Professional Identity and Performance Appraisal:Implications for Indian Medical Education

Rashmi Vyas*, Laura E. Hirshfield, Payal Bansal***, Page S Morahan******

* Assistant Vice President Education, Foundation for Advancement of International Medical Education and Research (FAIMER) and Director, FAIMER Institute, Philadelphia, PA, USA, ** Assistant Professor, Departments of Medical Education& Sociology, University of Illinois at Chicago, Chicago, Illinois, USA, *** Professor and Head, Institute of Medical Education Technology and Teachers Training, Maharashtra University of Health Sciences, Nashik, Maharashtra, India, **** Founding Director, Executive Leadership In Academic Medicine (ELAM), Professor, Emerita, Drexel University College of Medicine, Founding Co-Director, Foundation for Advancement of International Medical Education and, Research (FAIMER) Institute Philadelphia, PA, USA

Abstract: Teaching professionalism is important in the development of a health professional who is competent and responsive to the needs of the community. More recently, the concept of professionalism has expanded to include supporting students in the development of their professional identity. The purpose of this commentary is to describe the effect of diversity on the formation of professional identity, as well as the role of diversity in the development of a robust performance appraisal system. Considerable research has established that greater diversity in medicine, particularly in terms of gender and race, positively influences professional identity formation. This is because diverse identities bring unique perspectives and skills, exposure to which enhances educational experiences and contributes to identity formation. Issues related to language, communication, attire and impression management can be addressed through this sort of contact. Performance appraisals have been found to be a major source of discrimination in managing diversity and equity in workplace. There are many unconscious biases and assumptions related to identities including gender, race and nationality which need to be addressed in developing a fair and equitable performance appraisal system.Researchers have shown that the first step in combating biases is to increase an awareness of one's own biases, and then learn skills to deal with them in a way that is fair and non–judgmental. Faculty development programs can address this goal to some extent. While there are several such programs globally, in India there is a need for faculty development programs that address the issue of biases. The existing national faculty development program led by Medical Council of India and the programs by the Foundation for Advancement of International Education and Research (FAIMER) Regional Institutes in India can add inclusion and biases to their programs. [Rashmi VNJIRM 2017; 8(6):106-111]

Key Words: Professional Identity, Performance Appraisal, Indian Medical Education

Author for correspondence: Rashmi Vyas, Assistant Vice President Education, Foundation for Advancement of International Medical Education and Research, FAIMER Institute, Philadelphia, PA, USA E-Mail: rvyas@faimer.org

Introduction: Teaching and assessment of professionalism is crucial in the formation of a health professional who is both competent and responsive to the needs of the society. Professional identity has gained increasing attention in the recent years as educators have suggested that the purpose of teaching professionalism "is to support students and residents as they develop their professional identity"[1]. The purpose of this commentary is to discuss the impact of diversity in academic medicine in three parts: (1) professional identity and factors that influence its formation; (2) the effect ofdiversity in performance appraisal and thus institutional capacity; (3) suggest a way forward through faculty development initiatives.

Part I. Professional identity and factors that influence its formation:

What is Professional Identity?Professional identity is a professional's self-concept that is based on attributes, beliefs, values, motives and experiences. It has been described as "the transformative process of identifying and internalizing the ways of being and relating within a professional role"[2] and "identifying one's self as a member of a professional group"[3].Studies ofprofessional identity include those on medical and other health professionals[2,3].Formation of professional identity is influenced by various factors including gender, race, and nationality, as well as socializing influences such as mentors, teachers and co-workers[1-4].

Effect of professional socialization: Vaidyanathan (2015),recently described how the formal goals of professional socialization in medicine can be undermined by the increasing cynicism and the negative effects of health care training and practice [4]. He further arguedthat medical students enter the first year of medical college with the belief of selfless concern for the well-being of others, but they then experience ethical erosion over the course of their training. Some important processes of professional socialization described by Vaidyanathan that

contribute to ethical erosion are the imitation of superiors and habituation by medical students. He explains that webelieve it is important that medical teachers "walk the walk" to ensure that the goals of professional socialization, specifically as they relate to professionalism and ethics, are met within both the explicit and hidden curriculum. For example, students can be taught good communication skills; however, if they then observe theirattending's being rude to patients, they are likely tolearn to be similarly rude. These issues can be addressed through increased diversity of medical students and medical teachers as described below.

Impact of diverse identities: Diversity in medical education addresses the idea that variediden tities provide unique talents, perspectives, and experiences, which enhance the educational experience. This sort ofpositive effect occurs through the process of students gaining respect for and valuing individual students, their unique life experiences, educational backgrounds, and identities such as gender, race, religion, ethnicity and socio economic status[5].The Liaison Committee on Medical Education (LCME) in the United States haspolicies and procedures to achieve appropriate diversity among its students, faculty, staff and other members of the academic community[5]. Several medical schools have intentionally implemented these strategies to increase diversity in academic medicine [6-8]. Achievement of an organizational culture of respectful diversity is expected to contribute to the formation of professional identity with enhanced cultural competency, empathy and respect for other health professions colleagues, and responsiveness to the needs of the community. Diversity in health professions workforce is thus a possible solution to address disparities in health care and contribute to medical school's social accountability[6,7].

Implications of professional identity formation and diversity for India: In India, the reservation system was started post-independence, in keeping with the constitution, to provide equal opportunity to people regarding access to education and employment. The government of India has policies in place to ensure appropriate diversity through reservation of seats for marginalized students and faculty (e.g., from scheduled castes and tribes, women, economically disadvantaged and other underrepresented minorities in the Indian social system) in government owned medical colleges and medical college hospitals. Though the reasons behind such policies are controversial, careful implementation could produce the benefits of diverse identities noted above.

Medicine deals with a society that is diverse; having health care providers and educators that reflect that diversity mayenhance the ability of health care providers to understand how to provide care. Take, forexample, the use of language for effective communication: India has 22 official languages and 1652 mother tongues (dialects). It isimperative that health professionals learn the local language to communicate to provide effective health care. Having students, faculty and staff from different states of India that speakdifferent languages in medical schools, in turn reinforces the importance of learning multiple languages.

Another aspect of professional identity and diversity is doing "impression management" that is respectful of the culture in which one is working.Goffman (1959) describes impression management as the "mobilization of once activity so that it will convey an impression to others which it is in his interests to convey"[9]. As an example, a female doctor /health professional serving in a rural settingin India learns to dress in a manner that is culturally appropriate to be respectful to the local customs. This kind of impression management is important to build the trust between the patient and health care provider. The younger generation in India, comfortable in western attire, must learn the importance of dress code and other ways impression management interacts withtheir professional identity formation. Exposure to diverse backgrounds will help students in this transition. Breaking bad news is another example where Goffman's views can be extrapolated; an individual is "expected to suppress his immediate heartfelt feelings, conveying a view of the situation which he feels the others will be able to find at least temporarily acceptable"[9]. Diversifying medical training communities provides insight about how certain cultures are likely to have different views of which "heartfelt feelings" are or are not "at least temporarily acceptable."

Another interaction of diversity and professional identity formation involves healthcare providers other than medical doctors. Many universities have medical, nursing, physiotherapy, dentistry, Ayurveda and

homeopathy colleges in the same campus or in close vicinity; this provides an opportunity to build the professional identity of students from these professions through inter-professional education. This type of education helps the medical students better understand their and others' role in a health care team, hone their leadership skills by helping other professionals who "look up to" medical doctors, and in turn to build professional identity of the other healthcare providers.

We have summarized above the rationale for and benefits of explicitly embracing diversity in professional identity formation. However, we need to recognize the tension between the discourse on diversity (which emphasizes individuality) and professional role standardization (which emphasizes uniformity)[5]. The role of the medical teacher is to be a facilitator, guiding students to balance the twoin their journey of professional identity formation. Exposure to diverse backgroundsis likely tohelp students and faculty broaden their perspectives on professional identity. This in turn will affect the type of medical students graduating (both clinically competent and responsive to the societal needs) and on the quality of patient care provided by the medical college hospital. Through embracing diversity in professional identity formation, a medical school is likely to gain a reputation for responsive patient care and benefit financially as the reputation attracts more students and patients. Intentionallyincreasing diversity in academic medicine and other health professions, coupled with explicit professional identity formation that embraces diversity,is likely to benefit students, faculty, staff, medical college/hospital and community.

Part II. Effect of diverse identities on performance appraisal:

What is performance appraisal?Having discussed the importance of the inclusion of diverse identities in developing professional identity, the next important piece is its effect on performance appraisal. A robust performance appraisal clarifies expectations and improves the accuracy and objectivity of performance evaluation. However, performance appraisals have been found to be a major source of discrimination in managing diversity and equity in workplaces, especially due to raters' influence on the actual process [10].

Biases related to race and gender: There are many biases and assumptions related to identity groups such as gender, race, and nationality thatneed to be addressed in developing a performance appraisal program thatis fair and equitable. Thus, medical schools/hospitals need to develop policies and proceduresto encourage diversity and equity at workplace.Leading a diverse work force requires that the organization supports women and minorities, thus providing them a favorable environment (organizational capability) to innovate and grow[10].

To develop such organizational capability, we need to be aware of biases related to evaluating diverse identities such as leaders who are women, minorities or from differing nationalities. Knight and colleagues (2003)have described the influence of race and leadership status on performance appraisals; in theirstudy, participants gave negative ratings to black leaders and white subordinates and positive ratings to black subordinates and white leaders. These results affirmed the stereotypical societal positions[11].

There are many similarities between theinfluence of race and leadership on performance appraisal with gender stereotyping on evaluation of women's competence and potential for leadership[12]. For example,women are presumed to be less competent thanmen to hold leadership positions[12]. While much progress has occurred in academic medicine over the past forty years, such that women have often reached equity in entry-level clinical or faculty positions, there is still considerable bias and paucity of women leaders in chair, dean or provost roles. Biases in performance appraisal, as well as in professional identity development, inevitably negatively affect health care for minorities and women[13,14].

Part III. The way forward:

As we have noted, we all have biases irrespective of the race, gender or culture we come from. Some of the biases are so deep rooted that we are not even aware that we have them (unconscious bias)[15,16]. The first step in combating them is to create an awareness of one's own biases and then learn skills to deal with them in a fair and non-judgmental manner. Faculty development programs can address this to some extent. However, the challenge is to move beyond the tried and tested methods of faculty development to strategies that will promote meaningful conversations

and develop a sense of collective responsibility for systemic changes[17].

Faculty development globally: In the United States, many medical schools have faculty development programs to educate the facultycommittees responsible for search, promotion and appraisal on methods to reduce implicit bias and foster equitable review. The Group on Education Affairs (GEA) of the Association of American Medical Colleges (AAMC) has recently published a position paper on racism and bias in health professions education with recommendations on how educators, faculty developers and researchers can make a difference[17]. There are also a few international faculty development programs in health professions education and leadership that explicitly incorporate inclusion, diversity and cultural competency in their curriculum and foster creation of an inclusive community of practice. These include the Institute sponsored bythe Foundation for Advancement of International Medical Education and Research (FAIMER)(www.faimer.org), and the Executive Leadership in Academic Medicine (ELAM) program (http://drexel.edu/medicine/academics/womens-ealth-and-leadership/elam/). However, most faculty development and leadership development programs have yet to embrace diversity, inclusion and cultural competency.

Faculty development in India: In India,existing faculty development programs in health professions education can be expanded to address the issue of diversity and inclusion.The Medical Council of India (MCI), under the leadership of its Academic Cell, has designed and implemented national faculty development through departments of medical education at some medical colleges recognized as regional and nodal centers. This robust system of faculty development programs can be redesigned to include sessions on diversity, inclusion, implicit and explicit biases and cultural competency. India also has four FAIMER Regional Institutes (https://www.faimer.org/education/regional.html) which offer Fellowships in health professions education and leadership to health professions education faculty that can offer these sessions in their programs.

The faculty development programs at the Maharashtra University of Health Sciences, which affiliates over 300 medical, dental, ayurveda, homeopathy, nursing and physiotherapy colleges, are already interprofessional in nature. Faculty who train through these programs appreciate learning about other professions and report a better understanding of how other professions contribute to diagnosis and patient management, including alleviation of distress and suffering. Medical doctors particularly express gaining insights into how the other systems of medicine and the allied health professions work, thereby acknowledging the professional identity of others and developing new respect for them. Most of this content is implicit in the curriculum, and some redesign could explicitly address aspects of diversity, inclusion and cultural competency beyond interprofessional education. This could have tremendous implications for health policy and the new task shifting strategies being adopted to achieve healthcare targets.

A recent medical education initiative through which faculty will be sensitized to gender bias in medical literature as well as professional practice has been introduced as part of faculty development in Maharashtra, India[18]. This is a great opportunity to reflect and recognize the unconscious dimensions of gender bias, and translate them into conscious understanding and behavior/attitudinal change.

At the medical college level, deans could empower departments of medical education to design, implement and evaluate new faculty development programs for faculty and institutional leaders. Research has produced a great number of proven educational interventions. These include: (I) the Implicit Association Test which tests a person's implicit (automatic, unconscious) reactions to cues in order to increase individuals' conscious knowledge of their own biases[19]; (ii) explicit criteria for appraisal committees and performance appraisal programs; (iii) specific support systems for minorities to provide them a favorable work environment; and (iv) specific activities and programs that facilitate development of an organizational culture that respects every individual in the workplace regardless of their gender, race and culture.

Summary: In summary, professional identity formation of a health professional is influenced by various factors including professional socialization and diversity. Diversityin health professions, integrated

with professional identity formation,brings diverse identities, with their unique experiences and competencies which can enhance cultural competency and responsiveness to the needs of the community. Likewise, performance appraisal is influenced by diversity and biases; this has been related to gender, racial, and other inequities in our health professions education and health care systems.Recognition of unconscious biases and development of skills for fair and nonjudgmental actions is essential. This requires changes at national, organizational and individual levels, which can be addressed to some extent through faculty development programs that include explicit curriculum on inclusion and biases. In India, the existing system for national faculty development programs through the MCI recognized medical colleges as Regional and Nodal centers, supported by State Health Science Universitiesand the FAIMER Regional Institutes could be a powerful strategy to address these issues.

Acknowledgement: This paper was first drafted as part of a Leadership and Professional Identity course taught by the second author at the University of Illinois at Chicago in which the first author was enrolled and did part of the work as the course paper.

References:

1. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. Acad Med.2015;90:718-725.
2. Johnson JL, Chauvin S. Professional identity formation in an advanced pharmacy practice experience emphasizing self-authorship. American Journal of Pharmaceutical Education. 2016;80(10)Article 172:1-11.
3. Crossley J, Schmidt PV. The development and evaluation of a professional self identity questionnaire to measure evolving professional self identity in health and social care students. Medical Teacher.2009;31:e603-e607.
4. Vaidyanathan B. Professional socialization in medicine. AMA Journal of Ethics. 2015;17(2):160-166.
5. Frost HD, Regehr G. I am a doctor: negotiating the discourses of standardization and diversity in professional identity construction. Acad Med.2013;88:1570-1577.
6. Price EG, Powe NR, Kern DE, Golden SH, Wand GS, Cooper LA. Improving the diversity climate in academic medicine: faculty perceptions as a catalyst for institutional change. Acad Med.2009;84:95-105.
7. Andriole DA, Jeffe DB, Hageman HL, Ephgrave K, Lypson ML, Mavis B, McDougle L, Roberts NK. Variables associated with full time faculty appointment among contemporary US medical school graduates: Implications for academic medicine work force diversity. Acad Med.2010;85:1250-1257.
8. Establishing a culture of inclusion as a strategy for excellence: a strategic approach, University of Virginal School of Medicine. Accessed on Dec 1st 2017 fromhttps://med.virginia.edu/asp/sample-reading-list/establishing-a-culture-of-inclusion-as-a-strategy-for-excellence/
9. Goffman E. 1959. The presentation of self in everyday life. New York: Double Day, Introduction.
10. Sharma A. Managing diversity and equality in the workplace. Cogent Business and Management.2016;3:1212682. Last accessed on Dec 1st 2017 from: http://www.tandfonline.com/doi/pdf/10.1080/23311975.2016.1212682?needAccess=true
11. Knight JL, Hebl MR, Foster JB, Mannix LM. Out of role? Out of luck? the influence of race and leadership status on performance appraisals. The Journal of Leadership and Organizational Studies.2003;9(3):85-93.
12. Carli LL, Eagly AH. Gender, hierarchy and leadership: an introduction. Journal of Social Issues.2001;57(4):629-636.
13. Carnes M, Morrisey C, Geller SE. Women's health and women's leadership in academic medicine: hitting the same glass ceiling? Journal of Women's Health.2008;17(9):1453-1462.
14. Volden C, Wiseman AE, Wittmer DE. The legislative effectiveness of women in congress. Centre for the study of democratic institutions; research concentration: legislative policies and policymaking.2010:1-47. Last accessed on Dec 4th2017 from https://www.vanderbilt.edu/csdi/research/files/CSDI-WP-04-2010.pdf
15. Glicksman E. Unconscious bias in academic medicine: overcoming the prejudices we don't know we have. Diversity and Inclusion. AAMC news. Last accessed on Dec 13th 2017 from https://news.aamc.org/diversity/article/unconscious-bias/

16. Ross H. Exploring bias in Proven strategies for addressing unconscious bias in the workplace. CDO Insights.2008;2(5):1-20. Last accessed on Dec 4th 2017 from http://www.cookross.com/docs/UnconsciousBias.pdf
17. Karani R, Varpio L, May W, Horsley T, Chenault J, Miller KH, O'Brien B. Commentary: racism and bias in health professions education: how educators, faculty developers, and researchers can make a difference. Acad Med.2017;92:S1-S6.
18. Gender in Medical Education. Last accessed on Dec 19th 2017 from http://gme-cehat.org/Aboutus/Aboutus.aspx
19. Karpinski A, Hilton JL. Attitudes and the implicit association test. Journal of personality and social psychology.2001;81(5)774-788.

Conflict of interest: None
Funding: None
Cite this Article as: Rashmi V, Laura H, Payal B, Page M. Commentary: Professional Identity and Performance Appraisal: Implications for Indian Medical Education. Natl J Integr Res Med 2017; 8(6):106-111