therefore, they are defined by the roles they hold within the group rather than as members of it. As their professional identities already are shaped by their participation in other social groups—the clinical, social, or basic science disciplines—individuals then must make a leap or, as one participant put it, "venture into unchartered territory" to medical education. However, too few medical educators have made this leap—to be seen as, and therefore defined by, their social group identity, rather than as individuals.

Because tensions exist between identities when different cues and contexts shape the salience of more than one identity at the same time, this lack of fit is important.[28,29] If, as a group, medical educators agree on what is important and how to go about achieving their goals, they could have a profound impact on the field of medicine in general.[23] Fit is also important for individual educators, as group identity may reduce stress[30] by increasing professional support and security.[31]

This lack of fit is perhaps best illustrated by the narrative of the medical education literature itself. On the spectrum of organizational identity, we only spoke to clinical educators and scholarly medical teachers, not to education researchers.[23] While identity boundaries may become clearer across this spectrum and medical education researchers may relate more closely to a shared medical education identity, we postulate that both are unlikely. For some time, medical educators have been debating the ideological foundation of the field[32]—some from a biomedical lens, appreciative of the audience (i.e., physicians and policy makers)[33]; others more recently from a social science perspective. Eva[34] recently described this debate as "the many layers of social in our science." This social perspective has led to a focus on theory generation and calls for the uncoupling of education research initiatives and patient outcomes.[35] This move, however, away from the bedside, may have implications for the relevance, impact, and ultimately funding of medical education research.

Although we recognize that our sampling method for recruiting participants may have biased our sample to include those who identify with the medical education field, we feel that this nonrepresentative sample strengthens rather than undermines our findings. In addition, although we conducted focus groups nationally, we did find a geographical bias towards participants from the South and South West of England, again affecting the representativeness of our sample. However, in comparison to the literature from other countries, the United Kingdom is not unique in the perceived challenges in medical education.[1] Another limitation to our study is that we included many more clinicians than scientists; hence, the views of scientists may not be adequately represented. Finally, we acknowledge that we did not have the opportunity to share our early analyses with the participants. Therefore, the interpretation presented here is solely that of the authors.

Further research is needed to explore, with larger cohorts (especially scientist–educators) and across international borders, the important factors that shape identity construction within medical education with the end goal of improving patient care.

## Conclusions

Medical educators face an identity problem. Educators do not see themselves as belonging to the field of medical education. Instead, they inhabit the field. Thus medical education is an activity or a series of roles rather than an owned social and professional identity. To end this

identity crisis, increased collaborative and participative practices will be important for the future of medical education, medical education research, the practice of medicine, and ultimately patient care.

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*Previous presentations*: E.S. presented this article at the Academy of Medical Educators annual conference in London, England, in June 2012.

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