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“Making the leap to medical education”: a qualitative study of medical educators’ experiences of career transition

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Abstract

Background

Medical educators often have prior and primary experience in other academic and clinical disciplines. Individuals seeking successful careers in the education of medical students and doctors must, at some point in their development, make a conscious transition into a new identity as a medical educator. This is a necessary move if individuals are to commit to acquiring and maintaining specialist expertise in medical education. Some achieve this transition successfully, while others struggle and may even lose interest and abandon the endeavour. We explored senior educators' experiences of achieving the transition into medical education and their views on what helps and hinders the process.

Methods

In 2015 we conducted three focus groups with 15 senior medical educators. All focus groups were audio recorded and transcribed verbatim. We applied transition theory to guide our deductive analysis, using Schlossberg's Four S (4S) framework to code and report the participants' self-reported perceptions of those factors relating to Self, Situation, Support and Strategy that had assisted them to make a successful transition to a fully acknowledged medical educator identity. Through inductive analysis, we then identified 17 explanatory sub-themes that were common to all three focus groups.

Results

Background and circumstances, individual motivation, a sense of control, organisational support, and effective networking and information seeking behaviour were factors identified as contributing to successful transition into, and maintenance of, a strong self-identity as a medical educator.

Conclusions

The experiences of established medical educators, and in particular an exploration of the factors that have facilitated their transition to an acknowledged self-identity as a medical educator could assist in supporting new educators to cope with the changes involved in developing as a medical educator.

Introduction

This paper aims to identify and explore factors that help or hinder individuals from making the transition into a successful, self-identified medical educator identity.

Medical educators develop their professional identities as part of a continual process of career and role change (1) (P90). Many medical educators, it has been argued, occupy a liminal space between identities (2) and even academic disciplines (3). Consequently some individuals struggle to develop a clear identity as a medical educator and to maintain it in the face of competing career demands and the increasing pace of change within medical education (4, 5). This is a particular challenge in circumstances where the individual views him- or herself primarily as a clinician or researcher (6-8). These primary professional identities almost inevitably take precedence over the educator role, since these are better supported, carry more social capital, and because individuals are likely to have invested more emotionally in acquiring them (5). Both Hu (9) and Sabel (5) suggest that the stress involved in negotiating the changes necessary to acquire what is perceived as an inferior and nebulous identity often deters junior educators from becoming more involved, regardless of programme or organisational support.

Despite these tensions, some medical educators are able to arrive at a point where they are comfortable with both role and identity; i.e. the point where they have transitioned from 'someone who does medical education work' into a self-acknowledged medical educator identity. Our primary research questions explore how this happens and attempt to identify factors that may help or hinder.

Using psycho-social transition theory we conceptualise the process of becoming a medical educator as moving out of one relatively stable state (primary professional identity) through a series of sometimes stressful changes that lead to a transition into another relatively stable state (medical educator identity) (10).

There is a difference between change and transition (11). Change is situational: taking on a new teaching or leadership role, starting a new job, encountering a new group of students or managers, or working within a different appraisal system. Transition, however, is psychological: it concerns the inner alterations that are necessary to enable an individual to incorporate changes into their lives. As Bridges remarks: 'Unless transition happens, the change won't work because it doesn't "take"' (11 xii).

An individual's success in negotiating a series of changes is what leads to transition into a self-identified medical educator role: this, we suggest, is what constitutes the 'leap' to medical education reported by Sabel and colleagues (5). Self-identifying with the educator role is a required transition if individuals are to feel that they are legitimate participants within the medical education community, ready to commit themselves to the difficult task of developing and maintaining specialist expertise in the field (12).

An individual's ability to adapt to a particular change or set of changes is affected by multiple factors, both intrinsic and extrinsic. The individual's response to these factors will vary depending on his or her perceptions of deficits versus resources available to meet them (13). Intrinsic tendencies (such as, for example, openness to experience and conscientiousness) may play a part but previous experience, personal values and ambitions also have an effect. Moreover, adaptation may vary with the timing, nature and circumstances of the change; whether it was imposed or chosen; individual circumstances when the change occurred; and whether the terms on which the change has taken place are understood and accepted. Finally the ability to adjust to change is affected by the support available, and the strategies that the individual is able to adopt (14, 15).

A number of recent studies report the perceptions of individual clinical teachers as they juggle their competing identities; but proffered solutions (for example in terms of developing career opportunities, time for teaching, or professional development schemes) are often at a programmatic or organisational level since this is where the chief stressors appear to be felt (16, 17). However, as Monrouxe argues, "identities are not fixed cognitive schemas; rather, identities are what we do" so it is important to understand what factors, at an individual level, facilitate or impede the 'doing' or performance of medical education (12). We were concerned to explore the factors that may tip the scales in favour of an individual's persistence when faced with change and challenges in medical education.

This paper therefore adds to the literature in two key ways. First, it introduces transition theory as a conceptual model for considering the process of developing self-identity as a medical educator, and secondly it looks at the individual factors that may support or deter an individual's persistence in pursuing a medical educator identity.

Methods

The authors participated in a large-scale Higher Education Academy (HEA) funded project exploring the information needs of members of professional education bodies. The Academy of Medical

Educators (AoME) engaged us to undertake the medical education aspect, and we conducted a study using an online survey and focus groups before submitting a disciplined- focused report (unpublished) that informed the HEA report. The HEA across-discipline report was published in 2015 (18).

We subsequently re-examined the data we collected during three medical education focus groups, which had been conducted with individuals who had experience of transitioning successfully into and maintaining a medical educator identity during a number of career changes.

We wanted to know:

- What factors at an individual level had helped or hindered these individuals to make the transition into becoming a successful, self-identified medical educator?; and
- Can we draw any conclusions from this that could help develop individualised support for professionals who are struggling to adjust to the medical educator role and are thus at risk of rejecting a medical educator identity?

Data collection

Cardiff University's School of Postgraduate Medical and Dental Education Ethics Committee granted full approval for the project on 7 May 2015. Three focus groups were conducted during 2015 with 15 senior UK-based medical educators (six women, nine men; including nine clinicians from diverse medical specialties). Participation was voluntary. All participants were recruited from among AoME Fellows, in a deliberate effort to focus on senior self-identified medical educators. As Fellows, their achievements had been peer reviewed and recognised through AoME's professional recognition scheme at level 2-3 (i.e. senior level) of the AoME *Professional Standards* (19).

The first focus group comprised six assessors for the AoME's professional recognition scheme. The second group consisted of five elected AoME Council Members. The third focus group comprised four individual AoME Fellows, all of whom held senior positions in medical education. KW facilitated group one with JB supporting; JB facilitated group two with JB and AB supporting; AB facilitated group three with KW supporting. The question guide for the focus groups is appended (List 1).

Discussions were audio-recorded and transcribed verbatim. All identifying information was removed to protect the anonymity of the participants.

Data analysis

Psycho-social transition theory is a useful tool for exploring an individual's need for support in negotiating stressful changes. Since the progress towards identifying as a medical educator can involve a good deal of stressful change (20), we theorised that Schlossberg's 'four S' (4S) model would make an appropriate analysis framework for the focus group data (13) as it was originally designed to support interventions to help individuals adapt successfully to change. It has been successfully used as a basis for developing support services for adults who are finding change and transition in education settings difficult and was therefore particularly promising in this context (15). We used it deductively through a framework method (21) to examine if the data were a good fit. JB and KW independently coded and charted the data against the 4S main themes using a matrix framework format. The authors then inductively identified sub-themes within each of these four framework areas. JB and AB worked further on charting to ensure that analysis had been systematic and coherent. Finally all three researchers engaged in review of the analysis for implications for practice and conclusions.

Results

Our data aligned with Schlossberg's 4S framework (15). The 17 bulleted sub headings in each quadrant reflect our own analysis, and are drawn from the larger set of sub-themes within Anderson, Goodman and Schlossberg's account (22). Our sample was too small and directed at professional issues to be expected to reflect sub themes such as, for example, intimate partner support, spirituality or sexual orientation.

Insert Figure 1 here

Theme 1: Self

In Schlossberg's framework, self refers to personal characteristics and psychological resources: how comfortable individuals feel with the change/new role; how confident they are in their understanding of what is expected; how prior experiences and expectations have brought them to this point; whether it is where they want to be; and how their personal values align with the role. Participants were senior medical educators with many years of experience and had achieved recognition for this through a number of different channels (for example senior appointments, higher level qualifications, Fellowships, prizes, grants and awards), but their comments revealed a continuing sense that they were moving, or had moved, towards becoming medical educators from a primary prior identity as doctors, academics, scientists or in two cases, humanities scholars:

Quite a lot of us who are involved the design of teaching are no longer in the frontline of medical practice (FG2, participant K)

A number of participants referred to the complexity of the field, and for one participant the medical education workforce's diversity appeared to be a unifying factor:

We try to do some very, very complicated things with a very diverse group of people. Some of us are clinical. Some of us aren't clinical. Some of us are based in primary care, some of us in secondary care. Some of us are researchers (FG2, participant H)

The repeated use of 'we' and 'some of us' indicates that the speaker has a clear idea of who 'we' (i.e. medical educators) are. Successfully navigating medical education's diversity appears here to be a potential factor in medical educator identity formation.

Medical educators risk falling prey to 'imposter syndrome' (23, 24) – an uneasy sense that they need to be expert in all three fields (of scientific research, education and medical practice) to have credibility within higher education. Feeling comfortable in their own expertise was clearly crucial to the success of participants

You know, when I'm teaching in my own area then I'm, you know, I'm reasonably comfortable and I feel confident and competent to do that (FG3, participant M)

One participant appeared to suggest that their acceptance that they could not be expected to know everything might actually be a driver for forming a new identity.

Yes, it's not just about knowledge. It's about socialisation and identity, personability and all that sort of thing. So you're not just a repository of information. You are a different person almost. (FG3, participant P)

For this educator, the possession of information is necessary; but the distinguishing feature of educator identity is how one approaches facilitating others' professional development. The implication here is that a teacher is particularly identified through his or her professional ethics and the ways in which these are expressed through working relationships. Medical education is a value-led activity within a value-led profession (24). A number of participants felt that it was their values that had led them into their careers as doctors and scientists, and the fact that their work in medical education supported these values was important in maintaining their involvement:

Respect, integrity, scholarship, quality - are transferrable to anything really. I think whatever you do you need to have those four qualities. (FG1, participant A)

Theme 2: Situation

Situation in Schlossberg's framework refers to the characteristics of the change event, for example: what triggered the change; the individual's readiness for it; current ability to cope with the additional stress of change; whether the change was chosen; understanding how long it will last; and their sense of whether their status is improved or damaged as a result. In line with Schlossberg's view that change affects people throughout their lives but that change is not encountered in a uniform progression, age and stage of life did not appear to be significant concerns for participants, all of whom were in at least their third or fourth substantial role in medical education. However, changing (and increasing) clinical and academic workloads and their impact were constant themes.

I think for the last five to ten years having to do two appraisals a year, one academic and one NHS, both of which require a fair bit of information and ongoing CPD. It's a huge burden really (FG3, participant K)

And also working in university there's expectations that we'll do research as well. That's, time for that is really difficult with all these other time pressures on you (FG2, participant H)

The most significant factor affecting how participants experienced competing workload pressures between medical education and their other professional activities was the degree to which they had chosen to be involved in medical education and the amount of control they felt able to exercise within it. Our participants had themselves chosen or transitioned successfully into medical education careers but they expressed concern that educators' control of how they occupied the role could be decreasing for a number of reasons:

At a national level (...) we're in this transition from what I call old school medical education to what's really happening now (FG3, participant M)

Compared to other academic departments, very few are as heavily regulated and controlled and attract as much interest from politicians as we do (FG2, participant H)

While participants seemed able to accept this personally, they clearly felt concern for junior educators as the rate of change increased:

One of the things that is worrying for all of us is the fear that eventually being a medical educator is just going to be so flipping hard for clinicians that they vote with their feet and leave medical education (FG2, participant J)

At the moment we have a very good mix and a very good collaboration between the clinical and non-clinical staff within medical education, but I think it would a very sad day indeed if doctors actually just gave up the field and said, oh it's just... we have enough to do (FG1, participant A)

Regulatory and organisational innovations in the NHS and university environments such as revalidation, research assessment exercises and performance reviews, new legislation and technology, the growth in the recording and analysis of performance data and the increasing attention given to medical education in media and political circles were all mentioned as sources of change. Other factors contributing to this sense of involuntary change included alterations in student expectations (25):

You happen to open your emails at 8 o'clock at night and it's there and they're expecting you to answer it even though it's Saturday the next day and why haven't you answered? Why haven't you dealt with it? And you feel that demand (FG1, participant E)

Understanding how long the period of change is likely to last is an important factor in negotiating change successfully in order to achieve transition. Participants were pessimistic that this would ever be possible in medical education, particularly where the medical education community was not driving the changes (26). This inability to define a clear sense of direction or endpoint led some to hint at a sense of failure:

I guess one of the gaps is going to be how we transition into whatever multi-professional or inter-professional education is going to be. We've never been able to satisfactorily say, you know, what, in positive terms, we should be trying to achieve (FG2, participant G)

The NHS is changing and medical education hasn't changed to keep pace (...) I think the NHS is continuing to change and we're a long way from aligning, and I think that gap is going to be a difficult one to cross (FG2, participant K)

Theme 3: Support

Support for individuals undergoing change may derive from access to personal support networks (and willingness to benefit from these); strength of institutional support; availability, quality and

relevance of appropriate resources; and attitude of others concerning their wish to involve themselves in the role. Participants identified a number of sources of support for medical education activities including mentoring, advice, coaching, peer review and feedback, cover for new roles, appraisal, and access to resources for continuing professional development (CPD). Some respondents felt that increased formal recognition of medical education in recent years has led to better support:

I can see careers in medical education starting to blossom at last (FG2, participant H)

However, participants reported that support varied between sectors, institutions, departments and even between individuals working alongside each other, depending on their roles. Clinicians reported practical difficulties due to their multiple roles: all reported that funding and resources for CPD were difficult to secure.

The reasons for this lack of support were attributed to a variety of factors. For some, the challenges were personal and day-to-day, involving lack of administrative resource and expertise, and shortage of colleagues to share the workload pressures as student numbers and expectations increase. Others attributed difficulties in obtaining support to a continued lack of high-level understanding of the challenges and complexities of medical education. Obtaining ring-fenced time for teaching and CPD was a particular concern for respondents working in clinical settings:

You've got the same amount of CPD to do regardless of how much of your week you spend doing that (...) It makes you have to choose because you just haven't got the time to do all of the CPD to that required standard (FG2, participant J)

Despite the sense that employers were only slowly waking up to the particular needs of medical educators, respondents were keen to express their personal satisfaction in their educational roles and their sense of belonging to a wider educational community. These participants were confident and creative in identifying, securing and benefitting from the educational resources they needed.

I'm doing a master's in clinical education...I've been very well supported by my institution to do that (FG1, participant E)

A major source of their support came informally from colleagues in medical education and from the wider medical education community itself, particularly with regard to information-seeking.

I interact with lots of other medical educators and I depend a lot on what other people suggest and direct me to (FG3, participant P)

Participants were active both in accessing curated material and in sharing it with colleagues and students:

I mean, one of the NHS Trusts has a (...) bulletin that kind of comes out on a fairly regular basis, and it's one of the most useful things I've seen in a long time actually and I got it by accident and managed to get added to the list, and it's basically a librarian sort of scans the health professions education literature on a monthly basis (FG1, participant C)

They can find it in the App shop and some of the students do independently, but some of them need to be pointed to it (FG3, participant P)

Social media was a significant source of informal community support for these medical educators, although a number reported that it had required personal contact to get started:

Twitter has a lot of discussions (...) If you just use the hashtags like MedEd and things like that then it will bring up a whole host of discussions and articles that you can click on. (Name anonymised) actually showed me. She does a lot of things around that (FG3, participant N)

Again, while the participants themselves had navigated the challenging environment in order to maintain their educator identity, there was concern for the next generation, particularly in terms of career support:

We need to make sure that pressure is brought to bear on, you know, universities generally, medical schools particularly about creating obvious and transparent career progression. That means targets, metrics, things that are measurable (...) you know, I just see these people becalmed at lower levels and there's no real way of getting them out of that (FG3, participant Q)

Most respondents reported being involved in and feeling responsible for supporting less senior colleagues:

A lot of it particularly is around how you share things with colleagues. How you mentor people. How you lead in medical education and similar things (FG2, participant J)

However, there appeared to be some recognition that informal and personal networks, although invaluable, were less visible and therefore less accessible, especially to junior colleagues.

People early in their careers would find it much tougher (...) Because I've been around a lot you meet people over the years. So for example, (...) I needed to find out what the current

thinking on that was. So I just went to the person I knew had been commissioned to investigate this. So that's very helpful but it's not, you know, it's not a network that's immediately visible. It's one that remains within me (FG3, participant Q)

Theme 4: Strategies

Strategies are coping responses that include the tactics adopted in order to get through a change successfully. As a group, our respondents reported a large variety of strategies that they had developed as individuals, but which appeared to suggest a common approach towards coping.

Despite the difficulties in identifying and accessing educational support reported in Theme 3, many had taken a highly strategic approach to acquiring medical education expertise and had gone to considerable lengths to develop knowledge and skills. Several reported undertaking postgraduate medical education qualifications. One commented that although the course he chose had not been focussed directly on his learning needs he had been able to adapt it and benefit from it:

When I did my PhD (...) there was a tiny amount in the literature relating to medical students, in fact most of the literature base for my thesis came from teacher education (FG2, participant L)

Most participants expressed a resourceful and flexible approach to their own learning:

The stuff that's in textbooks can be of varying quality. So I find myself reverting back to foundational resources that are outside of clinical settings (FG1, participant E)

These educators were highly self-directed as a group. Most subscribed to medical education journals and were willing to sift through wider literatures in order to find relevant information. Others recommended new technologies including social networking, webinars, newsletters and mailing lists, electronic resources, including online courses and distance learning.

Participants had a uniformly positive approach to work and professional collaborations. Their discussions repeatedly reflected on the wider partnerships they had formed with colleagues from different academic disciplines, interprofessional groups and national and international organisations. There was a general view that more could be done to promote cooperation and co-ordination of effort. For example:

It's about generating new knowledge that's going to help patient care and where does that generation occur? It typically occurs at the interface between disciplines and yet we're

inward looking and we don't interface enough with other disciplines. Geography, mathematics - I've done lots of stuff with the school of mathematics and (...) I'm sure you can go across the whole of the university in that way (FG1, participant M).

What I would like to see is the profession uniting a bit more and I think all the bodies could do a bit more in that area (FG2, participant J)

In addition to taking advantage of and creating for themselves the informal networks and professional development opportunities discussed above, all of the interviewees had made a deliberate effort to engage with formal networks beyond their own institutions. All were Fellows of AoME, and most were also involved with at least one other national special interest group or organisation for the support of medical education. A number also mentioned other sources of formal support including advice and guidance from regulators, employers, Royal Colleges and professional organisations.

The role of professional recognition was a key theme and clearly played an important role in helping participants to feel that they had made a transition into medical educator identity in line with other observers' previous suggestions (27).

The Academy of Medical Educators and others actually have a role in badging people in that transition from being one thing where they are, you know, fairly well regarded to badging them as a medical educator and there are professional standards that are expected of that role (FG3, participant P)

While increasing regulation presented challenges, most participants also viewed it as an opportunity to advocate within their organisations and more widely for medical education, and to raise standards across areas of education that had formerly been poorly connected. For example, speaking of the role of the General Medical Council (GMC) in recognising educational supervisors in secondary care, one participant commented:

I can see that there will be more congruence between under-graduate and post-graduate and hopefully better lines so that students can actually see where they're going rather than there being a, sort of, cavern between under-graduate and foundation, and foundation and training (FG2, participant G)

These successful educators have been quick to identify the opportunities offered by changes in the culture around medical education for asserting their need for personal and professional development:

The regulatory climate that's what made it easier in the last year or two because it's been earmarked that something doctors have to do which means that ... it's much easier to do it. It's part of your job officially now (FG1, participant C)

You're professionalising it (the role). Getting the teaching time (...) and people seeing it as more of a portfolio or substantive career. So in getting, sort of, respectability in that sense (FG2, participant G)

Summary of key findings

By analysing sub themes from the focus group data we identified a number of key factors within each of the 4S themes that contributed to the participants' sense of medical educator identity.

The participants in our study were experienced professionals who had made a successful transition to a relatively stable medical educator identity. While they expressed some concerns for the future, particularly on behalf of more junior educators, they generally expressed satisfaction with their decision to become medical educators.

In terms of self, all were able to make a clear connection between being a medical educator and their personal values. Clearly the 'fit' between their medical education work and their personal values was close enough to allow these individuals to invest effort in making the internal adjustments necessary to successfully transition into a new professional identity as a medical educator.

Secondly, in terms of their situation – the characteristics of their increased involvement in medical education -the most significant factor affecting their adaptation to a medical educator identity was the degree to which they had chosen to be involved in medical education, the amount of control they felt able to exercise within it and their sense that they could influence its future direction.

Thirdly, the personal support they received to cope with changes in their working lives was a significant factor in helping them to deal with change. Participants consistently linked medical education's perceived status as less important than either research or clinical service to their

concerns about the shortage of resources both for planning and providing quality education and also for educational improvement including opportunities for career and personal development. Whilst participants were generally dissatisfied with the level of support they had received to make the transition to medical educator identity, all identified resources that had worked for them, such as informal sources of information, networking, qualifications, role models and mentors, learned societies and professional recognition schemes such as that offered by the Academy of Medical Educators.

Fourthly, these participants were characterised by their resourcefulness and energy in developing their own strategies. Successful strategies identified in our research included adopting creative and active approaches to information seeking, skills development, networking, and seeking recognition. They were all active in seeking educational opportunities and information, and expressed their willingness to support each other, their students and trainees, and early career educators.

Discussion

Our study was affected by our early decision to use purposive sampling for data collection. The findings are therefore limited to the UK context, and to the perspectives of senior medical educators (Fellows of the Academy of Medical Educators). The experiences of junior educators were not sought and it is possible that these findings would not prove transferable to other populations and settings. We believe, however, that the perspectives of those who have successfully adopted a medical educator identity have not been systematically explored before and are therefore of interest in themselves. They may also prove useful in identifying the aspects of self, support, situation and strategy that are likely to be most effective in supporting junior educators to adapt to their changing educational roles.

The literature on transition naturally tends to focus on the support of those struggling to adapt to life-changing events such as bereavement and trauma. Interventions such as counselling using the 4S framework and others were designed to help individuals struggling to adapt to major changes. It may therefore seem incongruous to view medical education as a significant and even traumatic life event when for many it is an enjoyable, stimulating and deeply rewarding daily activity that enriches their working lives. There is no doubt, however, that moving into medical education represents a major and occasionally painful career transition that profoundly affects individuals' sense of their working identity. The literature reports an almost universal experience among educators of periods of frustration, disappointment, stress, demoralisation and burnout, coupled with a lingering sense of loss at the erosion of their primary professional identity (4-9, 28). Furthermore although there is

little data to show how many of those who express a desire to teach actually go on to develop a significant medical education career, we do know that for most medical schools retaining teaching staff is a major challenge, with 42% of medical school faculty in one study expressing 'serious intent to leave'. (29, 30)

This 4S framework therefore offers an appropriate structure for helping colleagues who are inexperienced or at risk of struggling to explore some fundamental questions about the changes they will negotiate on their journey towards a settled professional identity as an educator.

The participants in our study were all in the latter part of their careers and had wide experience of negotiating the changes necessary to make the transition to a firmly established medical educator identity. While accepting that in many ways the career situation has improved for medical educators, they also were aware that expectations and challenges had risen correspondingly. By grouping their change negotiating strategies within the Schlossberg framework, we offer a systematic approach to considering the support needed by individual educators during periods of rapid change. Not all of those working in medical education are able or willing to make a successful transition to medical educator identity. Unless those responsible for faculty development can find a way to support these reluctant or struggling educators at a personal level it is almost impossible to engage them in scholarly and professional activities to improve and extend their educational practice. We have examined some of the possible reasons for this and propose that this framework should be used with individual medical educators to help them develop strategies to adapt to changes in their working lives. As they adapt, they will be enabled to make the transition to full medical educator identity and emotional engagement.

When providing support to staff who are commencing medical education careers, it is important to tailor advice and support to their particular circumstances, including: Self (their previous experiences and their ideas and expectations regarding the role); Situation (the circumstances in which they find themselves, including their understanding of and concerns about what is expected); Support (the resources they have available, what they may need, and whether they know where and how to access these); and finally Strategies (helping them to develop personal strategies to cope with changes so that they are enabled to thrive in the challenging medical education environment).

Finally, clear communication of the medical educator role with well-defined expectations and organisationally appropriate boundaries are important to combatting lingering feelings of insecurity around identity and legitimacy in both individuals and the medical education community (31, 22). These should be coupled with targeted advice on the acquisition of skills, and structural support and

time for personal development and practice. This has a twofold benefit in both supporting those who are in medical education roles and also in providing an easily recognisable public facing medical educator identity to permit a better understanding among those who are not themselves educators.

Teunissen and colleagues assert that: 'A transition is not a moment but rather a dynamic process in which the individual moves from one set of circumstances to another' (32). Medical educators can help junior colleagues who may be struggling with moving into an educator role by first, identifying and understanding the factors which influence their ability and motivation to adapt to change and make the transition into a new identity and second, helping them adopt positive coping strategies. Importantly, such a model could also help mentors to identify opportunities for targeting individual support for educators as they make the transition into their new role and identity (33).

Conclusion

Discussions based around the 4S framework may lead to better targeted support and mentoring for junior educators and could help seniors to identify those who ready to face the difficult challenges required in the journey towards educator identity and those who may potentially to struggle to cope with change at this point in their careers.

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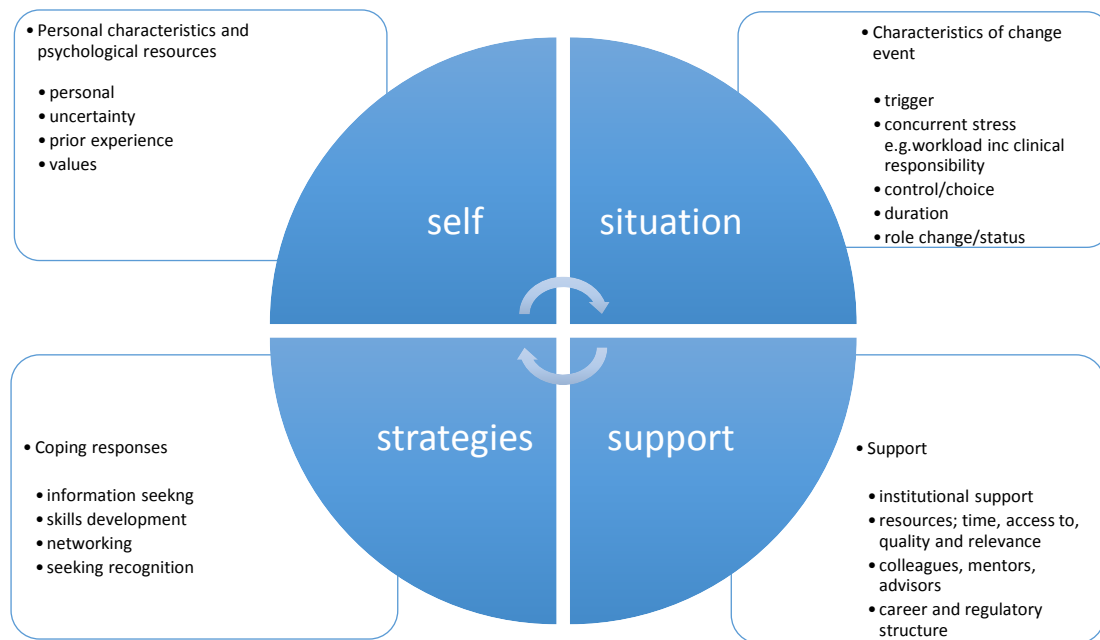
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Figure 1: Framework for data analysis



(adapted from Anderson M, Goodman J, Schlossberg N. Counseling Adults in Transition, Fourth Edition. 4th ed. Dordrecht: Springer; 2011. (29))

List 1: Question Guide for Focus Groups with Senior Medical and Dental Educators to Identify Challenges for Practitioners in the Profession

1. What are the key resources you use in your own teaching?
Are there any limitations within the resource? Can you think of possible improvements?
2. What are the learning and teaching challenges you face in your subject area/discipline?
Why do you say that? Why do you see these as a challenge to the subject? You may want to assess how these could be overcome?
3. How do you think the teaching in medicine and dentistry is likely to evolve over the next few years? Why do you say that? Why do you see the teaching in the subject going in this direction? Is this positive or negative? Why do you say that? What is driving this change/evolution in teaching?
4. What gaps can you identify in the current coverage of teaching and learning resources in medical and dental education?

5. How might the Academy of Medical Educators or the HEA best address the identified gaps?
Why do you say that?
6. Thinking back to question 2, what gaps might emerge in the near future, given the projected evolution of teaching and learning in medical and dental education?
Why do you say that? How can these be overcome?
7. Can you think of any other ways in which the Academy of Medical Educators or the HEA could support and advance learning and teaching in your medical education practice?
8. To what extent are the issues you have raised relevant to other higher education disciplines?
Are there particular challenges faced by medical educators?
9. What is your personal experience of professional development as a medical educator?