Professional identity formation among non-clinical professionals in the field of continuing medical education

by

Stacy Gail Weiss

B.A., University of South Florida, 2007
M.A., University of South Florida, 2009

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Adult Learning and Leadership
College of Education

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Manhattan, Kansas

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Abstract

This study explored professional identity formation among non-clinical professionals in the field of continuing medical education. Specifically, two research questions examined how these professionals both define and perceive the development of their professional identities. The theoretical framework of professional identity formation was used to examine the data. It provided a lens to explore how personal values, beliefs, and experiences might integrate with the norms, values, and expectations of a professional community. A basic qualitative design was chosen, with semi-structured interviews as the primary data collection method. Interviews with 11 non-clinical professionals in continuing medical education generated thick rich data for analysis. Four main themes emerged: (a) professional disorientation (including fear and isolation), (b) imposter syndrome, (c) resilience (with risk-taking as a sub-theme), and (d) empowerment (with mentorship and community of support as sub-themes). Findings revealed that these non-clinical professionals experience professional disorientation due to a combination of unclear career paths, regulatory pressures, and the absence of formal credentials, among many other issues. Participants found it difficult to articulate their professional identities and reported a sense of fear, isolation, imposter syndrome, and professional vertigo that destabilized their sense of identity. However, resilience, mentorship, and community of support emerged as themes that empowered participants to counter these challenges and embrace their authentic selves. These findings suggest that professionals would benefit from targeted support systems such as structured mentorship programs and solid supportive networks to reduce disorientation and affirm professional identity development in those fields lacking defined career paths. The study expands on existing research and provides new perspectives on professional identity formation in multiple contexts.

Key Words: professional disorientation, professional vertigo, imposter syndrome, resilience, empowerment, continuing medical education.

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Dedication

To be writing this dedication feels surreal. If you are reading this, you might be a doctoral student preparing for your own dissertation journey, a researcher looking for new insights, a non-clinical CME professional who is broadening their perspective, a lifelong learner, my family, my mentors, my friends, someone new, and everyone in between. This is dedicated to you. Wherever you may be on your journey, let your courage, your resilience, your inherent strength and determination be your compass guiding you forward. You have the power to make yourself proud of you! Use your strengths to contribute to humanity positively, to be kind, and to leave behind a powerful legacy. Trust your instincts, be brave, and letter by letter, keep writing, keep reading, keep learning, and keep going.

Chapter 1 - Introduction

Within the healthcare delivery system in the United States, engagement with, and participation in, lifelong learning has become inextricably linked to the practice of medicine (Currey et al., 2015). Many clinical researchers have argued both for and against the utility and importance of lifelong learning, with some signaling to eliminate the undue stress and pressure of mandatory education requirements within the healthcare workforce (Jayas et al., 2023). The critical nature of engaging in continuous learning to improve patient care is more than just a physician's professional responsibility, it is a federal and state mandate (Leach & Fletcher, 2008). The contradictory nature of these arguments can be distressing to the non-clinical workforce who have been tasked with upholding regulatory requirements regarding lifelong learning.

This study explored professional identity formation (PIF) among non-clinical professionals in the field of continuing medical education (CME). According to Janke et al. (2021), the process of PIF is unique and designed to be internal and external as an individual works towards adopting the behaviors, characteristics, and mindset of their profession. Essential to developing a professional identity are the methods used to construct meaning and the sense of professional empowerment that arises from aligning with one's purpose (Beijaard et al., 2004; Brown, 2014; Dadich & Best, 2024; Goldie, 2012; McMains et al., 2023; Wald, 2015). Wald (2015) explained that PIF, in the context of medical education, encompasses not only the convergence of professional development, including "knowledge, skills, values, and behaviors" (p. 702), but also links this integration of professional capabilities with personal identity and inherent core values (Best & Williams, 2019; Dadich & Best, 2024; Sawatsky et al., 2017).

Bechtel and O'Sullivan (2006) explained that in the United States and the United Kingdom, participation in CME is required at both the federal and state levels to maintain clinical licensure. In continuing education in the health professions, challenges are encountered when defining the field of CME comprehensively (Balmer, 2013). Moreover, non-clinical individuals working in continuing education in the health professions frequently hold job titles that lack specificity and are typically referred to as CME professionals or CME providers. The absence of a clear and encompassing job title is indicative of a larger issue; the efforts aimed at enhancing professionalism and rigor within the field going unnoticed (Balmer, 2013). Davis (1998) described how the establishment of "clear accreditation guidelines, articulating policies on ethical delivery of CME, and determining and promoting the competencies of the CME provider" (p. 388) were designed to meet the needs of learners and employers, but frequently overlooked the requirements and concerns of the professionals responsible for upholding and implementing these standards, criteria, and guidelines.

A commitment to lifelong learning and access to the latest clinical information allow clinical care providers and physicians to stay abreast of the rapidly changing landscape of medicine. Non-clinical CME professionals play crucial roles in facilitating the accreditation process, ensuring educational content is valid, ensuring disclosure and mitigation of conflicts of interest, as well as a myriad of other administrative responsibilities that enable physicians to engage in continuous opportunities for learning beyond their initial licensure (Ahmed et al., 2013; Bower et al., 2008; Cantillon & Jones, 1999; Cervantes, 2009; Clandinin et al., 2017). Within the healthcare environment, traditional career advancement pathways are available for the clinical workforce in ways that they are not available for their non-clinical counterparts.

Non-clinical CME professionals are not required to have any clinical training, nor is it a prerequisite for employment. Rather, they need traditional credentials typically obtained through conventional higher education. The absence of formal credentials and a prescriptive career path have amplified the lack of defined entry points into the profession (Cantillon & Jones, 1999). The confusion surrounding job roles and responsibilities has underscored the limited pathways for career progression. Consequently, as non-clinical CME professionals gain awareness of these challenges, their beliefs guiding PIF and the ways they derive meaning from their work are challenged (Sandars & Jackson, 2015).

Significance of the Study

This research holds significant value for the community of CME professionals and to the broader fields of medicine, continuing professional development, and adult education. Exploring PIF among non-clinical professionals in the field of CME contributes to a body of knowledge that lacks representation from this group of professionals. Regarding PIF, McMahon (2016) stated, “The point at which a clinician takes ownership of his or her own learning agenda is a pivotal moment in professional growth” (p. 1403). In contrast, non-clinical CME professionals lack structured pathways and struggle with available access to pivotal moments that promote career advancement and PIF. As a result, non-clinical CME professionals may find themselves putting in extra time and effort to develop their professional identities; something their medically trained colleagues typically experience as part of their formal training.

Non-clinical CME professionals often feel vulnerable and out of place among clinically trained colleagues in the same field due to the lack of formal professional pathways (Best & Williams, 2019; Dadich & Best, 2024; Sawatsky et al., 2017). My hope is that this study offers valuable insights to professionals who find themselves struggling with feelings of uncertainty,

confusion, and frustration as they attempt to articulate their professional identities, responsibilities, and contributions to the field. Formal professional pathways are only one part of the equation and establishing a universally accepted professional identity is the other. Unless meaningful professional growth opportunities become available for non-clinical CME professionals, the profession will continue to face distinct challenges related to PIF (Best & Williams, 2019; Dadich & Best, 2024; Sawatsky et al., 2017).The existing body of literature on PIF among non-clinical CME professionals is notably limited. Exploring PIF among non-clinical professionals in the field of CME contributes to a more comprehensive understanding of the unique challenges and opportunities faced by this group of professionals.

Statement of the Problem

Non-clinical professionals in the field of CME play a vital role in supporting lifelong learning for clinically licensed providers of healthcare. The utility of their role is clear, yet non-clinical CME professionals find themselves at a crossroads. Unlike typical healthcare jobs, the job description for a non-clinical CME professional lacks clarity which can lead to misrepresentation and an undefined path for career advancement. Becoming a non-clinical CME professional does not require specific prior experience, recognized credentials, nor traditional or formal training in advance of hiring. The lack of a universal and classifiable non-clinical CME professional identity challenges the practice scope and presents difficulty when explaining the depth and breadth of the work (Janke et al., 2021).

Uncertainty about professional identity suggests that non-clinical CME professionals may be confused regarding their roles and responsibilities. A comprehensive exploration was crucial to uncover how these non-clinical CME professionals navigate these challenges and develop their professional identities. To enrich their professional standing and highlight their

effectiveness in the field, this gap was addressed, thereby enhancing valuable knowledge in the broader field of medical education.

Purpose of the Study

The purpose of this study was to explore professional identity formation (PIF) among non-clinical professionals in the field of continuing medical education (CME). Central to this study was the concept of professional identity. In this study, Cruess et al.'s (2014) construct of PIF served as critical lenses through which the data was examined. The process of PIF provided structure for interpreting the lived experiences of non-clinical professionals in the field of CME. This framework facilitated a comprehensive analysis that led to a deeper understanding of the PIF processes among non-clinical professionals in the field of CME.

Research Questions

To accomplish the research purpose, the following research questions were addressed:

(1) How do non-clinical CME professionals define professional identity?

(2) How do non-clinical CME professionals perceive they develop their professional identities?

These questions guided the research enabling a detailed exploration of PIF among non-clinical professionals in the field of CME.

Theoretical Framework

To achieve the research goals, this study integrated the theoretical framework of professional identity formation (PIF) to explore professional identity among non-clinical professionals in the field of CME.

Professional Identity Formation

Professional identity formation focuses on the process through which individuals in a specific field develop and internalize the norms, values, beliefs, behaviors, and ethical standards of their profession (Best & Williams, 2019; Dadich & Best, 2024; Halverson et al., 2022; Hotho, 2008; Iserson, 2019; Janke et al., 2021; Sawatsky et al., 2017). According to Janke et al. (2021), "Professional identity influences how a professional perceives, explains, presents and conducts themselves" (p. 1128). For the non-clinical CME professional, forming a professional identity related to an undefined profession is a unique and multifaceted experience, particularly given the lack of a formalized educational pathway into the career (Beddoe, 2013). Beddoe (2013) further posited that defining a profession and further establishing a professional identity could be a "complex struggle to define itself within the context of a health system with many other powerful players" (p. 25). As a result, professional identity is formed through non-traditional routes, such as on-the-job experiences, mentorships, and sometimes trial and error professions (Best & Williams, 2019; Dadich & Best, 2024; Halverson et al., 2022; Hotho, 2008; Iserson, 2019; Janke et al., 2021; Sawatsky et al., 2017). These aspects of formation can make the development of a solid professional identity more challenging. For the non-clinical CME professional, developing a professional identity and articulating their profession may be challenging given the lack of a formalized educational pathway into the role (Eason et al., 2018).

Methodological Framework

This study adopted a basic qualitative design to explore professional identity formation (PIF) among non-clinical professionals in the field of continuing medical education (CME). The research questions explored how professional identity was defined among non-clinical CME professionals and how these professionals perceived they develop their professional identity.

Qualitative inquiry was pivotal in understanding the unique experiences of these professionals. The study was guided by two research questions:

(1) How do non-clinical CME professionals define professional identity?

(2) How do non-clinical CME professionals perceive they develop their professional identities?

These research questions explored the broad definition of what it means to be a professional and explored how non-clinical CME professionals perceive the process of constructing their professional identities. This developmental process shapes how they view themselves as professionals and can serve to inform future practice. This research was able to contribute to a gap in the existing research related to PIF of non-clinical CME professionals (Best & Williams, 2019; Dadich & Best, 2024; Halverson et al., 2022; Hotho, 2008; Iserson, 2019; Janke et al., 2021; Merriam & Grenier, 2019; Merriam & Tisdell, 2016).

The research design was chosen to align with the study's research questions (Merriam & Grenier, 2019). The focus on qualitative methodology provided this study tools to conduct an in-depth inquiry into individual experiences of non-clinical CME professionals (Crotty, 1998; Maxwell, 2005; Merriam & Grenier, 2019; Merriam & Tisdell, 2016). Merriam (2009) explained that basic qualitative inquiry is appropriate for researchers who are interested in interpreting experience, constructing worlds, and analyzing the meaning-making attributed to those experiences. For this study, I chose a basic qualitative design for its ability to uncover and understand the construct of PIF (Crotty, 1998; Halverson et al., 2022); specifically, how non-clinical CME professionals define their professional identity and how they perceive they develop their professional identity.

According to Merriam and Grenier (2019), qualitative research is "a powerful tool for learning more about our lives and the sociohistorical context in which we live" (p. ix). Similarly, Creswell and Creswell (2018) posited that a qualitative approach is appropriate when existing research is limited or when both the context and experience of the population being studied need to be closely examined. Qualitative research aims to explore meanings, experiences, or perspectives of individuals or groups within a natural setting and primarily yields informative outcomes; therefore, the analysis was inductive, working to identify recurring patterns or themes within the data (Creswell, 2013; Merriam & Grenier, 2019).

Professional identity formation served as the theoretical lens for the study and guided the inductive data analysis (Merriam & Tisdell, 2016). The study utilized purposive and snowball sampling techniques to recruit non-clinical CME professionals who met specific study eligibility criteria. I leveraged my professional network to recruit participants and invited interested individuals to participate in the study and share their experiences. Data collection was conducted primarily through responses to interview questions aligned with the research questions. Merriam and Grenier (2019) explained, "All qualitative research is interested in how meaning is constructed, how people make sense of their lives and their world. The primary goal of a basic qualitative study is to uncover and interpret these meanings" (p. 35), and this study shared the same goals.

Limitations and Delimitations

In qualitative inquiry, research limitations describe factors that could impact the trustworthiness of this study. Limitations may emerge from multiple aspects, including the design, data collection, analysis, or interpretation of the research (Crotty, 1998). This section acknowledges the limitations resulting from the constraints and choices that shaped the scope

and direction of the study. Understanding the limitations and delimitations is crucial for interpreting the research findings within their appropriate context (Meriam & Grenier, 2019).

Limitations

In qualitative research, examining and analyzing lived experiences grants the researcher insights into specific participant populations (Crotty, 1998). This study's qualitative nature introduced inherent limitations, elements in the research design largely beyond the researcher's control (Crotty, 1998). Ensuring the comfort, safety, and support of participants while sharing personal details is crucial in qualitative inquiry. These limitations outlined the assumptions I made and were pertinent only to the sample population of non-clinical CME professionals and not applicable to the broader non-clinical continuing education workforce. Qualitative inquiry assumes the truthfulness and relevance of participant statements (Merriam & Tisdell, 2015). This assumption highlights the significance of the data collected and the potential of the study's outcomes to provide insights that could support, refine, or revise best practices in the field (Creswell, 2013).

Delimitations

Theofanidis and Fountouki (2019) explained, "Delimitations are in essence the limitations consciously set by the authors themselves" (p. 157) and are important as they inform what the study did and did not cover. This qualitative study was deliberately delimited in several aspects to focus its scope and objectives. First, the selection of participants was confined to non-clinical CME professionals. This limited the breadth of perspectives but allowed for in-depth exploration within this small group. The study focused on individuals with particular jobs and experiences within the non-clinical CME field which omits insights from those in different positions. The theoretical framework was selectively centered on PIF, so other potentially

relevant theories were not explored. Data were collected primarily from responses to semi-structured interviews, excluding other methods such as focus groups or observational studies (Merriam & Tisdell, 2015). Additionally, as I am an active member of the non-clinical CME community, this insider perspective shaped both the approach and the interpretation of the study, which added a unique but subjective dimension to the research. These delimitations, while narrowing the research focus, were essential in defining the study's parameters and keeping it targeted and manageable (Theofanidis & Fountouki, 2019).

Subjectivity Statement

Peshkin (1988) asserted that merely recognizing subjectivity in research is as unhelpful as striving for complete objectivity. In this study, my unique position as both an observer and a participant within the non-clinical CME community enriched the research perspective. As an experienced non-clinical CME professional who has held positions in various health systems and academic institutions focused on the advancement of lifelong learning for clinical providers, I brought a depth of insider knowledge to the study. Initially, the research goal was to investigate how physicians make meaning from what they learn and how they integrate meaning into their work. However, my growing awareness of the absence of existing research on non-clinical CME professionals prompted a shift in focus. The lack of information regarding PIF in this population was particularly intriguing. Reviewing the literature clarified that appropriately cultivating a professional identity would require an intervention that would allow the non-clinical CME professional to articulate the meaning behind their work. This realization steered the research towards an in-depth exploration of PIF among these CME professionals.

Operational Definition of Terms

The following list of terms provide context and clarity over terminology in this research.

Continuing medical education (CME). This refers to educational activities aimed at sustaining, enhancing, or expanding the knowledge, skills, professional practices, and interpersonal interactions that physicians employ in patient care, public service, or within their profession (Bennett et al., 2000).

Empowerment. In the context of empowerment theory, empowerment is the process through which individuals gain the ability, authority, and agency to make decisions and author change in their own lives and communities. This involves acquiring the necessary skills, knowledge, and self-confidence to influence personal and social environments. According to Zimmerman (2000), empowerment encompasses both personal empowerment (an individual's growth and self-efficacy) as well as social empowerment (collective action and social change).

Meaning-making. Robert Kegan (1982, 1994) described meaning-making as the way individuals interpret experiences based on their cognitive development. Kegan (1994) posited that meaning-making is integral to personal growth and evolves as people progress through developmental stages. Each stage brings more complex self-understanding and represents a lifelong path of psychological growth (Kegan, 1982, 1994).

Non-clinical CME professional. This role is an administrative support staff with no clinical degree who is tasked with oversight of the development, planning, accreditation, review, of activities designed for the continuing education for the healthcare practitioner.

Professional. In the context of professional identity formation, professionals possess attributes that are trusted by users and contribute to social well-being (Beddoe, 2013).

Professional identity. Professional identity encompass the attitudes, values, knowledge, beliefs, and skills shared with others within a professional group (Kim et al., 2021; Matthews et al., 2019).

Professional identity formation. This framework represents the process through which individuals develop a sense of self in relation to their professional role. It involves the integration of personal values, beliefs, and experiences with the norms, values, and expectations of a professional community. This process is dynamic and continuous, often evolving as individuals gain experience and encounter different professional situations (Kim et. al., 2021).

Organization of the Study

Chapter 1 begins this dissertation with an introduction that describes the background context, statement of the problem, purpose of the research, the research questions, an overview of the theoretical framework used in the data analysis process, an overview of the study's limitations and delimitations, a subjectivity statement, and a list of key operational definitions. Chapter 2 contains the supporting literature reviewed for this study. Chapter 3 details and provides rationale for the research methods used for this study. Chapter 4 discusses the findings from the analysis of the data. Chapter 5 includes a summary, a discussion of the findings, implications for the field, and recommendations for further research.

Chapter 2 - Literature Review

The purpose of this study was to explore professional identity formation (PIF) among non-clinical professionals in the field of continuing medical education (CME). This literature review provides a comprehensive examination of the body of work germane to this study. This literature review revealed gaps in the literature and how this study was able to contribute to the body of knowledge on professional identity formation of non-clinical CME professionals. This chapter reviews the literature on (a) CME, (b) PIF, and (c) empowerment theory.

Continuing Medical Education

Innovation in healthcare research, science, and technology occurs daily in the field of medicine (Natterson-Horowitz et al., 2023). With every new scientific innovation or medical discovery, continuous learning has become paramount for physicians to provide competent clinical care (McMahon & Skochelak, 2018). Tasked with multifaceted responsibilities, non-clinical CME professionals play an essential role in developing, managing, and accrediting educational programming (Bower et al., 2008). These accredited educational offerings are designed to provide evidence-based, comprehensive, and relevant lifelong learning opportunities for physicians across all medical specialties. Each educational program provides opportunities for physicians to achieve and maintain clinical licensure and board certification (Ahmed et al., 2013; Bower et al., 2008; Cantillon & Jones, 1999; Cervantes, 2009; Clandinin et al., 2017). With CME established as a critical element of medical practice, examining the role and responsibilities of the CME professional served to solidify the profession within the domains of healthcare.

Responsibilities of the Non-Clinical CME Professional

The literature highlights the importance of CME and lifelong learning for physicians; however, it does not identify the responsibilities of CME professionals related to these educational initiatives. A search for "CME professional" returned thousands of results that (a) defined CME, (b) provided CME opportunities, (c) explained ways to become an accredited CME provider, or (d) argued for the general usefulness or utility of CME. With a lack of a definition for a CME professional represented in the literature, this study contributes to defining the profession and serves to characterize a CME professional as a leader and partner working on the strategy, design, development, implementation, and evaluation of continuing medical education programming.

Continuing medical education, both as a professional field and as an educational practice, is set in a highly standardized and regulated continuum that marries adult learning theory with the primary tenants of clinical practice (Cervantes, 2009). Watts (1981) explained, "Continuing education in health sciences finds itself at an interface, with its roots in the ivory towers of academe and its activities in the very competitive environment of the real world of health professional practice" (p. 5). This competition extends into the longest segment of a physician's lifelong educational undertaking, which underscores the importance of staying ahead of the curve and clinical competence. The pursuit of continuing medical education is a topic of interest to many physician learners, as CME is also incorporated into the legislature as a requirement for a medical license, credentialing, hospital privileges, and maintenance of certification (Watts, 1981).

Medical education in the United States today is strikingly standardized and demanding. It was not always so. Prior to the widespread implementation of educational reforms, medical

training was highly variable and frequently inadequate (Cruess et al., 2014). Only in the early decades of the 20th century was a structured and expensive system of medical education instituted nationally (Felch, 1987). While these roots of standardization and regulatory requirements inform the rigorous nature of CME, the literature failed to include how CME professionals can strategically influence healthcare, permeate compliance, create regulatory standards, and implement processes to ensure criteria adherence. Additionally, outside of Flexner (1910), a non-clinical, educational theorist, credited with standardizing medical education, the literature did not include CME professionals within the history of the profession. The literature did not represent the richness of the profession, nor the expertise required to perform the job at the highest levels (Best & Williams, 2019; Dadich & Best, 2024; Bower et al., 2008; Creus et al., 2014; Halverson et al., 2022; Hotho, 2008; Iserson, 2019; Janke et al., 2021; Sawatsky et al., 2017).

Adult Learning in Continuing Medical Education

The history of CME is a valuable foundational component to explain how the practice of engaging in lifelong learning for physicians evolved and how it turned into what it is today. According to Filipe et al. (2018), physicians are stewards of a self-directed approach to lifelong learning. Physicians have the ability to choose when they learn, where they learn, how they learn, and from whom they learn. To stabilize the ambiguity surrounding much of the lifelong learning efforts physicians experience, continuing medical education was developed to support this effort. The CME professional provides guidance, regulations, context, and structure to enhance the understanding of adult learning in medicine and patient care (Fox & Bennett, 1998).

The administrative functions of the CME ecosystem include a diverse group of professionals who onboard into this role with a limited understanding of the field of medicine

and limited knowledge of adult learning theory (Cervero, 2009). Without representation in the literature, the field has gone largely undefined with the role perpetually adapting to serve the needs of the learner, rather than to enhance the growth and development of the professional (Filipe et al., 2018; Fox & Bennett, 1998; Guenova et al., 2019). CME is recognized as a tool, a resource, and a mandate, yet no literature clarifies the profession (Fox & Bennett, 1998; Harden, 2005). All CME professionals contribute to the field of medicine by ensuring clinical providers have access to state-of-the-art accredited educational programming that directly influences knowledge, competence, and professional practice (Price et al., 2021). The current body of literature should better represent CME professionals not only as agents for change but as professionals on a path of professional identity formation (Larkin et al, 2008).

Professional Identity Formation

According to Kim et. al (2020), "Professional identity centrally includes the attitudes, values, knowledge, beliefs, and skills that are shared with others within that profession" (p. 161). Professional identity formation involves the integration of personal values, beliefs, and experiences with the norms, values, and expectations of a professional community. This process is dynamic and continuous, often evolving as individuals gain experience and encounter different professional situations (Kim et. al., 2020). According to Bleakley et al. (2011), "Identities are closely linked to professional roles, which are usually clearly defined, socially engineered, and legitimated" (p. 63). The researchers added, "Identities are names we give to different ways we are positioned by and position ourselves within the narratives of the past" (p. 63). In fields with clear educational and training pathways, such as firefighting, education, law, business, and medicine, students gradually come into a sense of belonging during their educational path — where a shift from learning to practice takes place. Halverson et al. (2020) described the

transition from a student to professional as one marked by well-defined stages and experiences; and, ultimately, where the student begins to think, feel, and act in alignment with their chosen profession (Cruess et al., 2014). Aspiring firefighters, for example, undergo extensive training at a fire academy where a rigorous and clearly laid out pathway awaits, including academic and extensive practical training. Similarly, the other fields mentioned can all identify a pivotal transition that occurs from a time of learning to one of becoming a professional. In these contexts, professional identity formation is facilitated by the structure and the clear progression from learning to practicing (Bleakley et al., 2011).

This transition from learning to practice is particularly notable in fields with clearly defined educational paths that result in a defined career after graduating from a prescriptive educational program. Halverson et al. (2015) noted that PIF emerged when nursing students continuously aligned expectations with experiences, where the identity as a nurse is consistently "constructed and deconstructed" (p. 11). Likewise, the researchers described PIF's transformation of medical students into professionals who gradually come to identify themselves with the humanistic qualities associated with the role of physician. The new professional then advances deeper into their field, fostered by "personal and professional growth through mentorship, self-reflection, and experiences that affirm the best practices, traditions, and ethics of the medical profession" (Holden et al., 2015, p. 762).

Professional Identity Challenges and Growth

While this structured approach to PIF is evident in many fields, it presents unique challenges in professions with less defined educational pathways. There is no well-trodden path to follow in this case, and that sense of belonging is much more difficult to achieve. Non-clinical CME professionals lack such a traditional educational path; hence, the path to forming a

professional identity is not as straightforward. Many CME professionals find themselves in a career different from that for which they were trained. This divergence results in a working environment where any chance for developing a professional identity would require an independent mindset and a creative approach to the problem. The distinction between professional identity and professionalism becomes particularly salient in the context of non-clinical CME professionals. According to Bleakley et al. (2011), "Identities are closely linked to professional roles, which are usually clearly defined, socially engineered, and legitimated" (p. 63). They also explained that identities are the names we give ourselves based on the ways we are positioned by others and ourselves from our past events.

Kim et al. (2021) reported, "Professional identity is emergent and involves ongoing self-interpretation" (p. 2). To develop a professional identity, understanding ways to "self-reflect and construct a consistent narrative and understanding of feelings and positions" (Kim et al., 2021, p. 2) relative to a profession is critical to the process of developing a professional identity. In healthcare, professional identity is closely connected to the transition clinical students make to practice. Halverson et al. (2022) reported that the "professional identity pathway is constructed and deconstructed by alignment of, or dissonance between, expectations and experiences of entering into the field of nursing" (p. 2).

The relevance of Rene Descartes' famous dictum, "cogito, ergo sum," (I think, therefore I am) is particularly meaningful when understood in the context of PIF. This statement lays the groundwork for understanding the connection between both the concept of self and the development of self-awareness as the core components of individual identity. Likewise, Marshall (2001) highlighted the lasting impact of Descartes' proclamation on current interpretations of identity and its foundational role in concepts central to professional identity formation.

Furthermore, Holden et al. (2012) described PIF as an integral part of the broader identity formation process. Holden's team defined PIF as "the integrative developmental process that involves the establishment of core values, moral principles, and self-awareness" (p. 246). The researchers emphasized the important interplay between self-perception and the perceptions of others in the workplace. The ways in which a professional is perceived in the workplace can have a direct impact on professional satisfaction and growth in a particular role.

According to Holden et al. (2012), PIF is approached through various paradigms such as professionalism, psychological ego development, social interactions, and learning theories. Moreover, it manifests in unique ways across different professions (Best & Williams, 2019; Dadich & Best, 2024; Sawatsky et al., 2017). In medical education, for instance, PIF represents the transformative experiences that medical students undergo as they develop "from layperson to physician" (Holden et al., 2012, p. 246). In contrast, the fields of counseling and nursing view it as more of an assimilation into a community of professionals who have shared attributes and a similar training path delineated by a stringent curriculum. This aligns with the central theme of PIF where understanding one's perception in the workplace is crucial for shaping professional identity and career ambitions.

In their 2014 study, Cruess et al. (2014) shed light on the complex relationship between professional identity and professionalism. They explain that these two concepts, while interrelated, are distinct. Professional identity is about the internal process of defining who one is in a professional context, whereas professionalism is more about the external expression of professional values and behaviors. The problem facing CME professionals in light of these constructs is understanding and defining one's professional identity in a field where the standard

pathway facilitating PIF exists only for their colleagues, effectively excluding them from the opportunity to experience this important process.

Cruess et al. (2014) describe how the evolving understanding of PIF in medical education can offer insights that can be applied to the challenges faced by non-clinical CME professionals. They argue that the current emphasis in medical education on identity formation marks an evolution in understanding and teaching professionalism. This focus explores the transformation of individuals into skilled physicians, though professional identity develops alongside an individual's broader lifelong identity formation. The researchers insist this process is influenced by factors such as gender, nationality, race, and class, and begins at birth; all contributing to a complex personal identity.

Frameworks of Identity Development

Developmental psychology pioneers, including Piaget (1969), Inhelder (1969), Kohlberg (1984), Erikson (1950, 1968), and Kegan (1982, 1984) have significantly influenced our understanding of identity formation (Cruess et al., 2014). Their research suggests that cognitive and moral development, as well as identity formation, follow distinct stages throughout life. Kegan's (1982) work particularly emphasized how individuals' worldviews evolve through increasingly complex stages.

Cruess et al. (2014) argued that understanding professional identity formation in medicine does not require detailed knowledge of these developmental stages. However, the researchers highlighted three key aspects. First, physicians-in-training bring their pre-existing personal identities to each life transition, like starting medical school or practice. These identities provide a foundation for their professional identity. Second, despite the isolation of medical training, external influences such as family and culture significantly shape personal and

professional identities. Lastly, developmental theory suggests that most medical students and residents are still forming their identities, making them more susceptible to their learning environment's influences. According to Cruess et al. (2014), this stage continues until a fully integrated moral self is developed in the early to mid-30s, as proposed by Kegan's (1982) theory.

Professionalism

Professionalism has been extensively researched in sociology and organizational psychology from two primary angles and the interaction between them: (a) the identity of a profession and (b) the individual's professional identity (Hotho, 2008). Researchers have underscored the importance of well-defined paths to professionalism, especially in fields like medicine, law, and public service (Farrell & Morris, 2005; Ferlie, et al., 2003). McMains (2023) noted that when professional titles of professions are used to describe individuals, the identities of both person and profession can become intertwined.

However, in professions with undefined paths, professionals often lack clear models of professionalism (Iverson, 2019; Matsuyama et al., 2021). Iverson (2019) emphasized the importance of self-reflection in these contexts, saying, "Self-reflection on professional identity is a way to introduce ideal professional norms and align them with personal attitudes, values, and goals" (p. 105). In the field of nursing, Fetzer (2003) further found that factors like "self-actualization and work experience were investigated as possible antecedents to the development of professional attitudes, values, and behaviors of associate degree nurses" (p. 139) and that "self-actualization was positively and significantly related to the degree of professionalism" (p. 139). Meaning-making is thus integral to shaping personal attitudes, values, and goals, serving as a pathway to cultivate professionalism aligned with one's profession.

The literature review on professionalism provided a broad range of research that was specific to identifying pivotal moments in training that allowed a professional to develop from a lay person into an expert. Focusing specifically on professions across the domains of healthcare, the literature featured personal attributes that were central and prominent to connecting ethics, humanism, and personal values to the construct of what it means to be a specific type of healthcare professional (Veloski et al., 2005). It is harder to define professionalism in career fields that are not structured and tend to be vital but vague. Thus, the research focused more on what it means to be an employee at a particular organization, rather than what it means to be a professional working in the field.

Flexner (1910) introduced the concept of professionalism in medical education during his pioneering work on legitimizing and standardizing medical schools and medical school curriculum throughout the United States. Flexner explored the markers for defining a profession, claiming they are situated between intellectual operations and individual responsibility and that the hallmark for a profession is not solely academic and theoretical, but includes a more practical approach (Halverson et al., 2022). Leo and Eagen (2008) argued, however, that professionalism in medicine has a long and storied history superseding the prominent work of Flexner.

Identity Development and Formation

The literature review on the term identity provided an exhaustive list with several meanings and iterations of the term, with text and articles dating back to Greek and early Roman literature, revealing early findings from both Descartes and Goethe. The unique and distinctive approaches that Descartes and Goethe had regarding the concept of identity revealed that their work did not influence one another, but rather created a contrast between their distinctive approaches to the construct of identity, with Descartes taking on a more scientific approach to

Goethe's more humanistic approach. This historical perspective is important to the body of work on identity, as it clarifies both the scientific framework and human development approaches to the concept. According to Bleakely et al. (2011), education in the "professions and apprenticeships is fundamentally a process of identity construction and reconstruction" (p. 63). The topic of identity has been discussed, defined, analyzed, argued, synthesized, and described with a consensus appearing sporadically and with broad generalizations appearing depending on who was defining the term and in which theoretical context they were approaching the concept.

Erikson (1950, 1968) and his empirical research on identity has provided the foundation and the springboard for research on identity and led to the development of the identity status model which was created and operationalized by Marcia (1966). Subsequent research on the identity status model was critical of the concept. However, Marcia's (1966) paradigm identified two key processes fundamental to identity formation: (a) exploration alternatives and (b) commitment choices. The mutuality phase of identity development incorporates autonomy and a form of interdependence, "transcending the individuals engaged . . . allowing the individual to be clear in their thoughts and actions, acting with intention and at the same time recognizing the impact of our actions on others" (Baxter Magolda, 2001, p.19). The existing research on identity development focuses on several factors, including gender, race, social status and the concept of self (Holden et al, 2012; Holden et al., 2015; Hotho, 2008). The lack of research surrounding non-clinical CME professionals leaves space to investigate if there is further analysis to connect the way in which a female or male non-clinical CME professional craft and create their identities based on the additional identities currently held. Baxter Magolda (2001) explained that further investigation of female identity development yielded a pattern focused on, "communion, the ability to connect with others, and to function in a collaborative way" (p. 19).

The description of the word communion in this context refers to being a part of something greater than yourself. As the non-clinical CME professional participates in the larger organism, the characteristics of communion are predicated on "connection to and fusion with others to achieve acceptance" (Baxter Magolda, 2001, p. 20). The idea of communion connects back to Kegan (1994) and his work on meaning making being a bifurcated experience that incorporates autonomy and connection. Baxter Magolda (2001) explained, "Autonomy constitutes the structural element of one's meaning making, whereas separation or connection, constitutes the stylistic element of preference on has about meaning making (p. 20). As one seeks the balance between autonomy and community, opportunities to create meaning emerge.

The contradictory nature of autonomy and community suggests a connection to cognitive dissonance, which is "when individuals hold two or more cognitions that are contradictory, they will feel an unpleasant state—dissonance—until they are able to resolve this state by altering their cognition" (Hinojosa et al., 2017, p. 171). Hernandez et al. (2013) speculated that in an effort "to reduce cognitive dissonance about one's beliefs or behavior, individuals may compare their behavior to personal and/or normative standards" (p. 1082). This comparison can be predicated on implicit bias highlights the dissonance between beliefs and behavior.

Empowerment Theory

Empowerment theory encompasses numerous dimensions and has been discussed extensively in the fields of education, organizational theory, management, and psychology (Dowling, et al., 2011). Joseph (2020) defined empowerment as the "interpersonal process of providing the resources, tools, and environment to develop, build, and increase the ability and effectiveness of others to set and reach goals for individual and social ends" (p. 142). Joseph

(2000) is positing that individuals can develop an empowerment process that is linked to growth and development, both personally, and professionally.

Empowerment theory is a multidimensional concept linked closely to pragmatism, and this literature review revealed no specific link to the field of continuing medical education. However, empowerment theory has been identified and found in the literature in relation to the fields of nursing, education, human resources development, social work, and developmental psychology (Dewi et al., 2023; DiNapoli et al., 2015; Dowling et al., 2011; Hawks, 1991; Rodwell, 1996). Thus, empowerment theory is defined based on the parameters of the profession in which it is being discussed. For example, DiNapoli et al. (2015) described empowerment theory in nursing as the "ability to get things done in an organization" (p. 303), whereas Hawks (1991) described empowerment theory as "the interpersonal process of providing the resources, tools, and environment to develop, build, and increase the ability and effectiveness of others to set and reach goals for individual and social ends" (p. 609). Defining empowerment as an action means to identify one person who empowers, and another who by association becomes empowered (DiNapoli et al., 2015; Dowling et. al., 2011; Hawks, 1991; Rodwell, 1996).

The literature supports that the concept of empowerment has been utilized across many professions and is represented in this literature review as a theory, a process, and a practice (DiNapoli et al., 2014). Dowling et al. (2011) posited that the origin of the concept of empowerment varies depending on the profession in which it is being utilized. Some researchers believe that the term gained popularity during the 1970s and could be closely connected to early works on the topic of power from Paulo Freire (1970). Freire's work revealed that to feel empowered, one first has to cultivate an inherent power that comes from within. To Freire

(1970), power cannot be provided by external sources, it has to be grown from the inherent belief that human beings have the right to feel power on their own terms.

Empowerment Theory and its Relevance to CME

Empowerment arises from the proactive behaviors of individuals who have aligned their innate strengths and competencies with their natural support systems. Perkins and Zimmerman (1995) explained that empowerment theory connects individual well-being to a broader social and political context, stating that empowerment "connects mental health to mutual help and the struggle to create a responsive community" (p. 569). Crawford Shearer (2009) explained empowerment is a dynamic process that "emphasizes facilitating one's awareness of the ability to participate knowingly in their own decisions and conversations where decisions are being made" (p. 1). The literature provided several inferences to empowerment across the vast domains of healthcare where decisions are being made quickly and confidently.

Inherent in empowerment theory is the concept that self-agency is a principal tenet of what it means to be alive. When one is in control of one's surroundings, environment, and life, a sense of accomplishment in choices made emerges along with a sense of power in the decision-making process. Empowerment theory emerged in the field of education through the seminal works of Paulo Freire (1970). Freire (1970) examined empowerment through the lens of the oppressed and took the approach that empowerment is not something that is given, it is developed through identifying that innate to all humans is the ability to become powerful on their own accord. According to Valoura (2011), Freire's logic to describe and explain the concept of empowerment was unique stating that for him, "the empowered person, group or institution are the ones who perform, on their own, the changes and actions that cause them to grow and become stronger. The power is not given to them but instead comes from them." (p. 142).

Empowerment then becomes a byproduct of connecting an individual's strengths and competencies to natural helping systems through a series of proactive behavior patterns. Perkins and Zimmerman (1995) further explained that empowerment theory highlights the connection between "individual well-being with the larger social and political environment. Theoretically, the construct connects mental health to mutual help and the struggle to create a responsive community" (p. 569). According to Joseph & Macgowan (2019), "Theories are excellent ways of helping make sense of elements of the world and that of human experience" (p. 269). Viewing the research through the lens of empowerment theory provided an opportunity to make sense of the lived experiences of the CME professionals. As research on continuing medical education continues to develop, it was critical for the researcher to understand how power can be birthed in work environments that support and enable employees to exercise personal agency as they work to form their professional identity.

Joseph and Macgowan (2019) noted the significance of theories in making sense of the world and human experiences. With limited research on CME professional identity formation and CME professional development, it was challenging to find research from the perspective of empowerment theory that would enable the researchers to make sense of the lived experiences of CME professionals more effectively. Research specifically on this topic would support a better understanding of their individual paths but also serve as discovery related to these experiences, how meaning is made from them, and how they are integrated into larger social and community structures.

The Intersection of Empowerment, Meaning-Making, and Professional Identity

Kegan (1980) explained, "Our meanings are not so much something we have [rather] they are something we are" (p. 374). Thus, the present study goes beyond asking non-clinical

CME professionals how they make meaning, but rather examines their meaning making process in relation to their workplace identity and contribution to the field of health and science. Assessing the value and contribution of their intrinsic work values is as important as the meaning behind their intrinsic motivations. Meaning making is a foundational pillar of the present study as the non-clinical CME professionals expand their understanding of their professional identity.

How adults cultivate meaning and how that meaning influences their professional experience is central to this study's research questions. The principal tenets of meaning making can be found in Kegan's (1983) influential work on human development. Kegan's (1983) model of development examined the evolutionary process humans endure as they seek, "temporary solutions to the lifelong tension between the yearnings for inclusion and distinctness" (p. 107). The desire for inclusion brought forth the researcher's current questions and was amplified in their current work environment where there is not a specific space dedicated for them to occupy professionally.

It is challenging to compare the meaning making opportunities that exist for physicians with the meaning making opportunities available for the non-clinical CME professional. Zepke and Leach (2002) explored contextualized meaning making and the three unique features that allow for an extension of limits levied on opportunities to make meaning. These three features include (a) the relationship between learners, (b) the view of the learner as a teacher, and (c) the critical reflection of the learning experience after the fact. The first feature, the relationship between learners, is where, "experiences are shared, analyzed, and questioned. Meaning is made of this shared discussion" (p. 210). The second feature, the view of the learner as a teacher, is explored and "concerns the underpinning beliefs, values, emotions, and attitudes that influence individuals' meaning making" (p. 210). The third feature examines critical reflection, with Zepke

and Leach (2002) describing that only through critical reflection can one know that "normal understandings of life are a constructed reality that does not necessarily possess equal value, merit, and significance to the realities of others" (p. 210).

Critical reflection as a meaning making experience is what Kegan (1980) explained as the understanding that it is "not so much what happens to us, as what we make of what happens to us" (p. 374). This is the path that many non-clinical CME professionals experience as they ask themselves questions to allow for critical reflection while they cultivate meaning of their work experiences as a non-clinical professional in a clinical environment. Kegan (1980) further stated, "There may be nothing so powerfully helpful to us as the feeling that we are understood" (p. 380). To be understood by others, one must understand themselves; thus, the path to knowing and understanding is as unique as the individual that travels down the path to understanding.

Meaning-Making and its Connection to Self-authorship and Empowerment

Kegan (1983) described meaning-making as a construct that develops over time, dependent on the lived experiences of the individual. He explored how meaning-making development allows human beings not only to make meaning of themselves, but of others, and of their experiences throughout the life span. The author contends that individuals actively construct their own sense of reality. An event does not have a solitary meaning attached that simply gets transferred to the individual. Instead, meaning is created between the event and the individual's reaction to it. Kegan (1983) shed light on how an individual's identity is not designed for stagnation. It is designed to change and grow along the different stages identified within the theory.

To understand the lived experiences of non-clinical CME professionals, a deeper understanding of the influence of socio-cultural factors must be examined. The non-clinical

CME professional develops knowledge in complex ways driven by their experiences in the workplace within a healthcare setting and with those who share the same career field (Baxter Magolda, 2001). The path to developing this complex understanding can be solitary; however, it does not need to be lonely. With limited resources and inherent competitiveness, asking for help or soliciting good company can be challenging. Baxter-Magolda (2001) stated that "successful journeys, even short ones, require good company" (p. xv), and the pathway for the non-clinical CME professional is developed on the same principles. The community of non-clinical CME professionals assists in eliminating the feeling of isolation and provides context for the newly minted non-clinical CME professional. The clarity from a network of peers allows a path riddled with helpful breadcrumbs to come into view rather than hurdles.

Baxter Magolda (2001) claimed that self-authorship is not prescriptive and consists of varied terrain that is not always consistent or smooth. The joy is in the traveling, and there is no set pace nor guidelines one needs to follow to forge their way towards self-authorship. Self-authorship is characteristically divided into four phases (1) following external formulas, (2) crossroads, (3) becoming the author of your own life, (4) internal foundation (Baxter Magolda, 2001, p. xviii). The first phase, following external formulas, allows the individual to focus on creating their internal voice. This phase is when adults "continue to follow formulas for knowing the world and themselves that they borrowed from the external world around them" (Baxter Magolda, 2001, p. xviii). Those new to the field of CME arrive in Phase 1 where they are inundated with new terms, new tasks, and new rules to follow, which can be overwhelming and challenging. Baxter Magolda (2001) stated that one participant described becoming disillusioned with Phase 1 stating, "We are taught to make our plan. Plan your work and work your plan and you are going to get where you want to go" (p. xviii). Baxter Magolda (2001) reported some of

the Phase 1 participants did work on their plan, arriving at their goal with a profound dissatisfaction that achieving their goals were less meaningful than expected.

In Phase 2, the crossroads, Baxter-Magolda (2001) demonstrated that the dissatisfaction experienced in Phase 1 was the result of "ignoring internal needs and perspectives" (p. xviii) and the individual had to evolve from looking to external forces for meaning to looking inside to define oneself. The third phase of becoming the author of one's own life is founded on how one develops and formulates their thoughts and ideas and uses those thoughts and ideas to propel them forward rooted in their own merits. Baxter Magolda (2001) stated that the third phase of the path towards self-authorship "involved deciding what to believe, one's identity, and how to interact with others" (p. xviii). Movement through the phases towards self-authorship is the fourth and final phase, internal foundation, which reveals the most important part of self-authorship, taking charge of the outside influences rather than being dictated by them. As the non-clinical CME professional moves towards self-authorship, the culmination of the variety of meanings made serve as a valuable tool to the field as a whole. According to Sandars and Jackson (2015), CME of the future will be designed to "not only stimulate intellectual growth, with the development of cognitive maturity, but also facilitate the emotional, cultural, and social development of all learners, with the personal development of an integrated identity and mature relationships" (p. 521). With a renewed focus on the emotional aspects of healthcare, there is an opportunity to investigate how self-authorship is a significant resource for those in the field.

Theoretical frameworks that address the involvement of non-clinical CME professionals and their contribution to the field of health and science are largely absent in the literature. The learning opportunities for non-clinical CME professionals to make meaning are largely of the learner's own design. Kegan (1980) referred to this approach as a constructive-developmental

process. Critical reflection also plays a role in meaning making activities, allowing room for preventative measures that acknowledge an individual moving from a reactionary state, to an anticipatory state in their day-to-day operations. It is through the anticipatory state that the non-clinical CME professional can move towards self-authorship.

Although the majority of CME research focuses on the physician learner, the theory of self-authorship defined first by Kegan (1994) and expanded on by Baxter Magolda (2008) is applicable to non-clinical CME professionals, as it is the "internal capacity to define one's beliefs, identity and social relations" (p. 269) and is amongst the "developmental capacities that helps meet the challenges of adult life" (p. 269). Baxter Magolda (2008) explored how a thorough understanding of the principal beliefs of self-authorship can have a transformative effect as adults endure the complexity of the human experience. The author explained further that self-authorship does not arrive all at once, but rather in cycles. The different phases of self-authorship as identified by Baxter Magolda (2014) and King et al. (2009) emerge in adulthood beginning with identity exploration.

Magolda and King (2004) characterized ten unique clusters divided amongst three major meaning-making structures: (a) external meaning making, (b) crossroads, a mixture of external and internal, and (c) internal meaning making. When the categories were identified, Baxter Magolda and King (2004) explored self-authorship as a multi-dimensional meaning making experience that was nonlinear in nature and scope. The non-clinical CME professional experience was also non-linear in nature. The duplicity of the CME work, the role, the process, and the experience allow for self-authorship to shift naturally from the external orientation to the internal orientation of meaning making (Baxter Magolda, 2001). Baxter Magolda (2008) posited an individual undergoes a transformation, evolving into someone who independently shapes their

beliefs, identity, and social interactions, while also thoughtfully evaluating the viewpoints of others. This shift in orientation signifies the complexities that adults navigate towards developing a perspective where they are the authors of their own lives.

Kegan (1994, as cited in Baxter Magolda, 2008) emphasized self-authorship's position that mutually-beneficial relationships are constructed by the individual. Hence, self-authoring individuals reconstruct rather than separate from others. Non-clinical CME professionals rely on their relationships and their professional networks to be successful in their roles (Tulgan, 2019). The lack of advanced formal training for non-clinical CME professionals makes relationships a foundational component to their personal and professional growth and achievements. Although Baxter Magolda's (2008) seminal longitudinal study focused specifically on college students, the principal tenets of self-authorship theory allow room for individuals to move towards self-authorship at any stage of life.

Self-Directed Learning as an Empowerment Mechanism

The educator, the learner, and the learning resources all work collaboratively to meet the goals associated with self-directed learning (Hiramanek, 2005). According to Brookfield (1988) "the prime purpose of adult education, or of any kind of education, is to make of the subject a continuing inner directed, self-operating learner. The focus of both is the self as the source of learning" (p.103). At its core CME, is education designed for adults, by adults. Cy Houle, Malcolm Knowles, and Merriam and Brockett (Merriam & Brockett, 1997) all subscribed to the school of thought that adult education is defined broadly as any space in which adults are learning. Knowles (1970; 1975; 1980; 1985) considered a founding father in adult education, is known for establishing the andrological approach and propagating the self-directed model for adult learning. Adult learning considers that learners do not stay stagnant, they grow, they

experience life, and their learning must take that into consideration. The problem-solving methodology of andragogy relies on the experience of the learner, the content relevancy to the learner, and the value the learner places on their own connection to the topic in question (Knowles, 1975).

Challenges and Opportunities in CME

The Accreditation Council for Continuing Medical Education (ACCME) has provided guidance to accredited CME providers to consider any conversation had between two physicians as a teachable moment that they are eligible to receive credit for (ACCME, 2024). The learning from teaching designation provides greater context to how adult education is represented in the CME space. The partnership between clinical and non-clinical professionals provides the opportunity for delineation of roles to be misinterpreted, with the non-clinical person being pushed into serving an administrative function. This collaboration has been a longstanding debate in the field of medicine dating back to Sir William Osler (1900), who openly criticized Abraham Flexner for his lack of clinical training when completing his report. This supported the argument that non-clinical educators experience challenges within their defined space.

Role and Impact of Non-Clinical CME Professionals

In their environment, non-clinical CME professionals work according to the ACCME criteria, as well as their individual organizational requirements. They are tasked with providing a process for ensuring the content seeking accreditation is relevant, scientifically rigorous, and situated within the context of a given specialty area. Non-clinical professionals in the field of continuing education for health professionals are adult educators (Bower et al., 2008; Cervero, 2003; Manning & DeBakey, 2001). Research has suggested that adults learn more deeply and permanently when the learning occurs as a product of their own initiative (Knowles, 1985). The

non-clinical CME professional is responsible for taking the initiative to learn and design a process for accreditation that sustain their departments. Thus, the self-directed approach to their work is fundamental. Knowles (1985) explained that a note-worthy characteristic of an adult learner is how their interest to learn is birthed out of their desire for "action, to perform, to solve problems, to make decisions, or otherwise to have impact in their life work" (p. 81). The action is accreditation, the problem is how to accredit content when not clinical, and the decision is made when determining how to accredit content in the context of adult education, all while still learning how to perform the job.

Knowles (1985) described self-directed learning as the process in which "individuals take the initiative, with or without the help of others, identifying human and material resources for learning" (p. 81). Hoban et al. (2005) expanded on this theory further in the context of medicine, exploring the educational demands of physicians and how those demands take a great deal of self-direction in both the approach and navigation strategy. The personal responsibility that the learner feels is the connection or central concept for understanding self-directed learning (Brockett & Hiemstra, 1991). Self-directed learning highlights the autonomous process of the individual learner and shifts or eradicates the power dynamic typically seen in a teacher/student paradigm (Zepke & Leach, 2002).

In relation to the physician learning environment, where there are often many opportunities for physicians to take on a self-directed approach to their learning, the landscape is not as lush with opportunities for the non-clinical CME professional. As the non-clinical CME professional works towards making meaning of their work, there is a shift in focus from learning how to do the functions of the job, to learning how to self-initiate their own learning when there is an educational dilemma identified (Cullen et al., 2019). They work towards bridging their own

gaps in practice and adjusting their ability to solve problems that occur in real time, using past experiences to guide their targeted learning opportunities. These internal realizations allow them to design opportunities to make meaning that are high yield, measurable, and achievable in a short amount of time (Hiramanek, 2005).

Evolving Landscape of CME

As the landscape shifted in the CME ecosystem, physicians recognized that they were unable to fulfill the administrative role required for success in a CME office in a meaningful way. There is a multi-layered accreditation process that must be adhered to and abided by through the ACCME. The ACCME is an organization that continuously revises, renews, and re-establishes guidance and criteria for providers of accredited education to maintain. There is a set of standards and criteria that ensure that accredited providers are in alignment with producing and disseminating scientifically rigorous content that meets the needs of physicians in a quantifiable way (Cervero, 2003).

Lifelong learning is a steadfast companion in the ecosystem of a physician's professional identity formation (Casebeer et al., 1995) The goal with CME is for the physician to engage with content that is meaningful, relevant, scientifically rigorous, and measurable (Cohen, 2006; Felch, 1987; Manning & DeBakey, 2001; Qidwai, 2016). No individual professional handles the planning, management, dissemination, and evaluation of the content physicians consume. The ACCME designed a highly sophisticated and collaborative approach to the design and delivery of accredited content, allowing space for both the non-clinically trained and clinically trained professionals to share the same space and work together to reach the goal of accreditation. The ACCME has provided their accreditors with a broad latitude and put the responsibility of

defining roles of planners, speakers, moderators, reviewers of CME content in the hands of the accrediting provider (ACCME, 2024).

Bellande (2005) stated, “Professions take pride in professional competency (knowledge and skills) as the hallmark of professionalism” (p. 204). As non-clinical CME professionals continue to grapple with defining who they are and how they make a meaningful contribution to the field of health and science, several entities have been developed to track the professional competency of those involved in CME. The National Commission for Certification of CME Professionals, Inc. (NC-CME) is a nonprofit organization founded in 2008 by an independent group of peers within the CME community for the purpose of establishing a definitive certification program. In July 2008, the NC-CME began designating qualified individuals as certified CME professionals (CCMEP); within six months from the date they were created, more than 150 CCMEPs were listed in the National Registry at NCCME.org. However, this is not a widely sought-after certification, nor is it required for many jobs in the CME profession.

VanNieuwenborg et al. (2016) posited the “theoretical base for CME was highly influenced by the views of educators and researchers on the concept of learning. The learning theory for adults, andragogy, become the standard against which CME finally was measured and assessed” (p. 218). As physicians go through their education, they shift their focus from their existing skill set to the development of new skills that are accompanied by support and resources required for lifelong learning. They cultivate a self-directed approach to their learning, as they are responsible for selecting where, when, and how they engage with accredited content. Knowles (1980) described adult educators as having several metrics of success, yet they have only one mission. That mission is to satisfy the educational needs and goals of individuals of institutions, and of society. Continuing medical education departments operate similarly with a

need to provide education for the physician at a micro level and then ensure that what the physician learns is relevant to their patient population on a macro level. Continuing medical education departments reflect the tenants that Knowles (1980) described as they are responsible for providing a service, providing professional development, and subscribing to the mission of the institutions that employ them.

Continuing professional development in the health professions actively pursues the link between knowledge, competence and performance of educational opportunities, with the delivery of high-quality patient care (Balmer, 2013). This singular focus on the physician learner creates a gap in current research concerning non-clinical professionals who support educational functions related to CME. The way their role is amplified, depending on the environment and organization, leaves little room for discussions about the self-directed approach these non-clinical CME professionals must adopt.

Providers of accredited content are interested in designing content that is measurable, scientifically rigorous, and helps to meet the demands of the inventive field of medicine. Influenced strongly by technological advancements and the need for on-demand learning opportunities, the field of CME continuously reinvents itself to meet the criteria of the regulatory board (ACCME) and the shifting focus in the educational marketplace. The ability to open up the CME space for choice in how one acquires knowledge means the playing field is designed for mutual inquiry (Knowles, 1980) from both the providers of accredited content and the physician learners. Knowles (1980) described mutual inquiry as a space where adult educators can share ideas and knowledge with adult learners. Consequently, CME providers understand this shared space of mutual inquiry very well as they are tasked constantly with navigating the mandates of a regulatory board and the ongoing demands of their learners.

Summary

A thorough review of the literature showed the gap in the existing literature on the topic of non-clinical CME professionals. There has not been extensive research conducted nor publications dedicated to professional identity formation (PIF) of non-clinical CME professionals. The literature review covered the history of the CME field, explored PIF, described meaning-making, and explained self-directed learning. Each of these sections serve as a foundational pillar to this study and reveal how the researcher came to conceptualize the research design.

The literature review provided a detailed history of CME, how it is leveraged, and why it plays a pivotal role in the life cycle of the physician. From the early, humble beginnings of CME to its current iteration, the evolution and metamorphosis of CME was described. This literature review also outlined a brief history of adult education, the role of the non-clinical CME professional, a review of meaning making, suggested future research in CME, and covered the theoretical frameworks used in this study, concluding with an overview of qualitative research. The research methodology and design are discussed in Chapter 3.

Chapter 3 - Methods

The purpose of this study was to explore professional identity formation (PIF) among non-clinical professionals in the field of continuing medical education (CME). This chapter describes the methods selected for the study and is organized into sections that address the research questions, research design, data collection, data analysis, trustworthiness, ethical considerations, and a summary.

Research Questions

Professional identity formation provided a framework for understanding the study's two research questions. By examining how non-clinical CME professionals define their professional identity, the first question addresses the specific ways in which individuals conceptualize their roles and the unique characteristics of their field. The second question focuses on the developmental process of how these professionals perceive the evolution of their identity over time and in relation to their experiences. Together, these questions reveal hidden aspects of professional identity within a field that lacks a standardized path. The construct of PIF allows for deeper insights into discovering both the articulation and the growth of professional identity among non-clinical CME professionals.

Research Question #1

- How do non-clinical CME professionals define professional identity?

This question was informed by literature from Beddoe (2013), Best & Williams, (2019), Bleakley et al. (2011), Cruess et al. (2014), Eason et al. (2018), Halverson et al. (2020), Holden et al. (2015) and Sawatsky et al. (2017). These researchers discussed how defining a profession allows for the profession's distinctive space to be represented and for professional capital to be examined. Beddoe (2013) defined professional capital as the

"aggregated value of mandated educational qualifications, social 'distinction' based in a territory of social practice, and economic worth marked by the artefacts of professional status, occupational closure, and protection of title" (p. 26). This research question explored the broad definition of what it means to be a professional and how defining professional identity can further inform practice.

Research Question #2

- How do non-clinical CME professionals perceive they develop their professional identities?

This question explored how non-clinical CME professionals perceive the process of constructing their professional identities and how this developmental process shapes how they view themselves. It sought to understand the career aspirations and goals of these professionals while exploring how defining the career field and establishing a framework for professional competencies can inform future practice.

Research Design

According to Merriam and Tisdell (2015), qualitative research design clarifies how these professionals perceive and navigate PIF. Given the complex and varied professional paths of non-clinical CME professionals, a basic qualitative approach was selected to capture and understand the construct of professional identity. The selection of the research design was influenced by the research questions and the study's purpose and goals (Merriam & Grenier, 2019). The choice of a research design requires a consideration of the research focus (whether orientation or action-based), the unit of analysis (the individual or object from which data are gathered), and the time required to conduct the study (DeMarrais, 2004). Maxwell (2012) suggested that the research design, the primary methodological component of a study, should

be customized to suit the most effective approach for addressing the research questions. Given the individualized nature of the CME field, qualitative research is particularly suited for its ability to capture and interpret the rich, detailed experiences of non-clinical CME professionals. With these fundamental principles as the foundation for the research design, I chose to utilize a basic qualitative design.

Research on CME has been approached most often quantitatively, focused on the learning experience of the physician, the utility of clinical learning, and whether or not education was impactful to the field of medicine (Pant & Panthi, 2018). A quantitative approach, while valuable, often overlooks the depth of individual experiences within the field. In contrast, qualitative research offers an opportunity to conduct rich and textured inquiries in this study of individual experiences provided by a sample population of non-clinical CME professionals.

According to Merriam (2009), qualitative research focuses on how participants experience and make sense of the world. Maxwell (2012) emphasized one of the goals of qualitative research is to provide valuable and trustworthy accounts of the human experience as it examines how meaning is made. Similarly, Crotty (1998) and Merriam (2009) detailed other elements and strengths of qualitative methodology, specifically its suitability for research aimed at understanding meaning connected to a specific context. According to Merriam and Tisdell (2016), this design helps uncover and understand ideas and experiences from the participants' perspectives. Crotty (1998) noted that individuals construct meanings uniquely as they engage with their world. Qualitative researchers examine and analyze lived experiences and gain insights into specific populations (Crotty, 1998). Most qualitative research designs conform to strict methodological requirements and tend to be firmly rooted within an

interpretative paradigm (Merriam & Tisdell, 2016). The literature supports the selection of basic qualitative inquiry when the parameters of the study do not meet the strict requirements detailed in other approaches (Crotty, 1998; Jamshed, 2014; Merriam & Tisdell, 2016; Walsham, 2006; Weiss, 1994).

According to Merriam and Tisdell, (2016), the researcher's role goes beyond data collection. The outcome of qualitative research is primarily descriptive in nature (Merriam, 2009). As the researcher, I provided the voice to understand the experiences and perspectives of the study participants, I translated and decoded the experiences and perceptions of the participants, and I actively interpreted the subjective data into understandable findings as described by Creswell (2013). Merriam (2009) stated that an inductive approach was best to analyze the data. I began with the collected data and allowed patterns, categories, and themes to emerge organically from the data itself, as opposed to deductive analysis which begins with a theory or framework against which the data are tested. Inductive analysis allowed me to sift through the data without predetermined categories or outcomes in mind for a more open-ended exploration of what the data reveal. As described in the literature, once those categories and themes were determined, I interpreted the data through the selected PIF framework (Alase, 2017; Hennink & Kaiser, 2022; Merriam, 2009; Merriam & Tisdell, 2016; Silverman, 1998). Professional identity formation (PIF) served as the theoretical framework for exploring how non-clinical CME professionals develop their professional identities.

One of the key aspects of qualitative research is the relationship between theoretical frameworks and the inductive analysis in a basic qualitative study (Merriam & Grenier, 2019). The researcher is tasked with balancing the openness of inductive analysis with this study's exploration of how these themes connect to PIF. The inductive process allowed themes to

emerge from the data naturally, and also provided a structured lens through which I interpreted the data.

Epistemological Perspective

The epistemological orientation of constructionism was utilized for this qualitative study. According to Rees et al. (2020), "Constructionism, from an epistemological standpoint, asserts that how we come to know the world is constructed through social interaction. Constructionism privileges subjective meaning making with truth seen as a dialogic transaction between individuals" (p. 848). Professional identity formation incorporates professional values, beliefs, motivations, and characteristics that align with professional experiences. Epistemologically, constructionism describes how the participants construct their professional identity, and ontologically describes how they made meaning from what they constructed. According to Crotty (1998), constructionism claims that "meanings are constructed by human beings as they engage with the world they are interpreting" (p. 43). Constructionism acknowledges the individual contributor as an important constructor of knowledge and trusts their individual descriptions of their experiences (Bhattacharya, 2017; Mohammad & Rob, 2018). Crotty (1998) further explained that "different people may construct meaning in different ways, even in relation to the same phenomenon" (p. 9). My epistemological assumption is that non-clinical CME professionals construct meaning through the development of their professional identities.

Professional Identity Formation

Researchers describe professional identity as an individual's sense of self within their profession (Best & Williams, 2019; Bleakley et al., 2011; Cruess et al., 2014; Dadich & Best, 2024; Eason et al., 2018; Halverson et al., 2020; Holden et al., 2015; Hotho, 2008; Iserson,

2019; Janke et al., 2021; Sawatsky et al., 2017). Professional identity formation incorporates professional values, beliefs, motivations, and characteristics that align with professional experiences. The process is not designed to be static and evolves as both the profession and professional grows and develops (Best & Williams, 2019; Bleakley et al., 2011; Cruess et al., 2014; Dadich & Best, 2024). Exploring PIF among non-clinical CME professionals is central to this study. This framework is closely connected with the principles of meaning-making and provides a comprehensive lens through which to view the development of these professionals (Merriam & Heuer, 1996). Eason et al. (2018) suggested, "Professional identity is an important self-concept that allows an individual an identity in relation to his or her profession" (p. 72). Professional identity formation centers on the process through which individuals in a specific field develop and internalize the norms, values, beliefs, behaviors, and ethical standards of their profession (Best & Williams, 2019; Bleakley et al., 2011; Cruess et al., 2014; Halverson et al., 2020; Holden et al., 2015). Eason et al. (2018) explained that PIF is the "process by which an individual achieves an awareness of his or her own self-concept in the context of the profession" (p. 72). For the non-clinical CME professional, developing a professional identity and articulating the profession is challenging, given the lack of a recognized identity (Eason et al., 2018). As a result, professional identity is formed through on-the-job experiences, mentorships, and trial and error (Halverson et al, 2020).

According to Korica and Molloy (2010), "Professions are not static, and power and autonomy are relative concepts, so to comprehend professional identity requires bringing the professionals into view as active agents in this process" (p. 1880). By incorporating non-clinical CME professionals as active agents, this study provided insight on the professional

practices and the development of individual skills and values of the profession which could inform practice (Best & Williams, 2019; Eason et al. 2018; Halverson et al, 2020).

Population and Sample

The population for this study consisted of non-clinical CME professionals. The study explored PIF among these individuals through a basic qualitative approach which highlights the necessity for quality over quantity. This approach is consistent with the concept of saturation, introduced by Glasser and Strauss (1977) and used as the "conceptual yardstick for estimating and assessing qualitative sample sizes" (Guest et al., 2020, p. 1). Merriam and Grenier (2019) further clarified that "a small sample is selected precisely because the researcher wishes to understand the particular in depth, not to find out what is generally true of the many" (p. 29).

To achieve the research goals, 11 study participants were selected using criterion, convenience, and snowball sampling techniques. This sample size was chosen once evidence of saturation had been reached and that no new information was being generated. It also ensured that the sample remained small enough to maintain the richness and depth of the data provided by each participant (Vasileiou et al., 2018). All participants met the following three criteria:

- They had been in their current roles longer than five years.
- They had not had any advanced training in the field of continuing medical education.
- They had experienced limited professional opportunities for career advancement.

The rationale for selecting these criteria aligns with the research questions, theoretical perspective, and evidence guiding the study. Sargeant (2012) noted that participant criteria are selected based on "who can best inform the research questions and enhance understanding of

the phenomenon under study" (p. 1). This approach ensured that the selected participants were well-suited to provide the detailed insights necessary for the study.

The recruitment process began with my professional network, where I identified and invited potential participants via an electronic recruitment letter (Appendix A). I utilized both my LinkedIN premium account and email for this purpose. Snowball sampling, as explained by Merriam and Tisdell (2018), allowed participants to refer the study to other potential participants who met the prescribed criteria. To create a snowball effect, I requested that individuals who had already been contacted disseminate the recruitment flier to others who might also meet the criteria through both their formal and informal networks. Additionally, my post received attention from my LinkedIN network and was reposted by other professionals on the same platform which helped disseminate the information farther. Once an individual contacted me with interest in participating in the study, I sent them a Consent to Participate in a Research Study form (Appendix B). After they returned that form, I followed up with a Criteria for Inclusion Verification form (Appendix C) to confirm their eligibility. If they met the eligibility requirements and consented to participate in the study, they were selected as study participants and interviews were scheduled. After the interviews, participants were sent an Interview Debriefing form (Appendix D) to confirm or deny authorization to retain data for research purposes. The participants' thick, richly-textured stories contributed to answering the research questions.

Participants

This study focused on a specific population of non-clinical CME professionals. Eleven participants were selected using criterion, convenience, and snowball sampling techniques. Criterion sampling was used to ensure that the participants met the criteria of the study. Moser

and Korstjens, (2017) explained that criterion sampling ensures that participants are able to meet the "predetermined criteria of importance" (p. 10). Snowball sampling allowed existing participants to refer others who met the study's criteria. This method ensured that the study gathered richly textured data that provided deep insights into how non-clinical CME professionals define and perceive the development of their professional identities. Each participant met the study criteria of being in their current role over five years, no advanced training in the field, and limited opportunities for career advancement. The criteria allowed for a sample of participants who were able to provide meaningful and informed perspectives on the construction of their professional identity development.

Determining the appropriate number of participants is a critical part of qualitative research methodology. The goal is to recruit enough participants to reach saturation, a point at which no new themes emerge from data collection. Emphasizing the depth and quality of the data, at 11 participants, clear indicators showed that this goal had been achieved and that the data gathered was sufficient to comprehensively understand the ways in which non-clinical CME professionals defined and developed their professional identity.

The participants acknowledged the variety of career fields they were a part of in previous job titles that were vastly different, then the ones they currently hold. Now, the participants have a similarity in roles and responsibilities, yet a diversity in current title. Participants included in this study held positions of CEO, Associate Director of Accreditation, Manager of CME Services, Principal Consultant, Assistant Dean, Director of Continuing Education, Executive Director, Manager of CME Department, CME Manager, Director of Education and Professional Development, and Director of CME.

Table 3.1. Participants' Current Professional Titles

Participant Pseudonym	Current Professional Title
Dakota	Chief Executive Officer (CEO)
Avery	Associate Director of Accreditation
Charlie	Manager of Continuing Medical Education Services
Riley	Principal Consultant
Aspen	Assistant Dean
Dylan	Director of Continuing Education
Theo	Executive Director
Otis	Manager of Continuing Medical Education Department
August	Continuing Medical Education Manager
Ben	Director of Education and Professional Development
Jackson	Director of Continuing Medical Education

The participants entered the field of CME from a wide range of unrelated professions. Their diverse backgrounds ranged from the arts, fashion, social work, and politics to theater, nutrition, and even probation. It was important to explore their professional point of entry and the ripple effects that impacted the construction of their professional identity. Several participants referenced a lack of onboarding, minimal to no training, and an overwhelming need to find their footing in their new roles. This highlighted the lack of preparation and clear job descriptions in CME, which led to initial confusion and discomfort when discussing their professional identities. Despite these challenges, participants reflected on how they discovered new versions of themselves and evolved into professionals capable of navigating the complexities of their new field.

There was a degree of hesitation around the utilization of identifying language related to the participants. They were very hesitant to share the depth of their stories and the truth of their experiences if those experiences were going to be connected back to them. The fear of their identity being known was so pervasive that one participant dropped out of the study due

to the possibility of their identity being revealed. To ensure the comfort of the participants and to respect their wishes for anonymity, I provided each with a pseudonym.

Instrument

Mulholland (2007) described the use of the "self as an instrument" (p. 54) as essential in qualitative research. For this study, I collected data from participant interviews, researcher journal entries, and field notes. The leading instrument was an interview protocol (Appendix E) designed and tested by the researcher. I created the interview questions with the conceptual framework of PIF in mind (Creswell, 2013; Grbich, 2013; Merriam & Tisdell, 2016). The interview questions involved an iterative and reflective process to ensure an in-depth understanding of the participants' stories (Agee, 2009).

Interview Protocol Development

Castillo-Montoya (2016) emphasized that an interview protocol "provides researchers with rich and detailed qualitative data for understanding participants' experiences, how they describe those experiences, and the meaning they make of those experiences" (p. 811). To develop the interview protocol, I immersed myself in the literature and designed questions that explored PIF in this group of professionals. Mellon (1998) posited, "Because there is a natural storytelling urge and ability in all human beings, even just a little nurturing of this impulse can bring about astonishing and delightful results" (p. 174). Although qualitative research does not begin with a predetermined outcome in mind, planning and nurturing a protocol that guides the interview process is key (Agee, 2009). Jacob and Furgerson (2012) explained that the development of a research protocol should include developing questions that are situated within the literature, open ended, big and expansive, flexible, and practiced. Additionally, Jacob and Furgerson (2012) recommended paying special attention to the words used when

crafting questions in an effort to showcase "genuine care, concern, and interest for the person you are interviewing" (p. 8), as well as provide "basic counseling skills to help your interviewees feel heard" (p. 8).

The interview questions were developed and carefully crafted and the interview protocol was adhered to during each participant interview. Jacob and Furgerson (2012) also explained that a marker of deep qualitative analysis includes trusting your instincts, and that adopting a willingness "to make adjustments in the interview allows for the design of the study to emerge as you conduct research" (p. 5). After the first two interviews, I adjusted the order of the questions to provide a more natural flow to the conversations and to make the participants feel more comfortable in the interview environment. Additionally, remaining flexible allowed for unexpected findings to emerge which, according to Jacob and Furgerson (2012), is "one of the hallmarks of qualitative research; and sticking to your interview protocol exactly does not allow for the design to emerge naturally as you conduct research" (p. 5).

Applying the PIF framework into the interview protocol allowed for a comprehensive analysis that enhanced the understanding of how participants construct their professional identities. Each participant's journey in developing a professional identity is complex, unique, and individualistic. Developing the interview protocol ensured that PIF guided the data collection and analysis. The questions were designed to create a safe space where participants could express their vulneratbilities and uncomfortable experiences. This approach accounted for the constant evolution of PIF. The interview protocol captured how participants understand and interpret their current roles, the paths they have taken to reach their positions, and their aspirations for future advancement.

For example, the question, *How do you describe your current position to someone else not in the field?* explored how participants articulate their roles. It revealed how they perceive the complexities and unique aspects of the CME field. The question, *When thinking about the term "professional identity," how do you describe your own professional identity to someone else?* prompted participants to reflect on and describe their own sense of professional identity. In fact, the participants' struggles with this question provided valuable data in the development of themes discussed below. Finally, the question, *Think back to before you got the job. What did you imagine a career in this field would be like?* was included to understand the expectations and initial perceptions participants held before entering the CME profession. It shed light on the discrepancies between how their initial expectations and their current experiences contribute to the construction of their professional identities. These questions ensured intentional integration of the PIF theoretical framework into the data collection and analysis process.

Data Collection

The rich nature of data collection in qualitative research supports an unstructured and flexible approach. For this study, employing a well-designed and flexible method for data collection was essential (Moser & Korstjens, 2018). Patton (2002) stated qualitative findings grow out of four kinds of data collection: (a) in-depth, open-ended interviews; (b) direct observation; (c) written documents; and (d) audio and visual materials. Qualitative inquiry allowed me to collect data from participants who had a direct connection to the construct being analyzed (Patton, 2002). Barrett and Twycross (2018) offered further support that "qualitative research requires data which are holistic, rich and nuanced, allowing themes and findings to emerge through careful analysis" (p. 63). To ensure that the data collected was holistic, rich,

and textured, this study used interviews as the primary method of data collection as it allowed for the participants to share their stories and experiences with me in a meaningful way.

Interviews

Prior to conducting the interviews, Institutional Review Board (IRB) approval was achieved from Kansas State University due to conducting research with human subjects. Before the interviews began, I informed each participant of the minimal risks involved, that their participation was completely voluntary, and that if they felt uncomfortable at any point during the interview and wanted to discontinue, the interview would be terminated. It was of critical importance that the participants were treated respectfully, provided with a platform to share their stories, and felt safe asking clarifying questions at any time during the interview and afterwards.

Galletta and Cross (2013) explained that during qualitative interviews, a researcher must develop a keen sense of awareness regarding "what is unfolding between themselves and their participants" (p. 108). Jacob and Furgerson (2012) explained that during an interview, focused and intentional listening helps participants feel comfortable sharing their personal stories. During the interviews, I made comfortable eye-contact, actively listened with intention, focused on participants tone, and paid attention to the words spoken and unspoken. Jacob and Furgerson (2012) refers to this as the "magic" that happens when interviewers pay attention to non-verbal behaviors. Ensuring these interview tactics were employed allowed the participants to feel heard, understood, and comfortable sharing their stories and lives with me.

Jacob and Furgerson (2012) described the beauty of semi-structured interviews in qualitative research and illustrated that making meaning from people's stories is a privilege that allows researchers the opportunity to describe the human condition, enrich research, and

provide a voice to a multitude of lived experiences This study used semi-structured, in-depth interviews as a primary mode of data collection. The interviews were recorded using Zoom, transcribed, and stored on a password protected computer. The participants' identities were kept confidential, and participants were provided with an alias in the form of a participant number. Most interviews lasted between 90 minutes up to 240 minutes, with length attributed to the participants availability and willingness to share.

Researcher's Reflective Journal

Cresswell (2013) explained that a data analysis spiral can occur in qualitative analysis given the sheer amount of data generated by qualitative methods. To analyze the amount of data collected in this study, I used self-reflective journaling to enrich the data analysis. Creswell (2013) described journaling as "a process in which the researcher writes down ideas about the evolving theory throughout the [analysis] process" (p. 67). I used self-reflective journaling to critically reflect and crystallize my thoughts related to the participants' descriptions, stories, and experiences.

Slotnick and Janesick (2011) further supported the utilization of the researcher's reflective journal "to create a cohesive, coherent, and deeply textured analysis" (p. 1354). They further explained that journaling is a way to immerse the researcher in the participants responses. I used self-reflective journaling as part of the constant-comparative analysis process and to create deeper meaning from the stories the participants shared during their interviews. Additionally, reflective journaling allowed me the time to ensure that the research was not influenced by my own inherent bias as a non-clinical CME professional.

Field Notes

In qualitative research, field notes remain a primary method for documenting information coherently, consciously, and contextually (Phillippi & Lauderdale, 2018). I used field notes, a hallmark of rigorous qualitative research, to provide rich descriptions and contextual information that let me explore the study in relation to a specific time and place (Phillippi & Lauderdale, 2018). A comprehensive field note "is created shortly after the conversation ends, as the researcher's memory is fresh" (Phillippi & Lauderdale, 2018, p.386). I wrote field notes immediately following each interview to ensure important observations did not get lost.

Data Analysis

Merriam (2009) explained that the goal of qualitative analysis is to make sense of the data. This approach is essential in qualitative research where the goal is often to gain a comprehensive, in-depth understanding of complex human experiences and social constructs. For this study, I applied Creswell's (2013) phased approach to data analysis. According to Creswell (2013), "Data analysis is not off the shelf, rather it is custom built, revised, and choreographed" (p. 150). The choreography began with Cresswell's (2003) phased approach to analysis. The phases include (a) preparing and organizing the data (b) reading and memo writing (c) describing and classifying data into codes and themes, and (d) interpreting the data.

Creswell (2013) explained that "qualitative research consists of preparing and organizing data for analysis, then reducing the data into themes through a process of coding and condensing the codes, and finally representing the data in figures, tables, or discussion" (p. 148). Meriam and Grenier (2019) described how data analysis in qualitative research "is simultaneous with data collection" (p. 15), "employs an inductive strategy" (p. 15), and is

"embedded in a world view that sees meaning constructed by individuals in interaction with their world" (p. 33). This process for data analysis allowed me to immerse myself in the data and begin analyzing the data from the first interview and first observation (Meriam & Grenier, 2019).

Coding Procedures

Preparing and Organizing the Data. Phase 1 involved organizing and preparing the data, which started at the onset of the analysis. The semi-structured interviews were recorded and transcribed verbatim and included transcribing the researcher's notes and observations made during the interviews. To preserve the data's richness, transcription was completed immediately after each interview. See Table 3.2 for an example of the coding procedure from the data.

Reading and Memo Writing. Creswell (2013) states, "Following the organization of the data, researchers continue analysis by getting a sense of the whole database" (p. 183). He suggested that transcripts should be read multiple times in their entirety to allow the researcher to immerse themselves fully in the details. This immersion helped me understand the data from both a micro and macro perspective. The richness of the interviews required an initial read-through of the transcribed data, followed by two additional complete readings. During each reading, I took notes in the margins, which helped facilitate my own process of meaning making. This iterative process allowed the reading of the transcripts to become a thought-provoking experience, with each participant's story providing a unique perspective and context. By the third read-through, I began to notice saturation and could see patterns emerging through repeated phrases, words, or experiences.

Describing, Classifying, and Interpreting Data Into Codes and Themes. Creswell (2013) stated, "Codes and categories (terms used interchangeably) represent the heart of qualitative data analysis" (p. 184). For this study, the coding process involved three rounds, each allowing for deeper analysis of the extensive data. Coding became a key component of this qualitative research and occurred in stages throughout the analysis. It enabled me to organize and derive meaning from the collected data (Saldaña, 2011). Following the initial read-through of the verbatim transcripts, the first round of coding, or initial coding, began. Initial coding involved looking for similarities and differences in the data with an open mind to potential themes. Being conscientious allowed me to actively code and reflect on the data while maintaining flexibility in identifying emergent patterns.

During the first round of coding at the line-by-line level, codes were transformed into units of analysis, as described by Saldaña (2016). This iterative approach allowed for what Saldaña (2016) called the "re-coding" process, where data are analyzed more thoroughly in each round. The first round involved dividing, coding, categorizing, and theming the transcription data for thick, rich data analysis (Clandinin & Connelly, 2004; Kim, 2016; Merriam & Grenier, 2019). Open-coding began with no preconceived notions, examining the data line-by-line. The analysis included both hand coding and coding using Nvivo data analysis software. Instead of utilizing traditional 4x6 notecards for hand-coding, Microsoft Excel was used. This technique offered what Saldaña (2016) described as control and "ownership of the work" (p. 22). While reading the transcript data, I took notes in the margins and used Excel to organize the identified codes.

The second round of coding aligned with what Williams and Moser (2019) described as a "cyclical and evolving data loop" (p. 47). This approach involved continuous interaction with

the data, constant comparison, and techniques for data reduction and consolidation. The second round allowed for deeper explorations, where codes were "sifted, refined, and categorized" (Williams & Moser, 2019, p. 50) to develop core codes from the findings. This phase incorporated both inductive and deductive analysis, used the constant comparison method, and included further refinement that culminated with another line-by-line coding session to identify emergent categories. During this process, key words or phrases were identified as descriptive codes which led to the creation of categories (Clandinin & Connelly, 2004; Creswell & Poth, 2016; Merriam & Tisdell, 2016).

Saldaña (2016) described coding as both an art and science, heavily influenced by the researcher's judgment. In the third round of coding, I made decisions on how the existing codes and categories would guide the emergence of themes. During this phase, categories unrelated to the research questions were set aside, while relevant ones were refined. Saldaña (2016) emphasized that "coding is not just labeling, it is linking: it leads you from the data to the idea, and from the idea to all the data pertaining to that idea" (p. 8). This final round of coding focused on selecting and connecting data points to the emerging themes and enabled a deeper and more comprehensive analysis (Saldaña, 2016). See Table 3.2 for an example of the coding procedure from the data

Interpreting the Data. Interpreting the data involved an immersive and ongoing process throughout the data analysis. To achieve a thorough understanding, I continuously revisited the connections between codes and categories, reviewed my field notes, examined the margin notes, and performed additional readthroughs of the transcript data. The data points represented in the codes were linked to key concepts, phrases, and ideas, which were then connected to notable aspects of the research questions.

Table 3.2. Example of Coding Procedure

Transcript Line	First Round Coding	Second Round Coding	Third Round Coding
RESEARCHER: How do you describe your current position to someone else not in the field?			
DAKOTA: So yeah, I mean, I typically say that my role, my primary role is funding and executing projects. When people have no idea what CME is, I often preface with asking "Do you have any lawyers in your family or financial professionals or clinicians who are mandated to take continuing education to maintain their license?" Usually, I ask at first because then that simple explanation I gave is generally sufficient. (Dakota)	Uncertainty about Role Primary Role Project Management Funding Execution CME explanation Audience Understanding Starts with a question Continuing education Professional groups Maintenance of licensure Simple explanation Clarification Concerned with audience understanding Audience Confusion Contextual explanations	Role ambiguity Professional identity uncertain Professional role confusion Context based clarification Efforts to clarify role Simplifying explanation	Professional destabilization
Dylan: The elevator pitch. Yeah, well. I guess I just say that I manage a group of professionals that are dedicated to providing continuing education to healthcare professionals. I guess first and foremost I try to translate our world and verbiage and our nomenclature to a non CME type of person and to kind of educate them about what we do and why we do it, because sometimes our jobs have stupid rules. Well, there are reasons for the rules and if you really want me to dig into it, I can tell you what they all are. But just bottom line it for you, you know, give me the disclosure form. So there's a lot of educating and then reeducating and reeducating about what we do and why we do it the way we need to do it, for, for compliance purposes and things. So, there's a lot of that. A lot of guiding and being helpful. (Dylan)	Elevator Pitch Views self as manager Dedicated Translation Wants to educate Wants to explain the why Stupid rules Bottom line, get there quicker to move on Frustration from rules Education and re-education Compliance Trying to be helpful Discomfort Regulatory rules	Management responsibility Role clarification Role ambiguity Translation of work Professional frustration Justification of compliance rules Try to be supportive Communication challenges Simplifying explanation	Professional destabilization

As I began identifying patterns, I established relationships between them. Categories were refined and emergent themes were investigated to represent broader concepts within the data. Given the continuous nature of data interpretation, it was crucial that once these preliminary themes were identified, they were written in a narrative structure that integrated selected data and quotations from all participants. Desantis and Ugarriza (2000) described a theme as "an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature of basis of the experience into a meaningful whole" (p. 362). Thematic analysis provided a deeper level of

understanding and strengthened the iterative process. This process revealed new connections among the themes that were applied to the research questions and the participants' experiences.

Internal Trustworthiness

Internal trustworthiness concerns the extent to which a study's design, execution, and analysis in providing credible responses to its research inquiries, safeguard consistent and reliable responses to the questions it aims to address (Andrade, 2018). Trustworthiness involves the risk of making broad inferences from the findings of the study to other settings or populations, which could lower trust in the findings. Components of trustworthiness in qualitative inquiry include credibility, dependability, and transferability (Carcary, 2009). To enhance internal trustworthiness, I utilized triangulation and audit trails.

Triangulation

Lincoln and Guba (1985) described triangulation as a way to cross check a variety of different data sources. Triangulation was used to solidify the trustworthiness of this qualitative study by avoiding reliance on a sole source of data. Triangulation was accounted for in this study by collecting and analyzing data from various sources, including interviews, researcher journal entries, and field notes (Johnson et al., 2020; Patton, 2002). The results of the study maintain clarity and meaning while the inherent researcher bias has been minimized (Johnson et al., 2020; Fusch et al., 2008). Triangulation was a continuous process taking place during analysis involving repetitive and critical approaches in observation, recording, coding, analyzing, and reporting (Fusch et al., 2008). The process resulted in a thorough and iterative review of emerging data.

Audit Trail

Lincoln and Guba (1985) explained that dependability is included as a hallmark of rigorous qualitative research. Forerro et al. (2018) further explained the purpose of dependability is to ensure the study can be replicated and produce similar outcomes. To ensure dependability, this study followed a consistent and thorough process which included an audit trail. According to Meriam and Grenier (2019), an audit trail provides "a detailed account of the methods, procedures, and decision points in carrying out the study" (p. 31). Audit trails serve as another measure to ensure trustworthiness and dependability in qualitative research (Schwandt et al., 2007). I viewed the audit trail similar to a recipe card where all of the key elements and ingredients are outlined to provide a framework for how the findings were obtained. The audit trail for this study included all coded and numbered transcripts to facilitate quick access to the data and ensure participant anonymity. Additionally, data collection methods, analysis procedures, interviews, field notes, and journal entries were included in the audit trail, and then organized and filed.

External Trustworthiness

External trustworthiness concerns the degree to which research findings can be generalized to other contexts (Creswell, 2013). This study used the most valued approach to enhancing external trustworthiness which include providing thick, rich descriptions of the data, carefully crafted to determine the extent to which the descriptions are consistent across different settings and experiences (Creswell, 2013; Merriam, 1998).

Ethical Considerations

Meriam and Grenier (2019) explain that a marker of a "good qualitative study is one conducted in an ethical manner" (p. 29). During the time this research was conducted, all

participants were currently employed and identified as a non-clinical CME professional. The ethical considerations for this study surrounded consent, privacy, confidentiality, integrity, and the responsible management of collected data. I removed all identifying participant information from the transcripts and used numbers to identify them. This study followed all ethical standards and criteria for qualitative research. Approval from the Kansas State University Institutional Review Board (IRB) was obtained prior to data collection (Appendix F) and provided procedural and ethical guidelines which were followed.

Chapter Summary

In Chapter 3, I described the research methods for this basic qualitative study. The purpose of the study and research questions were reiterated along with a review of the theoretical framework used to analyze the data. An overview of the development of the primary data collection instrument, a semi-structured interview protocol, was discussed, followed by a review of the data collection and analysis methods used in the study. Ethical considerations, comparative methods, thematic coding, and organized audit trails are all outlined as part of the data analysis. Discussions regarding internal and external trustworthiness included triangulation, audit trails, rich thick descriptive elements, field notes, interview transcripts, and the researcher's reflective journal. In Chapter 4, I present the findings of the study.

Chapter 4 - Presentation of Findings

The purpose of this study was to explore professional identity formation among non-clinical professionals in the field of continuing medical education (CME). This chapter presents the key findings from the semi-structured interviews with non-clinical CME professionals. These findings capture the experiences, challenges, and strategies used by the participants as they navigate their professional identity formation. The study was designed to answer two overarching research questions. The two questions were how do non-clinical CME professionals define professional identity and how they perceive they develop their professional identities. These two questions guided the data analysis and allowed for a detailed exploration of professional identity formation among non-clinical CME professionals.

The data was collected during one interview with each participant, with sessions lasting between 1.5 to 3 hours. Data analysis identified four themes and five sub-themes: (a) professional disorientation (with two sub-themes: fear and feelings of isolation), (b) imposter syndrome, (c) resilience (with one sub-theme: risk taking), and (d) empowerment (with two sub-themes: mentorship and community of support). See Table 4.1 for an overview of the themes of this study. These themes represent the common experiences and challenges shared by the participants and reveal a consistent pattern across their stories. The next sections present a detailed narrative report for each theme and sub-theme derived from the data.

Table 4.1. Emergent Themes of Professional Identity Formation from Non-Clinical Continuing Medical Education (CME) Professionals

Theme	Sub-Themes
Professional Disorientation	• Fear • Feelings of Isolation
Imposter Syndrome	
Resilience	• Risk Taking
Empowerment	• Mentorship • Community of Support

Professional Disorientation

An overarching theme that emerged from the data was professional disorientation. Professional disorientation described the sense of confusion, uncertainty, awkwardness, and embarrassment participants felt as they tried to define their profession. I wanted to honor the unique voices and individual stories of the participants, as they struggled to find the words to explain their professional identity, which for some participants evoked shame, and for others determination. Participants shared the ways they coped with being unable to articulate their profession, overcame the pervasive confusion, and worked through their feelings that revealed they longed for a sense of belonging.

Professional disorientation emerged from the data as participants were asked how they describe their current position to someone else who was not in the field. Prior to this question, participants were asked to provide their current titles and provide an overview of their current professional responsibilities. During the first two questions of the interview, participants were able to clearly and succinctly articulate their current professional titles and provide details of their role within their organizations. Many of the participants held senior positions within their

organizations and detailed the extent of their work with pride. Their professional titles ranged from managers, to directors, to CEOs; and they spoke confidently about their accomplishments and how they perceive their career success. However, the disposition and demeanor of the participants unilaterally shifted when they tried to articulate their profession to those outside of healthcare. Many participants chalked this up to "not fitting in" (Theo) or not being able to "find their place" (Riley), leading to what participants described as a sense of disorientation.

Professional disorientation explored the distinct challenges the participants experienced in defining their professional identity. Highlighted in this process were the participants feelings of isolation, their challenges establishing a professional culture, and the underlying worry that being unable to define their professional identity may result in questions about the legitimacy of their profession. Many of the participants admitted that being unable to define their professional identity has been a struggle since they entered this unidentifiable profession.

When participants were asked *How do you describe your own professional identity to someone else?*, all 11 participants either answered with variations of "I don't." or "I have never had to do that before." See Table 2 for the responses from all participants.

These responses suggest that participants experience an untethering from knowing who they are and explaining what they do. The responses capture the inherent confusion related to their professional identity, which resulted in the participants having to interpret and individually define the profession on their own. Dakota shared how, in her eyes, she had a primary role and an outward facing role. She believed her work was multi-faceted and was a mix of marketing, project management, and business development. She shared,

> So yeah, I mean, I typically say that my role, my primary role is funding and executing projects. When people have no idea what CME is, I often preface with asking "Do you have any lawyers in

> your family or financial professionals or clinicians who are mandated to take continuing education to maintain their license?" Usually, I ask at first because then that simple explanation I gave is generally sufficient. (Dakota)

Dakota explained that although she was aware of the complexities of her work, explaining her profession caused her to resort to analogies, and simple explanations, which most of the participants also experienced.

Table 4.2. Interview Question Response to *How do you describe your own professional identity to someone else?*

Participant	Response
Dakota	I don't.
Avery	I don't know that I have thought about describing my professional identity.
Charlie	I've never had to do that.
Riley	I don't, and I don't think I explain it well.
Aspen	I struggle with this one.
Dylan	This one is challenging.
Theo	This is hard for me to answer.
Otis	Where do I even start?
August	Wow, I've never thought about that, I don't . . .
Ben	It's too complicated to try and answer.
Jackson	This is challenging to say in a simple way.

Avery shared, "I don't know that I have thought about describing my professional identity". Her response indicates that thinking about a professional identity was not something she could relate to as it is not a part of the collective consciousness and does not exist as a goal to be met. Charlie shared that a part of her identity was accuracy and said, "I like to get things done. And I like them done correctly the first time." Even with the apparent confusion regarding professional identity, the reverence for compliance and accuracy was another aspect of their search to develop their professional identity.

The participants described how their inability to answer this question was a shame inducing experience. Some laughed and tried to infuse humor into their description, with Dylan saying, “Maybe it’s called compliance, maybe it’s called accreditation, it’s hard to answer. I order the doughnuts, book the hotel reservations, and, you know, everything, from soup to nuts.” Role confusion was a common finding among the participants, with Dylan further explaining how she relies strongly on her education background as her identifier, but only does that as a way to move the conversation forward. She said, “I still rely on my background in education, and although I struggle with answering about how to describe my role now, I usually just say that I’m in education. And that doesn’t really define what I do now, but it’s what I say to just move on when someone asks.” She identified as an educator and as a jack of all trades. She practiced an elevator pitch early on in her career and then when that was not sufficient, she began to view herself as a translator, sharing,

> The elevator pitch. Yeah, well. I guess I just say that I manage a group of professionals that are dedicated to providing continuing education to healthcare professionals. I guess first and foremost I try to translate our world and verbiage and our nomenclature to a non CME type of person and to kind of educate them about what we do and why we do it, because sometimes our jobs have stupid rules. Well, there are reasons for the rules and if you really want me to dig into it, I can tell you what they all are. But just bottom line it for you, you know, give me the disclosure form. So there's a lot of educating and then reeducating and reeducating about what we do and why we do it the way we need to do it, for, for compliance purposes and things. So, there's a lot of that. A lot of guiding and being helpful. (Dylan)

While Dylan described her understanding of her professional identity, she was cautious and ended her story with “I’m still having trouble with professional identity, I guess I don’t feel

like I really have one". This response indicates that despite her wide-ranging role, there was a professional disorientation leaving her with nothing to anchor to for her professional identity.

Riley was also unable to anchor herself to any one profession or professional identity. She explained that she doesn't view herself based on her job title. Rather, she refers to herself as a person so dedicated to her craft that she has spent a considerable amount of time specializing in a particular area where she believes she has the most impact. She said,

> Well, I don't think of myself first as a CE educator, like somebody thinks I'm a teacher. I'm a policeman. I'm a ballerina. But I feel sometimes like I stand out because when im asked "what do you do for work? " I have said so many things, but I also have said I'm a niche within a niche. You know, I'm already in a niche industry. I'm even more specialized though because really my jam is the accreditation and compliance. It's not the education part, even though it is. (Riley)

After a brief pause, she continued,

> I'm, you know, professional services— I kind of put myself under that wing, you know— LinkedIn was actually really helpful of all things when they created a couple of different categories that I've seen medical education companies file under. Education management, I think, is the one that most medical education companies, you know, fall under. I sometimes pull that out. Not very, very often. But the short answer is I teach docs. (Riley)

Riley described the co-existing realities in her story, which revealed how her identity as a specialist provides her with a sense of pride, but her inability to articulate her work leaves a void that she filled with a simple "I teach docs." The professional disorientation she was experiencing was the result of complex trauma from being at risk of losing her job so many times. She said,

> There was one time where I was sure I was losing my job. You're anxious under the bed, but essentially in hindsight, we were being re-interviewed for our jobs as the organization was bought by private equity and they wanted to see whether they would keep us or not and one guy, who was in charge of the interviews, he was doing the whole man spreading and you know, looking down on his phone. The whole time. So I walk in and they introduced me and he did not look up and when the interview started, I can't remember what the questions were, but I was able to explain that I was their surveyor the year before and was very aware of the organization, it was then that the guy sits up, puts his phone down and I think I surprised him and I'm still very, very proud of that because he dismissed me. I have very, very fond memories, you know? So, you know, I was old enough and mature enough or dumb enough to take advantage of his attention and I feel like it put me in a position to negotiate. I won't say it put me in a position of power, but it put me in a negotiating position where I did not want them to treat me like a doormat. I'm not going to be a yes woman. I'm not gonna just push things through to accreditation. We always get treated like the redheaded stepchild, we're the bureaucrats, we're the blah, blah, blah, blah blah blah, you have to do this, and not do that and I really loved just the immense joy of defying expectations. On top of that it was a total ego trip for me. (Riley)

This was a defining experience for Riley, a time when she was able to be proud of her interactions with a fear inducing situation. Yet the co-existing reality of being afraid and feeling proud of the way she handled herself describes the establishment of professional vertigo.

Most participants were unable to clearly articulate their profession, as Aspen's story also describes. He explained how he borrowed from his previous profession when faced with an inability to anchor his identity to his current profession. He said,

> I say we do a lot of opening nights, you know, big CME is often like getting a lot of stuff ready for opening night because project management is always deadline driven. I also say every show needs to be funded first, so whether it's a movie we're making or teaching CME or a live course or multi day event at a resort, we've got to get the dollars. You know, first or at least a plan for the dollars and then similar to the hunt for talent. We have lots of great physicians. They don't always see themselves as teachers, so we do a lot of working with them the way a director directs a cast of actors to feel more comfortable in the spotlight. (Aspen)

This analogy illustrates how Aspen understood his professional identity. He used this story to maintain his connection to the arts, and as a way to provide a meaningful context for his work now. Like Riley and Dylan, Aspen related his work to his passion for theater. His delivery was full of pride and smiles. However, shortly thereafter, he added,

> But when I'm asked what I do, I say that I'm an educator and I would always tell [my] staff we're not just compliance cops, you know, we don't just point out the guardrails or the violations. We're here to educate people out of maybe bad habits or ignorance of the rules. So, educator is the umbrella of all of it. Even the compliance part of it. (Aspen)

This response from Aspen represents his desire to set an example for his team even while still figuring out where he fits in the bigger picture. He further explained,

> It surprised me. Opportunities came that I wasn't really looking for and I think also, many people in CME that I know that are more junior see clerical excellence as their whole mission, and they don't

> always understand the why. I guess that's what I would like people to have more of a big picture understanding of how we help all the pieces fit together. It took me a long time to have that kind of understanding. (Aspen)

This was a way of Aspen explaining how his professional identity is closely connected to his definition of the "bigger picture". He was aware of his self-doubt and uncertainty yet was confident in his abilities to share his insight with others.

Theo explained that his professional disorientation represented a professional dysmorphia, where he understood that he was working in a hospital but struggled to articulate the part of his professional identity that was connected to healthcare. He explained, "The question about my profession is hard for me to answer, as I sometimes say I work in healthcare, and sometimes say I am in a silo, a department of one, and that I am responsible for compliance" (Theo). This suggests confusion regarding his ability to describe his professional identity.

Expressing humility was consistent across all of the participants as many considered their experience with their profession a "fluke" (Theo) or "serendipity" (Otis), rather than an active choice they made to apply for a position they were not qualified for and stand firm that their belief in themselves was stronger than their fear of failure. Theo further shared that his experience defining professional identity was not something he could describe in tangible terms. He was honest and vulnerable when sharing that this was a field he had never heard of before. Once he had arrived and began working, he quickly realized that it was going to be up to him to explain its value and meaning, and that he was not a secretary. He explained,

> I had never heard of [this field] I've never worked in a hospital and I had no idea what I was in for. But after a while, I truly found footing in it. I knew my business skills would allow me to work anywhere. Didn't matter which capacity because my drive to get

> the job done to the best of my ability was always going to be there. When the interviewer started to explain to me what CME was, I had no idea the words that were coming out of his mouth. I did not understand accreditation. Now, when I'm asked about my work, I have always felt like I have had to expound upon what it was that I did because otherwise it could be taken for a secretarial position, 'Oh, so you're just hiring a speaker. Oh, so you're just scheduling a room. Oh, so you're just printing a sign in sheet" the unescapable thought process from the C suites has always been similar. They don't get it and they don't appreciate that truly what we're doing is making the practice of medicine better for patients. I think that if you educate your physicians if you invest into your physicians, if you invest into your patients, then the rewards will come. The C-suite doesn't realize the nuances of what we have to do because no one's planned an activity before and so it's easy to denigrate the position as merely 'go find speaker X, bring them in on this date, hold it in this room' and they don't realize that for each hour of CME that I'm being asked to create, it takes me 7 to 8 hours of front loading to do. (Theo)

Theo reflected on feeling uncertain that the job was right for him, but feeling certain that his drive, determination, and willingness to take on a self-directed approach to learning the role would be something he could count on. The initial embarrassment seemed to fade over time, which reflected his ability to adapt and grow despite discomfort.

Charlie shared the pervasive feelings of awkwardness, discomfort, and embarrassment in the first few years in her role. She was adamant that a part of the work she enjoys is ensuring that bias does not influence education in any way. She admitted that thinking about her professional identity was not something she could recall doing, sharing,

> I've never had to do that and have never thought about explaining what I do. I know that I am very passionate about making sure that the education is not bias. That is like my biggest thing, and that's what drives me day-to-day. Before entering this field, I didn't even know there was a career in this field... My first two years I was OK with just learning... It took me time to even begin to see a career path going from there. It is hard though, because, yeah, you know, it's not, it's not like lovey dovey profession... CME as a profession has not been established... So, to me your professional identity starts with how people perceive you, but then it becomes reality. (Charlie)

To Charlie, professional identity was not something she had control over. She relinquished the control to external sources, instead opting to adopt their perception of her as her reality.

Avery, for example, also admitted that thinking about her professional identity was not something she had ever considered nor believed existed. She said,

> I honestly did not have any idea that this field existed. Even when I was applying I didn't know. I thought I was going to be sort of checking boxes and like QC and then building online courses and I think about this a lot because even now I don't know what to say about what I do. I have absolutely no idea even how to explain like this industry, because when I say 'you know, I teach clinicians' I mean, you can't even say HCPS. You can't say healthcare professionals because nobody knows what that means unless you're in this world. So I follow up with, I teach clinicians, providers, you know, healthcare providers, doctors, nurses, whatever. 'Oh, so you're a. Teacher. Oh, so you're a doctor?' No, because I'm really more on the compliance side. I've said I say no for a living, so I say no to pharmaceutical promotion in medical education and I make sure doctors don't see advertisements. I am like there, that's a job and that's me. (Avery)

Although Avery was unable to articulate her role, she was able to stake claim to an aggregate of responsibilities that made up her professional identity. She stated clearly and directly, “That’s a job, and that’s me.” representing the ability to identify her profession if she needed to. The statement was so powerful that, like the other participants, she began to second guess herself, and followed up with

> I think I've said probably all of the parts of the job when trying to define it, but none of them really seemed right. I'm so curious. Does anybody in our field have a good answer for how they define their professional identity. Honestly, I don't know how I will evolve and I think a big part of that is because I don't know what the possibilities are. Sometimes are work is a mystery. All of the pieces and how they come together and some of the mystery I did not understand the what or how. I'm a context person too and I know that our world can be very check boxy and it compliance is very much my whole world. But once I felt solid, the other pieces came in and the piece that made me the happiest was realizing that I don't just say no for a living. There's this whole other thing in our work about adult learning theory and like adult learning principles and instructional design and backwards planning. And I mean, it was like it was sort of a whole new world. And it made things make sense. And that's when I started thinking, I’m not stuck, and I get that accreditation compliance is not just checking boxes. I really like to check boxes and I really like to like, do one thing and then check check multiple boxes. That's a lot of fun, but it's about working with people and supporting the organization and education and that's really I think when I started to change that perspective. (Avery)

The data revealed that although the participants struggled to define their professional identity, they did not struggle to answer questions regarding other aspects related to their identity.

They identified their resourcefulness, dedication, determination, and inherent strength related to compliance, accuracy, and truthfulness.

Fear

All 11 participants highlighted fear as a central aspect of their professional experience. Their stories described both internal fears, such as the fear of failure, job loss, and limited opportunities, and external fears, particularly the strong and pervasive regulatory presence in the CME field. Concerns about failure, job insecurity, and limited career advancement were common throughout the data, especially given the confusion and uncertainty surrounding their roles as non-clinical CME professionals. This sub-theme included codes such as terrified, scared, afraid, and anxious.

The impact of fear on this study's first research question shows that fear plays a significant role in shaping how non-clinical CME professionals define and develop their professional identities. Participants consistently expressed how fear influenced their perceptions of themselves within the profession. Fear of failure, job loss, and not meeting regulatory standards were prevalent concerns. For instance, both August and Ben spoke about the pressure of maintaining accreditation and the potential consequences of failing to meet these standards, which could result in job loss or a lowered professional value. This fear not only affected their day-to-day operations but also contributed to their professional identity as individuals constantly working under the shadow of potential failure.

In terms of professional identity development, participants described fear as both a motivator and a barrier, addressing the study's second research question. Otis, for example, expressed how fear related to financial instability and lack of understanding from leadership limited their ability to grow and take risks within their roles. Conversely, Dakota used fear as a

catalyst for change, ultimately making difficult career decisions to pursue growth opportunities. Throughout the stories, fear remained a persistent thread that continues to shape how they approached their professional development and the decisions made regarding their careers.

When discussing career milestones and their impact on her professional identity, Dakota described a time when she felt paralyzed by fear. She reflected on her father's "legendary work ethic" (Dakota); how she modeled her own work style after his determination and how proud she was to share his drive regarding pursuing career goals. However, she believed that those goals would have remained unattainable in her earlier position, where she felt she was nearing a glass ceiling with no room for upward mobility. Dakota also touched on the paralyzing effects of fear regarding making career changes and the struggle to overcome them. She described being afraid to leave her job because her boss wielded tremendous power and influence in the field. At that time, she doubted her own reputation and worried that opposing him could leave her unemployed and struggling financially. Her fear was compounded by concerns about reputational damage, financial obligations including two mortgages, and the responsibility of raising young children. She vividly recalled her fear of leaving, stating, "I was so scared of leaving my first job because the owner of the company had a lot of influence in the industry, and I didn't quite have the standing that I do now, and I was terrified." Dakota used this story to illustrate her personal experience with fear and to explain why fear is so prevalent in the profession. She expressed frustration, questioning,

> Why do we still do this? We know better. Why are we so stuck in the fact that we can't change that much? It is so antithetical now to who I am. My thoughts are always, we'll try it. If it doesn't work, at least we tried. But, like, we're so scared, and it's really a struggle for my personality to accept that. (Dakota)

The integration of personal and professional fears was also evident with Riley, who expressed concerns about how her age and experience might lead to being overlooked for promotions or burdened with additional job duties if her team members were eliminated due to financial pressures on the organization. She articulated this anxiety, saying,

> I am always nervous of the question, who do you want to cut from your team? Because I know if I get rid of someone, it all rolls uphill and comes back to me. I've done it all. There are parts of it I really enjoy, but I'm afraid at this point in my career, there truly are things I do not want to do. (Riley)

Her fear of an increased workload without corresponding compensation or recognition was clear, and she extended this fear to the profession as a whole, expressing anxiety about what she perceived as threats to the integrity of the field. Riley specifically mentioned her concern about external threats to the profession and the anxiety it causes about the future of the industry:

> One of the single greatest threats to medicine in general right now is the same threat to CME, and that is private equity. It is these private equity corporations and companies that are buying up the companies. They're merging them. They don't understand the business of CME. They don't care to understand the business of CME. All they're looking at is the bottom line of profitability, and that makes me nervous. (Riley)

Similarly, Ben believed that the root of fear was beyond his control and linked internal fear of failure to the external pressures imposed by the regulatory board and the intimidation and consequences professional feel when faced with the possibility of failing to meet those standards. This pervasive fear became a central part of his professional identity:

> There's a lot of pressure on us, I think, whether you're in charge of it or just contributing to meeting standards, this idea that you could, you know, lose your accreditation is really, I think, one of

> the biggest deterrents to the job. And it's kind of scary when you think about it. (Ben)

August expressed similar fears about job security, particularly over the potential loss of accreditation. He explained, “Learning the criteria is one thing, but losing your accreditation and your job is another.” His fear of job loss was closely tied to his anxiety about meeting regulatory criteria. But for August, the constant concern about job security also created a coping mechanism. He shared,

> One of the things that works for me, but it takes a lot of work, is not being afraid of losing your job. And that's key because if you are doing the right thing, you're safe. But if you're going to lose your job, then you're going to lose your job anyways. And so that is a key factor in everything that I do. (August)

Other participants connected their fears to a lack of resources, a lack of understanding from leadership about their work, and financial anxieties beyond their perceived control. For example, Otis reflected on his experience of facing fears amplified as his organization shifted from a growth mindset to a scarcity mindset over several decades. He explained,

> After all these years, my boss now is very much a micromanager—a kind of know-it-all personality, even though they have absolutely no idea what I do or how it gets done—and just doesn't understand or try to understand the intrinsic value that we bring to the organization. It’s out in the open that, to them, I don't have a return on investment, and I’m not an income generating department. And every time a new leader comes into the organization, the same conversation happens over and over. They start with explaining that due to financial constraints, we are severely limited in what we are able to do, what we are able to access, how we are able to connect to our docs, what we were able to provide, and that the financial problems make me feel like I’m on the chopping block

> and always make everything uncertain and makes me feel scared. (Otis)

Also describing fear as an inherent part of her experience and exacerbated by external factors, Avery recalled the terror she felt when she was new to the field, only mitigated by relying on the reassurance of those around her. She explained,

> I definitely think it was a lot of trying to figure [the job] out and relying on other people's opinions when I was kind of first starting out because I didn't, you know— It was like the old guard and then like the new incomers, and I was a new incomer and I didn't know— like, I didn't know the interpretations and the understanding of the standards, and I was terrified. (Avery)

The data reveals that fear is a pervasive theme among the participants. They described how their fear manifests both internally, through feelings of anxiety, stress, and job insecurity, and externally, through pressures related to regulatory board compliance, challenging work environments, and demanding expectations that often felt unreasonable given the limited resources available to them.

Feelings of Isolation

Intricately connected with fear, the sub-theme "feelings of isolation" emerged prominently across the participants' experiences. These feelings of loneliness, exclusion, and a general lack of support shaped how they defined and developed their professional identity. Many participants described a sense of disconnection due to generational gaps, lack of support, or exclusion by peers and supervisors. At times, they believed they were victims of discriminatory practices and workplace bullying.

The experiences of isolation intensified due to a lack of standardization in the field. Several participants identified this absence as a source of frustration and disconnection. Without

clear guidelines, participants felt confused and felt like they were "on a raft out in the middle of nowhere" (Avery). The competitive nature of the CME profession, where knowledge is often guarded and collaboration is limited, also deepened the sense of isolation. As non-clinical professionals working in clinical environments, the participants reported feeling like outsiders. These challenges made it difficult for them to integrate into the broader medical community.

Many participants described a persistent feeling of disconnectedness from healthcare, often viewed as "just another secretary" (Dylan) or a "doctor's helper" (Aspen) rather than an integral component of lifelong clinical learning. One participant spoke about the challenge of finding common ground within the profession, admitting that she does not "have anybody to relate to" (Jackson) anymore. Another participant expressed feelings of exclusion rooted in gender bias. Their feelings of isolation often amplified their loneliness and caused a loss of confidence, which challenged their meaning-making practices. The data indicate systemic issues within the workplace contributed to this sense of isolation. The participants' stories described in thick, rich detail feelings of isolation both in their individual organizations and in the broader professional CME community.

Confusion also contributed to these feelings. For example, Avery explained that her feelings of isolation stemmed from the lack of support she experienced, which made her feel isolated and misguided. She found it difficult to trust those around her:

> The first four years I 100% felt isolated because I just felt like I had no idea what was going on. The learning curve was super steep, and I didn't have any idea what was going on. I felt very out of the loop. I think it was just the lack of community. I felt very much like I was on a raft out in the middle of nowhere. I felt like I was flailing, and I was being led down lots of paths, feeling like I had to justify everything. It made me feel like I was being torn

> back and forth without knowing where to go, or having the truth, or anyone who would give me direction. (Avery)

Avery also equated her feelings of isolation to a generational divide, a factor present in many participants' experiences. She believed that the "old guard" (Avery) made acceptance more challenging. She explained that support was key:

> The old guard has a very conservative perspective, and I remember feeling so isolated. They were having this conversation without me, and I just remember feeling very angry. They were having a discussion where I was the expert, but they were not letting me get a word in. I remember feeling very angry and then realizing this is where support is critical. Like, you need support in a way that you don't feel like you have. (Avery)

The lack of support and the disregard for her expertise exacerbated her feelings of isolation.

Similarly, Jackson described being in a "very lonely position" (Jackson). She felt that her organization intensified those feelings by overlooking her for promotions, ignoring her concerns about bullying, and discrediting her expertise due to her lack of clinical credentials. She shared a story about feeling isolated, marginalized, and alone within a previous organization, where her boss "worked to surround himself with strong women but also did everything possible to keep them in their place" (Jackson). She also shared how feelings of exclusion were frequently linked to gender discrimination, fair pay practices, and the absence of growth opportunities:

> I feel excluded frequently. It still happens to this day and has happened throughout my career. I cannot point to any one given point in time, but it is something that I have seen, and I have experienced and felt throughout my career. It is very frustrating when you know for a fact that somebody in a position less than you makes as much, if not more than you do. Especially when they come into an organization after you, and it is very much gender

> bias. Typically, the only way to combat that is to leave your organization and the role you're in, and go to another one and hope for a better situation, but it means you start from scratch and are alone again. (Jackson)

Jackson also explained that while organizational isolation is one challenge, feeling isolated in the broader community was equally painful. She noted that even within her own professional community, she was unable to relate to other professionals: “I find that I don't have anybody to relate to in any of the [conference] sessions any longer” (Jackson).

Ben also experienced feelings of isolation but coped by ensuring that those around him would never feel isolated and alone. He believed exclusionary practices in the profession were due to generational differences rather than a lack of clinical credentials: “In the very beginning of my career, I will be very honest, maybe it was a generational difference, but it felt exclusive. It felt like you couldn't ask anyone anything, and there's still some of that around” (Ben). He continued,

> I don't think we have enough people in our profession, because we're not a known career field. I think we struggle significantly with recruitment of people into the profession. I would say that the people who have isolated me have been people above me that maybe don't have vision, maybe don't have the mission focus that I want or need in my profession. They have individual goals or unclear goals, no strategy or vision. I would say, in my case, it's usually the people above me that don’t realize they are excluding me. (Ben)

August said feeling alone did not make sense to him and was difficult to cope with. “Keep in mind that the academic and clinical snobbery is pretty prevalent in our space, and even though it can feel uncomfortable and lonely, I have a hard time making sense of it” (August). Riley shared a similar experience: “I have absolutely felt like an outsider for being non-clinical,

especially when in a hospital setting. I feel like with age and experience, you start to feel less like an outsider, but it takes time" (Riley). She believed that the passage of time helped her combat exclusionary practices that made her feel alone.

Many participants who felt isolated described the pain these experiences caused and focused on the lingering effects of these exclusionary circumstances. Many were unable to overcome their feelings of isolation and are still working on ways to experience connection, even though they realize it is an uphill battle. Interestingly, Dakota positioned her feelings of isolation more as a badge of honor, sharing that although she still "feels like an outsider" (Dakota), being on the "fringe" (Dakota) does not make her feel sad and instead makes her feel pride. Where the other participants believed their gender, credentials, or lack of support were their demise, Dakota believed the number of times she was called "too something" (Dakota) only served to embolden her resolve. She even shared that it was painful, but not as painful as it could have been: "I get it, I am too young, too female, too direct. Oh, the amount of times I've been told, 'You are too something' is a long list" (Dakota). She explained that feeling alone is a part of being a non-clinical CME professional, and shared that she believes that there is "a lot that can be done in the community to foster collaboration a lot better. Can't we just all be in this together?" (Dakota).

Feelings of isolation emerged as a common experience among non-clinical CME professionals, shaped by a lack of support, generational divides, and systemic exclusion. Participants described how these feelings led to a sense of disconnection within their organizations and the broader medical community. While some found ways to manage or even embrace their isolation, the data reflects that this experience significantly influenced their professional identity development.

Imposter Syndrome

The data collected from the participants revealed that imposter syndrome was prevalent which they described leading to feelings of exclusion, isolation, rejection, and self-doubt. Participants frequently discussed the inherent knowledge of the importance of their work, but they also described feelings of shame and discomfort regarding the lack of acceptance they experienced within the larger healthcare ecosystem. They recognized their accomplishments less as inherent capabilities, experience, or competence, and more as an ability to "get shit done" (Dakota), be "in the right place at the right time" (Jackson), or have "mentors who took a chance on" (Otis) them. Other feelings related to imposter syndrome described a general lack of confidence. The participants indicated that feeling like an outsider often amplified their feelings of imposter syndrome. For some, their non-clinical status inherently became the lens through which they identified as the imposter.

Many participants acknowledged the contrast between clinical and non-clinical professionals. Not holding a clinical background often diminished their perceived value, as described by Aspen, who admitted struggling with the

> . . . glass ceiling [when] you're not a clinician. A lot of people in leadership roles in this field come from clinical backgrounds and obviously, I do not come from a clinical background. And I always had a little bit of impostor syndrome from that. (Aspen)

Aspen further stated that imposter syndrome was still present, particularly when speaking to non-healthcare people, stating,

> I still have a trace of the impostor syndrome, especially when speaking to non-healthcare people. [Working in a clinical environment], the first question is, “Oh, you're a doctor?” No, no, no, no. I'm an educator, you know. So [I have to] thread that needle

> on how you describe yourself . . . understanding that physicians are not the superheroes I was taught— to put them all on pedestals. They're just people. They have limitations. They have blind spots. And they need— they need help and guidance and, you know, and that's what we're here for— CME people. So, I'm a doctor's helper. (Aspen)

Although his role as an educator was crucial, the non-clinical status often made him feel more like a "doctor's helper" (Aspen) than a respected professional.

Dakota shared a similar story, questioning her expertise and placing among her peers and leadership within the organization: "I have very close relationships with a specific specialty group of physicians. We have worked together in the same space for a long time and 90% of the time, it's all clinicians. And then there's me". Describing imposter syndrome as being amplified by moments of exclusion and discounted, Dakota made a conscious decision to challenge those doubts: "I definitely left one of those receptions . . . feeling like, 'No, this is ridiculous,' and [then] went back in." This experience illustrates how her confidence was undermined by a sense of inadequacy but it also highlights her resilience in facing these feelings head-on.

Avery shared a similar experience where imposter syndrome made her question the impact of her work and the contribution she was making to the larger healthcare ecosystem, stating,

> I would like to say that [my work] impacts patients, but really, does it? I think that's altruistic, and we can't measure patient outcomes because we are not in a hospital. We don't have the resources, and I think people for the most part try to do good work for the larger good, but sometimes I feel like I make a difference and sometimes I don't think it really does. I don't think it probably has a big effect, but who knows. (Avery)

Avery's inability to identify and acknowledge her own accomplishments is a fundamental component of imposter syndrome, where success is often attributed to external factors rather than individual competence.

Similarly, Dylan, despite being a highly regarded expert in the industry, struggled to accept that her success was due to her own efforts, admitting,

> There were times, especially when I first became director, that I really second guessed myself saying, "Oh my gosh, what did I do? I don't want to deal with all this HR stuff. This is not my forte." And I never call myself an expert because you can always be learning, right? After 20, no 25 years, was when I finally started to feel like I could contribute something. (Dylan)

This account demonstrates how even seasoned professionals can experience imposter syndrome and question their qualifications and leadership abilities despite a long history of success.

The pervasive nature of imposter syndrome among non-clinical CME professionals was evident throughout their narratives. These feelings of self-doubt and inadequacy shaped their professional identities and influenced how they perceived their roles within the CME field. The participants' experiences reflected a struggle to reconcile their achievements with their internal fears of being exposed as unworthy. Participants described that feeling like an imposter impacted their confidence and their ability to fully embrace their contributions to the profession.

Resilience

The theme of resilience emerged prominently from the data, as all participants shared experiences of overcoming adversity. The data revealed a strong determination to persevere, despite the barriers, difficulties, and stressors encountered in their professional lives. Resilience was intertwined with adaptability and risk-taking, as participants described how they learned from challenging experiences and applied those lessons to grow professionally and achieve their

goals. Many participants emphasized their natural ability to "stick it out" (Dylan) and shared how each challenge taught lessons that brought them both gratification and a sense of pride in their ability to overcome hardship.

Many participants described how their lack of credentials, fear, feelings of isolation, and unconventional career paths forced them to adopt coping mechanisms that highlighted their natural abilities rather than magnified their perceived deficiencies. Through their stories, the participants showcased how developing resilience was essential to raising their well-being and reinforcing their confidence in their abilities. Resilience not only helped them define their professional identity (RQ1) but also influenced their perceptions of how their professional identity developed (RQ2).

Jackson openly admitted initially hating her job, which led her to question her career choices and life decisions. She believed that the lessons learned from the early challenges as well as those still prevalent today were fundamental to her development, reflecting,

> I'll be perfectly honest, when I first started, I hated CME. Well, when you stumble into a career like I did, in the beginning, you question yourself. I know that experience can be a tough taskmaster and a tough educator, but I wouldn't trade any of it. Well, maybe I would a little. But not in the beginning. In the beginning it was all new. It was a brand-new world. (Jackson)

Statements like “wouldn’t trade any of it” describe the connection between self-confidence and the lessons learned along the way, including how those challenges were navigated and overcome.

Similarly, August described resilience as an inherent belief that no matter what adversity was faced, he could rely on their internal drive and determination to overcome any challenges. August linked confidence in his ability to bounce back to the ways in which he provided a safety net for themselves, stating,

> One of the disciplines I subscribe to is just being able to walk through fear no matter what, and whatever the outcome is, you're going to get on the other side of it. . . I built this colorful life. It has given me a . . . safety net, but . . . if I lose my job, there's something else out there I can do. I know it's a different point of view, but it's my experience and it's worked for me. (August)

Relying on resilience and a safety net, August demonstrates how overcoming adversity has reinforced his professional identity. This perspective highlights the importance of adaptability in navigating their career.

The transformative effects of professional identity development were evident when Riley shared that her resolve was closely connected to how she developed resilience. Riley believed that every lateral move, although disappointing, was an effort to re-story their experience. Rather than viewing these moves as defeats, Riley actively chose to see them as necessary steps toward achieving their professional goals, explaining,

> You got to just go make it happen. . . Through my career path, I was never afraid of lateral moves, knowing it may lead to other pathways of, you know, forward motion or promotion or what have you. And I think that can teach you a lot. And I have always liked, kind of starting at the bottom because you see everything. It is just a totally different perspective when you come from the bottom up, versus coming top down. So, I think to me that has something to do with my perception of myself. (Riley)

Despite the disappointments in their career trajectory, Riley maintained a positive sense of self and demonstrated resilience as an internal coping mechanism used as a means to make meaning from any setbacks that occur.

Similarly, Aspen described how resilience was closely tied to working through his imposter syndrome and gaining confidence to make decisions, including acknowledging that his

job brings happiness and fulfillment, sharing, “I decided, you know, I kind of like health care because I feel like it makes me feel good that I'm doing something that matters to people.” Aspen recognized that resilience stemmed from finally shedding the shame of not having clinical credentials or prior experience in the field. He embraced the fulfillment found in the work as a key source of well-being.

Dakota also linked resilience to her upbringing, particularly how her father instilled the ability to both face fear and persevere through fear. Her experiences provided a pathway to view every obstacle as an opportunity to learn, using challenges as fuel to continue moving forward rather than allowing obstacles to hinder any progress. She described the ability to forge ahead even when deciding to start her own company, sharing,

> I laughed. In August of ’21, I started this company and had no idea what I was doing. I still don't. Don't tell anybody. And it gives me a lot of fulfillment being here because I am doing things differently. I do feel like I'm pushing the ideal. I mean my frustration at prior organizations was because I just was there and had no purpose in what we were doing. We were just meeting some basic arbitrary need for some company that— I mean, it didn't really change anything. Patient care didn't really [change]. I mean, it was just checking a box and that definitely leads to burnout. And so, here I am now like, “Oh, I feel like I'm making a difference.” (Dakota)

Dakota further shared that she experiences the world differently through a unique lens as an artist, believing that a creative outlook allows her to overcome challenges while preserving her well-being.

> I think so few people self-identify as artists in our space, and artists think very different. We do think very differently. And even though I don't really think I have any of this designed or figured

> out, I reach down and hear my Dad saying— again, I'm gonna give credit to my dad because my dad views everything as an opportunity— Something should happen. It's an opportunity. He would always say you have something to learn from everyone, even if it's not a lesson that you want to learn at that time and you don't know what it is. So like, constant, constant, constant taking in information. I mean, I can think of so many times in my career where things went wrong, but it never stopped me. (Dakota)

This approach allowed Dakota to turn obstacles into opportunities for growth. It demonstrates how resilience is deeply rooted in both their upbringing and their artistic perspective.

Another interesting finding was that several participants identified as artists and used their arts-based education as a foundation for defining and developing their professional identity. Avery, for example, shared that her background as an artist was driven by passion, which was recognized as the source of well-being rather than financial independence. Like Aspen, Avery's resilience emerged in her decision to separate passion from her profession, only allowing them to intersect when intentionally chosen, reflecting,

> It's so funny, I think about this a lot. Growing up, you constantly hear, “Find your passion, find your passion, find your passion. Then your life will work out.” I'm not going to be telling my daughter to find her passion, because then she will be scared, because there may not be one single passion, she may have many. And now, I can say that I did not start out passionate about compliance, and even though I fell into this world, I kind of found that I grew and learned to love accreditation and compliance, and it really did turn into a passion. Which is weird because I didn't even know that was a thing. But I always move forward even when I did not think I could. (Avery)

Within the theme of resilience, participants shared how they overcame adversity and drew strength from these experiences. Collectively, they expressed that each negative experience served to teach andd guide them toward empathy and meaning making in their ability to overcome hardship.

Risk-Taking

A sub-theme of resilience was risk-taking. Many participants found this intriguing and noted that their current roles and expectations of the profession were often predicated on being risk-averse, which they also felt was to the "detriment of innovation" (Theo). Participants often referred to themselves as the "box checker-in-chief" (Avery), the "compliance police" (Charlie) and the "person who always has to say 'No'" (Aspen). These labels contrasted with stories of taking risks that came naturally to them and were recognized as being essential for their development. The participants consistently described their methodical and strategic approach to risk-taking. Their narratives explained the connection between their ability to take risks and how they perceived their professional identity development.

The participants shared experiences of reaching impasses in their lives when moving forward beyond known and unknown barriers meant taking risks. These risks involved applying for jobs they believed they were not qualified to perform: "In the beginning, I had no idea what I was doing" (August). The data clarified the participants bravery as they described how they had to "force themselves to be courageous" (Theo). They were frequently "on the lookout for the next open door" (Aspen), with an acknowledgement that taking a risk was synonymous with betting on themselves. Additionally, risk-taking was crucial when overcoming barriers. The participants acknowledged that to move forward and grow, they had to develop strategies to fight past their fear and trust in their own capacity to try.

Aspen shared that he came to risk taking from an acting background. His identity was built upon natural abilities to "fake it until you make it". Aspen stated that being in the "right place at the right time" meant "going for it", with the self-trust to know that any obstacle could be overcome. Aspen's story began,

> As an actor, a lot of my development was, "Fake it till you make it." And that was my most used tool early on in my professional life. I mean, starting out as an unemployed, starving actor in New York, talking your way into a temp agency, and taking a typing test over and over until you get really good at one typing test is a way of faking till you make it. And also just, you know, doing that in CME. I was like, I don't have any idea what I am doing. I'm drinking from this fire hose. So, it's really fake it till you make it—and don't be afraid to take a risk and train on the job or teach yourself. (Aspen)

August recalled how readiness to take risks was tied to a willingness to walk through any door that opened, saying, "When opportunities present themselves, you just have to be ready to walk through the door." Coming to the CME world following a successful first career, August believed that "on the other side of the risks were meetings with people I wanted to know." Describing a colorful life before entering the CME field, August explained that staying in that first career had become detrimental to his physical and mental health. At an impasse, he realized that the next career move needed to be something entirely different, "something really outside of what I had been doing" (August). This desire for change required August to leave behind previous accomplishments and accolades, and risk becoming "the new kid on the block" while finding his footing.

August also alluded to the importance of strategic risk-taking when confronting the "old guard," sharing a story where this profession "celebrates" a high degree of risk aversion. August

said, “I think that there are a lot of challenges in trying to substantiate the work that we do and why it's done. And I believe that that could be a detriment over time” (August).

Similarly, Dylan described risk-taking behavior as rooted in an innate ability to seize opportunities that came her way. Observing that many people in the profession are self-identified “lifers” (Dylan) with limited opportunities to advance, as promotions often depend on the departure of individuals in more senior positions. Dylan explained that when a position opened up, regardless of feeling ready or not, she was determined to go for it.

> When I first started, I really liked just doing the conference work, and so I did second guess myself. But so many in our profession are lifers and we have little upward movement until they retire, so when the opportunity [to get promoted] came about, I seized it. (Dylan)

Otis described a natural inclination for risk-taking as a willingness to challenge himself to take leaps. He recounted an initial job interview, where a gut feeling generated a sense of “kindred spirit” with the hiring manager, making the risk feel more like a leap of faith. For Otis, risk-taking extended beyond the job title, as he decided to try to run the department despite holding only an assistant title and to take a chance on their own skills, saying,

> I interviewed for the job and kind of felt this kindred spirit with the person I was interviewing with, and she was like, you have all of the skills that's necessary to work in in this environment. And once I kind of took that leap, I felt so fulfilled because I really felt like I was using all of my natural born skills to the best of my ability. You know, planning, organizing, checklists, just kind of detail-oriented work. And that really spoke to me as a person, and I was really excited. So, I trusted my gut and I went from kind of being an assistant to kind of running the department within a few months. (Otis)

Similarly, Theo's risk-taking manifested as a pursuit of the thrill; the adrenaline rush felt when inserting himself into meetings when required to "speak up, even if it meant risking exposure of being underqualified" (Theo). In a previous position, Theo's tendency to follow the rules conflicted with a desire to try new things, and an inclination to take risks often clashed with the courage to act on them. Theo explained,

> I always wanted to push forward regardless of the rules. Basically, in the beginning, when I was invited to various meetings, I always had to force my way in, and had to trust my instincts and push my way into places that I previously had not been allowed because I was not clinical. And I knew that if I just had the courage to speak up, what I had to say would be important. (Theo)

On the other hand, Riley explained that when taking the risk to start her own business, she was terrified but went "all in" because taking that risk was an announcement to the world that they were ready to believe in their personal vision. Riley said,

> I know it can be really uncomfortable sometimes and the best thing about starting my consultancy, other than the obvious, is that I had to believe in myself, that I could even do it. Even though I was terrified, I am the mistress of my own domain, and it really did all rest on me. (Riley)

Riley positioned risk-taking behaviors within the context of "high risk, high reward" and felt prepared to step outside her comfort zone and push through a door that once seemed "welded shut."

Charlie believed that taking risks was closely connected to pushing past discriminatory practices, confronting fears, and breaking down barriers once thought to be out of reach due to gender bias. Even applying for their first CME job was outside some comfort zone, but a need to "just try" persisted. For Charlie, identity became inextricably linked to taking risks and defying

expectations, particularly those imposed on anyone because of their gender. Charlie shared, “Part of my life honestly has been to do what all the males I've known tell me I can't do.”

Avery believed that risk-taking was not only integral to how she perceived she developed her professional identity but was also closely tied to her meaning-making practices. She shared, “I have always been big on trying to make things meaningful” (Avery). She explained that while she “fell into her first job” (Avery), it had been a significant risk because she left the career field that had been her passion. She shared,

> Some of that helps when we encourage lay people who don't you know understand what we do, because sometimes we don’t even understand what we do, It's like, OK, we need to think a little bit deeper and encouraging them to take a risk and try. (Avery)

Her risk-taking behavior was particularly evident when she encouraged others to confront their fears, believe in themselves, and take a chance.

Meanwhile, Avery believed that risk-taking was not only integral to her perception of professional identity development but was also closely tied to meaning-making practices, sharing, “I have always been big on trying to make things meaningful.” Avery explained that while she “fell into [their] first job,” it had come as a significant risk because of the career field left behind for which she had so much passion. Risk-taking behavior was particularly evident when Avery encouraged others to confront their fears, believe in themselves, and take a chance.

Finally, Dakota viewed risk-taking as an inherent part of the meaning-making process. Identifying strongly as someone willing to “disrupt the status quo,” Dakota understood that achieving the life and career desired required believing in themselves, even risking “piss[ing] people off sometimes.” Dakota recounted an experience of being asked to present at a national

conference, never anticipating that sharing stories of their career journey would provoke such a critical response:

> And one of the evaluation comments was just such that, like, fragile white male ego, saying how that when I talked about how I've struggled to get an executive role, until I basically made one for myself, essentially couched my presentation as male bashing. And I'm like, no, that wasn't male bashing. You just subconsciously are trying to uphold a system that benefits you. And I know I piss people off sometimes, but I'm not sure I actually care. I think for a second, like, I'll care. I have this sense of, no, I want to just belong. I don't want this to be so hard. But I've really found my community of people who celebrate me in rooms I'm in and celebrate me in rooms I'm not in. And we do the same for each other. And now I'm just like, well, you know what? This is ours. This isn't theirs. This is our space this. (Dakota)

Dakota demonstrated a willingness to challenge deeply ingrained biases by asserting her place within the professional community. Despite facing criticism, Dakota relied on resilience and the support of a cherished network to continue meaningful progress. Additionally, she emphasized that taking risks might be the key to "unlocking the shackles" of the industry, explaining,

> This community is going to have to be willing to take some risks if we're going to move this thing forward, because we've gone almost nowhere in the 15 years I've been in this. Take off the shackles because we're only putting them on ourselves. Go out and try. . . . Supporters can give us money to try to do whatever, and they're willing to take that risk. Yet, we're supposed to be the safe space. Treat it more like a safe space. Take risks. Advance things forward. (Dakota)

Dakota identified risk-taking as a critical factor in advancing the CME profession. They emphasized the importance of overcoming self-imposed barriers and viewed risk as essential for developing a professional identity. This perspective, shared by most participants, suggests that calculated risks are seen as necessary for progress and the continued development of professional identity within the CME community.

Empowerment

Participants shared stories that illustrated their experiences with self-agency, personal authority, confidence, and a sense of meaningfulness developed in their work. The data revealed that while participants viewed empowerment as a deeply personal experience that helped shape their identity, they also believed that professional empowerment continued to evolve. Empowerment served as an important link between their intrinsic motivation, their intent to persevere, and their awareness that professional validation was still forthcoming.

While the participants' experiences with empowerment varied, they generally saw it less as a result of external support from their organizations (apart from mentorship, which is discussed separately) and more as an internal process rooted in a belief in their own abilities. The concept of empowerment is difficult to define universally due to its complexities. For the participants, empowerment was not a single entity but a multifaceted experience. Some, like Otis, connected empowerment to external support, stating, "my mentors empower me." Others, like Jackson, linked it to self-recognition of her growing professional strength, saying, "I believe in myself and know that I can do anything I set my mind to." For Theo, empowerment was evident in how he emphasized resourcefulness and rule-following, saying, "If there is a will, there is a CME person able to find the way, compliantly of course".

The participants reflected on the impact of their work, the meaning it held for them, the confidence they developed in their roles, and the self-determination they nurtured to achieve success. For Dakota, empowerment was closely tied to empowering others, captured in the phrase "lift as we climb." Reflecting on life, Dakota noted that each decision made strengthened resolve, bolstered confidence, and fueled desire to create meaningful change. Job satisfaction was deeply connected to her belief that she was "making a difference," further elaborating,

> It gives me a lot of fulfillment being here, because I now am confident saying that I am doing things differently. I do feel like I'm pushing the ideal. I mean, my frustration at prior organizations was because I just felt that there was no purpose in what we were doing. We were just meeting some basic arbitrary need for some company that, I mean— it didn't really change patient care. It honestly didn't really. I mean— it was just checking a box and that definitely leads to burnout. And so now I actually feel like I'm making a difference. (Dakota)

Dakota further described how a sense of empowerment was directly tied to the perceived impact of her work in the world. As she integrated the concept of empowerment into all aspects of life, she shared,

> I would like to enact change. I think all the other life experiences I have had led to that. I may have been afraid in my past, but I would say my future would involve higher levels of activism. Like now, I really don't hesitate to say that I am doing this work because it's the right thing to do and we should do it for that reason. And I do not have a problem calling out bad behavior and now operate without fear of retribution. (Dakota)

Dakota described taking ownership of the future and boldly stated their detailed intentions as their interpretation of empowerment. She described how this perspective anchored her sense of professional identity development, explaining,

> As a female, I have had to push my own personal comfort level and boundaries. And I definitely don't mind disrupting the status quo. So I think that's a huge part of my identity, because I think we tend to get very formal and academic in our industry. And we forget the clinicians are also humans. (Dakota)

For Dakota, empowerment was characterized by her ability to envision and actively shape the future on her own terms.

Another way empowerment emerged was as a partnership between growing confidence and a desire to deeply understand the work. Avery explained,

> I think a lot of my career has been trying to understand and break through the theory to the rubber, where the rubber really meets the road. When I started feeling confident in my skills is when that sort of opened up my eyes to really understanding my work. (Avery)

Avery linked empowerment to self-directed learning, a connection also noted by Riley and Theo. Riley described how learning on the job was a significant source of pride, not only as a recognition of the personal effort invested in honing her craft but also as an exercise of power. Riley started at the bottom and worked up through the leadership structures of the organization, and was one of few participants to outwardly express pride in how progression resulted from the ability to control outcomes when possible. Riley shared,

> I taught myself on the job, certainly for the first 15 or 20 years, I would say absolutely organic on the job training. But right around that time, I think that was when I really started to really understand and kind of feel like I was right about my gut instinct. I mean, I

> started out as a coordinator and I consider myself very lucky because, you know, I started at the bottom, you know, it's just the grunt work and you know, [I am] very proud of my progression, you know, and I grew because I did learn and absorbed things. (Riley)

Participants, like Riley, described how self-directed learning strengthened their confidence, and empowered their personal instincts.

Another aspect of empowerment was linked to self-directed learning. Theo focused on mastering the profession by learning everything possible to gain control over the work environment. Initially, he described the environment as "icy," with no sense of empowerment. However, as Theo began to identify more with the profession, he realized the need to dedicate time to perfecting his processes to succeed. Through this self-directed learning, Theo began to feel empowered, stating,

> When I initially took the job, I had no clue what I was getting into. I just needed a job. But over time, I started to truly feel like I wanted to learn more about this profession. I wanted to do better, be better. And I started dedicating a certain portion of my time every week to reading and learning about the profession and going beyond the tasks that I was given. Over time, I found that I truly did have a passion for this kind of work. (Theo)

For Theo, empowerment meant situating oneself within the broader scope of the organization and gaining the confidence to move on when growth opportunities were unavailable. As a result, Theo took the lead in learning about the profession. He shared,

> I think, when I felt that it was no longer just a job, that it was a profession where I could see [a future], I was more drawn to it and I felt validated in it. That continued my path forward and when I had considered leaving CME to become an executive director, I

> truly wanted the job I have now solely for the title. There were other mitigating factors, but getting an executive director title was more important than the work I was doing because it would open greater doors for me and if I didn't make that change at that time, I was forever going to be labeled as CME coordinator, which was far beneath my scope and capacity, and I felt it limited me. (Theo)

Despite a successful career within one organization, Theo realized the limits to promotion and the title he desired. He took the initiative to expand his knowledge and skills beyond the job description.

Similarly, August described empowerment as a work in progress and linked it to a deep sense of self-awareness, determination to grow beyond discomfort, and a commitment to do so with kindness. August viewed each challenge as an opportunity to assert self-agency and believed that connecting external feedback to the capacity for reflection and accountability enabled him to feel empowered. He explained, "I am always in this self-reflective space and wanting to just constantly be self-aware enough to pivot and make changes wherever possible." The ability to take initiative and identify areas for growth, even when uncomfortable, allowed August to take control of their future, saying, "I approach everything with kindness, even when feeling like an outsider, I work to tolerate the moment and move on." For August, maintaining self-worth in uncomfortable situations became a way to experience empowerment.

Other expressions of empowerment included the concept of "failing forward" (Dylan). Participants shared sentiments like, "I was allowed to try a lot of things and fail safely" (Dylan) and "Fail forward, get back on the horse, you know, learn from what doesn’t work" (Avery). Despite lacking resources, influence, or control in their organizations, the participants believed their unmatched desire to try new things drove them forward. Dylan noted, "It was really gratifying to me to become someone who was known for seeing the bigger picture." The

connection between seeing the bigger picture and failing forward shaped Dylan's confidence and perspective on professional aspirations.

The transformational implications of empowerment were evident in all participants' stories. Empowerment influenced their choices and decisions with long-lasting effects on their career progressions or, conversely, contributed to feelings of stagnation. Participants were realistic about their goals but remained optimistic about their journeys toward becoming empowered and empowering others. They described empowerment as integral to their meaning-making process, yet noted that the disconnect between their professional role and their sense of identity often made aligning their purpose with professional empowerment challenging. While empowerment played a significant role in shaping their professional identity, the data did not suggest it was the sole factor. Instead, it was one of several influences that, together, contributed to the ongoing development of their professional selves.

Mentorship

The data revealed that mentorship often played a pivotal role in how non-clinical CME professionals defined and perceived development of their professional identities. It provided participants with the tools, support, and guidance needed to navigate their careers and build confidence. Mentorship was closely connected to resilience, empowerment, and community of support. Many participants spoke highly of their mentors and described them as their "supporters" (Charlie), "champions" (August), "coaches" (Jackson), and "cheerleaders" (Dakota). They credited their mentors for guiding them through challenges and helping them develop into the professionals they are today.

Mentorship had a defining influence in the lives of many participants. For example, August credited mentorship with having a profound impact on identity development, stating, "I

am who I am because of mentorship. I think that the mentorship that I received has defined me." One of August's mentors taught him to view life through an analytical lens:

> One of my mentors was an auditor. And one of the things I was able to see immediately was how our work sometimes operates like an audit. You're piecing together a puzzle and you're telling a story about all the work that you do to be able to show that you're compliant. (August)

This analytical approach became a key part of how August understood and managed professional responsibilities. Mentorship also helped him gain confidence to seek out a support system that championed both his work and growth. August emphasized the importance of having champions in their professional life. He said,

> So, everyone that has given me this opportunity has helped me by being my champion. I always voice that if I don't have a champion, then I'm in trouble. Because in our role, we're outward facing. We're not only dealing with the physicians, but we're dealing with senior leaders. And you need support to be able to have those difficult conversations. (August)

August's narrative demonstrates how mentorship helped navigate complex situations by providing both personal support and professional guidance.

Another key aspect of effective mentorship was the mentor's willingness to advocate for and encourage their mentees. Advocacy can significantly impact a participant's confidence and professional development. It helps protect them from some harsh realities and reduce feelings of isolation when developing a professional identity. Many participants described how their mentors provided support that functioned as an antidote to their pervasive fears, actively stepping in to "go to bat" (Otis) for them when needed. Otis shared how his mentor's encouragement and advocacy helped him navigate challenges and overcome self-doubt, sharing, "My mentors . . .

allowed me to make my own decisions, and [whether I] fail or succeed, they supported me" (Otis).

A particularly powerful example from Otis's experience illustrates this aspect of mentorship. Otis's mentor not only trusted his professional judgment and provided steadfast support, even in the face of organizational obstacles. Otis explained,

> My former boss was the complete opposite of a micromanager. She was the type of person who said, 'You are the professional. You know what you're doing? You know your job better than anybody else. You know where I am. If you need me, I'm there. If you do something that's outside the lines and I need to talk to you, I know where you are.' And just encouraging—really supported my professional development—encouraged me to go to meetings—went to bat for me. When maybe they said, 'Oh, there's no money for that' or 'People aren't traveling,' she would go to bat for me. She was a wonderful mentor. I could reach out to her as a kind of professional sounding board. (Otis)

This narrative highlights the critical role of mentorship in providing both emotional and professional support. The mentor's actions demonstrate the value of a supportive advocate who can bolster confidence and success during challenging times.

Consistent encouragement was another aspect of mentorship discussed in the data. It had a particularly significant influence on Dylan, who said that the key component to professional development was, "Well, lots of encouragement along the way" (Dylan). The mentor's encouragement was pivotal in helping Dylan overcome self-doubt and build the confidence needed to advance in her career.

For Aspen, mentorship involved not only learning from others but also empowering those he worked with to see his value beyond routine tasks. Reflecting on his experience, Aspen

acknowledged, “I learned from a lot of great people,” which shaped the approach to mentoring others. Aspen explained,

> It's letting physicians know or encouraging them to believe in themselves and [that they’re] not merely care delivery automatons you know. Again, the reimbursement industrial complex wants them to continue delivering. Billable procedure, billable procedure, billable procedure, and it's hard for them to see themselves any other way, and I like to encourage them, and that's the story I'm always happy to tell them. (Aspen)

Aspen used mentorship experience to help clinical professionals see themselves beyond their roles as providers of billable services. His goal was to inspire confidence and recognize their broader identity within the healthcare field.

Other participants reflected on how their mentorship experiences were a blend of luck and good fortune. For example, Riley credited mentorship with helping through some of the most challenging moments in a career. Riley expressed gratitude for the mentors who "really helped [me] grow" and acknowledged the impact these relationships had on their professional journey, stating, “I had the immense, immense luck to be mentored. . . . I realize now that every mentor I [had] really helped me grow and I realize and understand now how fortunate I was” (Riley). Mentorship was a critical resource for Riley, and the knowledge gained under the mentor’s guidance became integral to both life and career:

> You know, mentorship—it's amazing. . . I think this is true for real life, too. It's just, sometimes even just that chance conversation—You may never, ever talk to them or see them again in your life, but it can be that course correction or stone in the stream that just pushes you in a completely different direction. (Riley)

Riley's story demonstrates how mentorship can offer ongoing guidance across both professional and personal spaces. These "chance conversations" shifted the trajectory of Riley's career and helped navigate the serendipitous nature of meeting mentors in unexpected places. Riley emphasized the value of mentorship stating that these mentors provided support "through every season of life."

Jackson echoed the importance of mentorship in her career, stating, "Mentors are important." Identifying and connecting with mentors was as crucial to success as drive and determination. Observing successful individuals to admire led Jackson to actively seek out mentorship, a step that required confidence she initially lacked. Over time, Jackson developed the ability to approach those respected and ask, "Hey, I really admire you. I've been following you for a while. Would you mind mentoring me? Would you mind coaching me along the way?" Mentorship supports the development of a strong professional identity through learned guidance. Jackson's narrative highlights how proactively seeking mentorship was a deliberate step towards professional growth.

Similarly, Ben attributed much of his learning and professional development to mentor influence, stating, "I have no formal training in this, you know. Someone mentored me. My first boss was unbelievable. She taught me. She was my mentor" (Ben). When Ben first entered the field, there was a struggle to understand the reasoning behind certain practices, noting, "I didn't understand the why" (Ben). The mentor provided the pathway to this understanding and taught Ben the *why* behind the work, which became fundamental to Ben's professional identity. This relationship also fostered a deep sense of trust:

> I know I can trust my mentor. I know I can ask him things [and] he knows he can ask me things. I don't know why he picked me, but he was like, just come along and I'll bring you with me. You

> know, he never said it, but I was just like, I just knew that like I had an in. (Ben)

This mentorship experience inspired Ben to become a mentor, with a particular focus on diversity, equity, and inclusion, explaining,

> And by [my mentor] opening that door for me, I feel it's incredibly important for me to open the door for others. I always look to equity and inclusion, and so making sure I'm bringing diversity to the table as well. (Ben)

This choice represents how mentorship inspired participants as they define their professional identities while moving towards their development as leaders by extending the opportunities received to others to foster an inclusive professional community.

The data also showed how mentorship allowed participants to build confidence and develop the skills that seemed lacking. Many did not isolate the lessons learned from their mentors but instead accepted the mentors' strengths and weaknesses as part of the learning process. For instance, Riley reflected on her mentor's aversion to confrontation, sharing,

> My mentor, bless him, was really confrontation averse. He hated confrontation, and for a long time, I did, too. But on the journey, you see the negative side of that, too. He was constantly frustrated 'cause he was afraid to speak up, you know. And s`o it took some time to recognize and acknowledge or even embrace the fact that in this profession, and maybe in all professions, tension is just going to exist in this world. So, as he got more conservative, I was wanting to grow, grow, grow, and do more, you know? (Riley)

This narrative shows how participants learned to navigate both the strengths and shortcomings of their mentors and use these experiences to shape their own professional identities.

Ultimately, mentorship emerged from the data as a fundamental influence on how non-clinical CME professionals defined and perceived their professional identities. Participants described how they worked to incorporate the lessons learned from their mentors into their own journeys, while using these insights to guide their career paths and professional growth.

Community of Support

Community of support emerged as a crucial theme in the development of professional identity among non-clinical CME professionals. It played a central role in combating feelings of isolation and fear. Participants often defined their professional identity through the supportive networks they engaged with. When experiences of feeling alone were shared, these stories were countered with accounts of community. This community provided validation, camaraderie, and a sense of belonging. It allowed them feel more connected to their profession. In a field without a well-established identity, time spent interacting with peers who shared similar experiences and challenges is crucial to understanding what it means to be a professional. Participants believed that the key to unlocking their potential was found in the mentors and the community of support that surrounded them. This recognition helped them realize that they were not alone.

The data revealed a strong emphasis among participants on the importance of community support systems. The theme *community of support* was identified as crucial to how participants perceived the development of their professional identity (RQ2). Participants relied on their community of support to cultivate optimism, hope, friendship, and professional camaraderie. They often described feelings of isolation that stemmed from a sense of being alone and without a professional home. Additionally, participants noted that being the only professional in their organizations performing their specific work made it challenging to foster peer relationships. When stories about connecting with a broader community of support were shared, many

described a “circle of trust” (August), a “very supportive environment” (Ben), and a sense of closeness within a “unique community” (Otis). However, some participants also expressed disappointment and observed that the community of support was not as welcoming as they had hoped. One participant remarked, “If you’re not involved, I think it’s a pretty closed community” (Otis), while another cautioned, “You have to be careful not to abuse your network” (Riley).

In the field of continuing medical education, the community of support often brings together driven and intense professionals who thrive in high-pressure environments. One participant reflected on the demanding nature of the profession and how it attracts individuals with strong, assertive personalities, noting that “You have to be kind of be a little crazy to work in this profession, because it’s nutty” (Otis). Otis also emphasized how the community of support provided much-needed connection and validation in the work:

> I mean, we're a really a unique community, you know, so sometimes it's really nice to talk to somebody who kind of gets it, you know? Sometimes, you just need to talk to somebody who understands what you're going through. It provides connection, validation, like— the camaraderie. (Otis)

Otis’s reflection here highlights the importance of having a supportive network that understands the unique challenges of the profession. For Otis, the community of support was not just a professional network but also a source of personal connection that validated her experiences and reinforced her commitment to the work.

While the data indicated that the community of support ultimately provided validation and connection for many participants, the path to finding this community was not always straightforward. Otis continued by describing initial challenges in establishing a community of support. Early experiences were marked by confusion and competition rather than collaboration. Otis reflected on his attempts to connect with colleagues in the field, saying,

> I think if you put yourself out there and get involved in the community, you will be well received, and find your people. If you're not that involved, I think it's a pretty closed community. Back when I started and I reached out to some of the medical school people and they were like, “What in the world are you doing reaching out to me? Aren't we your competitors?” And I thought, well, if we are competitors, we should also be colleagues. We should be talking to each other and saying “I'm planning a huge symposium on this day. Please don't plan anything on that day because I want your doc[tor]s to come.” (Otis)

For Otis, the process of building a supportive network involved navigating competitive dynamics and overcoming initial resistance from peers. Despite these challenges, his experience demonstrated the need for persistence in building and nurturing a community of support, which is crucial for professional growth and the development of a strong professional identity.

Ben also encountered initial difficulties in finding a community of support, but once the right group was found, a highly supportive environment was discovered. Ben described this community as one where help was always available, saying, “Once you realize that this community exists, like we're very supportive and you can reach out to someone and communicate with them. They always get back to you. They always want to support and help you figure things out.” Ben’s experience shows the importance of persistence in finding a supportive network, which was crucial for his professional development and sense of belonging within the field.

The concept of a “circle of trust” emerged as a crucial element of the community of support for some professionals in the field of continuing medical education. This circle provided a network of trusted individuals who were always available to offer guidance and a sounding board during challenging times. August described the importance of this supportive network,

> Engaging with my circle of trust has always been important to me. Someone I could pick up the phone and just have a conversation with and let them know, this is what's going on, even with how I might be feeling about myself, and the discomfort I might be having with not knowing or what direction to go in. And that's when I'm most comfortable. I could reach out and they'd be supportive with whatever my needs are. (August)

This trusted community gave him the confidence to overcome feelings of being an outsider. Although occasionally experiences of imposter syndrome still occurred, reassurance came fro knowing that others within the CME community understand his challenges and "gets it" (August).

Camaraderie and open communication are also important aspects of the community of support within the field of continuing medical education. This supportive environment allowed non-clinical professionals to speak freely and openly, without feeling the need to translate their feelings or be embarrassed by their challenges. Theo highlighted the importance of this camaraderie, stating,

> Being a part of such an exclusive group of professionals has its own rewards. Because you are meeting likeminded people who may have different passions, but we are all within the same realm, and we can speak freely to each other in a language that other people don't understand. (Theo)

For Theo, the ability to share experiences and provide support to others, especially those with little to no experience in CME, was a significant part of how professional identity was perceived. Theo explained,

> I am currently training someone who has absolutely no experience in CME, and I have explained to him the importance of maintaining those relationships and that sharing information back

> and forth as well as maybe some forms is just helping your brothers and sisters in arms. (Theo)

Theo described how their approach to cultivating a strong community of support ensured that newer members of the profession received the guidance and support necessary to succeed. By fostering an environment of open communication and mutual support, contributions were made to the growth and cohesion of the CME community.

Accountability and the exchange of best practices were other key elements of the community of support for some professionals in continuing medical education. Aspen viewed the community as a barometer for honesty and a means of holding oneself accountable. Aspen emphasized the importance of visibility within the community, stating, “The visibility in creating a community makes you maybe more careful in your work, and the networking also keeps you honest, you know. So, comparing notes across different shops is a very healthy practice” (Aspen). By engaging with others in the field, Aspen found that sharing best practices and maintaining transparency helped ensure high standards of work and reinforced professional integrity.

The role of identity formation within the community of support was described by Riley, who spoke about the profound impact that this community had on shaping professional identity, referring to it as having a “tremendous handprint” (Riley) on how the profession was viewed. Riley noted that the novelty of the profession and the lack of readily available information about the importance of this work made the community essential to understanding the role. Riley explained, “Our [profession] is relatively new or in the process of defining itself. And a community has a tremendous handprint on forming identity. You know, I couldn't imagine being successful without having that community behind me” (Riley). This connection to the

community of support was vital in helping Riley navigate the uncertainties of a developing profession and provided the necessary foundation to build and sustain a professional identity.

Stability, emotional support, and the need for improved networking emerged from the data through conversation with Charlie, who found that the community provided stability and emotional regulation needed to enjoy the work and feel free to be expressive. Charlie emphasized how this supportive network allowed for open expression and feeling understood, sharing,

> Having a community and support system makes me like my job. It helps me understand that I'm not crazy at times . . . It's where I feel I can speak my mind, you know, like letting you have a platform. And that's what community does, which is awesome. (Charlie)

However, Charlie also identified a challenge within the current structure of the community; there are not enough opportunities for networking to ensure continued stability. Charlie stressed the importance of networking but highlighted the need for it to be accompanied by initiatives that make new professionals feel comfortable building relationships. Charlie suggested "there needs to be more networking but guided networking with Ice Breakers for new people to the profession." This reflection highlights the dual role of the community in providing both emotional support and opportunities for professional connection, while also pointing out areas for improvement to enhance the sense of belonging for new members.

Validation, confidence, and the importance of a supportive community are key elements in the professional journey of some CME professionals, brought to light through Avery's narrative. Avery described how finding her "CME bestie" (Avery) was a transformational experience that provided the validation and confidence for career advancement. Avery emphasized the critical role that the community of support played throughout the professional

development process as it offered a safe space to ask questions and seek guidance. Reflecting on this experience:

> To borrow a quote from my mentor, it is important to find your CME bestie. So now I feel like I have several CME besties or CE besties, and I think the community has been amazing. I wish our community was not so expensive, and not so mysterious-behind the curtain sort of thing. Establishing a professional community is such a confidence builder too, but it also is humbling, because you feel safe to say, 'I don't know.' Your community is there willing to support and share and be open, and I truly think that having a safe space does wonders. I think it's crucial to anybody. (Avery)

Avery described how a strong community of support can provide both the encouragement, and the safe environment needed for professional growth and confidence, despite being in a field. with ambiguous and complex elements.

Avery's narrative also supports the importance of nurturing inclusivity and combating exclusion within the community of support. They emphasized the positive impact of being part of a supportive community where ideas could be exchanged freely and guidance offered without judgment. Avery also reflected on the challenges of establishing such a community, simultaneously expressing a commitment to nurturing new professionals and addressing the exclusionary practices observed. Avery shared her desire to bring in "younger faces, diverse faces" and to foster an environment where validation and positive influence are accessible to all. Avery explained,

> I want to be invested in bringing people up, younger faces, diverse faces. You know, that kind of thing. And maybe it's just because I'm super extroverted and I seek that stuff out but I think having validation and having people in your profession that you can look up to as a positive influence is critical. I really believe that the

> community, how open and supportive we all are or many of us are like you can sit down with somebody and say I feel really stupid and you hope they will help you, but I have also heard our field can be very clicky. So, it's been an interesting dynamic to sort of wrap my head around. (Avery)

This finding demonstrates the importance of creating a more inclusive and supportive professional community, even while acknowledging the challenges that exist in overcoming exclusionary behaviors within the field.

A final central aspect of the theme community of support is the idea of thriving through community support. This idea highlights how a strong community can do more than just help individuals survive, it can encourage them to thrive. Dakota emphasized the profound impact the community of support had both professionally and personally. Dakota described it as "very, very helpful and very community minded." She noted how this community played a crucial role in inspiring achievement beyond what seemed possible: "I think we're all just as human beings seeking community and that sense of belonging. So, I think it's really important because it provides a ton of satisfaction with my professional life" (Dakota). For Dakota, the sense of belonging extended far beyond the professional sphere and became deeply intertwined with personal identity. Dakota reflected on the unique bond within the professional community and compared it to living in the "land of misfit toys," but finding profound satisfaction and fulfillment in those connections.

> We live in the land of misfit toys. But here we are, like real friends both in and out of work. And so that's hugely fulfilling and a part of who I am as a person. You know, even just beyond professional, like all the facets of my life, that's a big, big, part of it. (Dakota)

The participants' narratives collectively reveal the critical role that a community of support plays in the development and perception of professional identity among non-clinical CME professionals. This theme emerged as a vital element that provides not only practical tools and guidance but also emotional validation, confidence, and belonging in a field that often lacks clear identity markers. For many participants, the community of support became a lifeline, offering camaraderie, a platform for open communication, and a space to navigate the complexities and challenges of their roles. The lived experiences of these participants represent how these supportive networks combat feelings of isolation, promote inclusivity, and encourage both personal and professional growth. Ultimately, the community of support is both a professional network and a foundational aspect of their identities.

Chapter Summary

This chapter presented the findings of the study. Following re-iteration of the research questions, I discussed the integration of the theoretical framework, PIF, for interpreting the data. Next, I introduced the participants, their current job titles, and the varied paths and careers they had all worked in before entering the field of CME. The narratives from the participants' stories were then presented thematically, beginning with professional disorientation and its two sub-themes, fear and feelings of isolation. This was followed by discussions of the themes imposter syndrome, resilience, and risk-taking. Finally, the theme of empowerment was presented along with two subthemes, mentorship and community of support. These themes articulate how the participants defined and perceived they developed PIF as non-clinical professionals in the field of CME.

Chapter 5 - Discussion

The purpose of this study was to explore professional identity formation among non-clinical professionals in the field of continuing medical education (CME). The first section of this chapter presents a summary of the study followed by a discussion of the conclusions derived from the findings. Next, implications of the study are presented for non-clinical CME professionals, clinical CE/CPD professionals, non-clinical CE/CPD professionals, continuing education regulatory boards, mentoring programs, and researchers using PIF as a theoretical framework in their research. Finally, some recommendations for further research are presented.

Summary of the Study

The purpose of this study was to explore professional identity formation among non-clinical professionals in the field of continuing medical education (CME). The two research questions guiding this study asked how non-clinical professionals in the field of CME defined their professional identity and how they perceived they develop their professional identities. The literature review summarized the historical and current state of the CME field, including the responsibilities of non-clinical CME professionals and the role of adult learning in CME. This was followed by reviews of literature on professional identity formation (PIF) and empowerment theory. The study used PIF as a theoretical framework to explore how participants developed and internalized professional norms, values, beliefs, behaviors, and ethical standards (Halverson et al., 2022; Hotho, 2008; Iserson, 2019; Janke et al., 2021). Given the individualized nature of the profession, qualitative research was well-suited to capture and interpret the rich, detailed experiences of the non-clinical CME professionals who participated. This approach allowed for a deeper understanding of how these professionals construct their identities in an evolving field.

A basic qualitative research design was chosen to explore the unique experiences of non-clinical CME professionals in healthcare, and to further understand how they made meaning of their roles. Interviews were conducted with 11 participants, which were then transcribed, coded, and analyzed resulting in the emergence of four main themes and five sub-themes. An inductive approach to data analysis allowed these findings and themes to emerge naturally from the data, without predetermined categories or outcomes.

The four themes and five sub-themes identified during the analysis revealed how professional identity was defined and the participants' perceptions of their professional identity development. These themes represent the common experiences and challenges faced by the participants and reveal a consistent pattern across their stories. The four primary themes were professional disorientation (with two sub-themes: fear and feelings of isolation), imposter syndrome, resilience (with one sub-theme: risk-taking), and empowerment (with two sub-themes: mentorship and community of support).

Within the themes of professional disorientation and imposter syndrome, there was a disconnect between how the participants viewed themselves, the perceptions they believed others had about them, and the way they described their professional identity. They articulated the confusion, frustration, and pain points they experienced, yet they lacked the language to articulate how this disconnect affected their professional growth and development. Janke et al. (2021) asserted that professional identity "involves more than just the tasks and functions associated with one's job" (p. 1130). Similarly, the participants were clear in explaining that they were much more than an amalgamation of tasks and functions. They expressed a longing for a professional identity that accurately represented both the professionals they are and the professionals they aspire to become. This finding illustrates how the lack of an agreed upon and

widely accepted professional identity can hinder identity composition, which aligns with Janke et al.'s (2021) description of the challenges in developing a universal professional identity. The themes highlight both the internal and external challenges to establishing a universal non-clinical CME identity.

Although research on PIF is abundant, a gap remains in understanding the process for non-clinical CME professionals. This study explored the experiences and influences that contribute to their professional identity. This study brought to light the complexities faced by non-clinical CME professionals in defining and developing that identity. The findings revealed that negative factors, such as professional disorientation, fear, and isolation are mitigated by positive factors like empowerment, resilience, mentorship, and a community of support. Additionally, the study highlights the profound impact of both external influences and internal struggles on PIF, while demonstrating the importance of mentorship and supportive networks in overcoming these challenges. By examining the unique experiences of this under-researched group, the study enhances the understanding of PIF and provides valuable insights for future research and practice in fields with unclear entry paths and vague professional identities.

The data collection involved semi-structured interviews with 11 participants who shared their stories and experiences in a thoughtful and vulnerable manner. In considering the diversity of backgrounds, current organizations, and support systems among non-clinical CME professionals, the study identified four primary themes and five sub-themes that are integrated into the meaning making systems used by the participants to construct a professional identity. The interviews produced over 700 pages of transcripts and 40 pages of field notes. The data analysis reflected the complexities associated with defining oneself, the pain of feeling unseen, and the triumphs of aligning inherent strengths with a larger purpose. The participant stories

embodied perseverance, resilience, and occasionally reflected my own struggles in articulating a professional identity. Witnessing the emotions, pain, and joy of their journeys was a privilege, and it is my hope that this study has given their stories and profession the validation they deserve. Cruess and Cruess (2018) connected PIF to the developmental stages of adult life, linking identity formation to social roles, while Janke et al. (2021) connected PIF to the universal acceptance of a profession in society. The data from this study offers a new perspective, connecting PIF to the concept of professional disorientation.

The data provided the foundation for identifying the themes that reveal how participants experienced their sense of self. These themes represent the complexities that emerged as the participants struggled to express their stories and articulate their professional identities. This struggle represented the challenges they faced in defining their professional identity and highlighted the pain associated with persistent self-doubt. Each encounter with the participants revealed a heightened awareness of the evolving process of identity construction. Professional identity formation intersects with the ways in which individuals make meaning and perceive the world in relation to that meaning. I observed in real time how the participants' stories offered them a framework to interpret their past, see those experiences as foundational in the present, and use them to shape their hopes and aspirations for the future. This process also resonated with my early career experiences and helped me construct meaning in my own professional identity.

Professional Disorientation

The beliefs that participants formed about their professional identity were bound together with fear, imposter syndrome, regulatory pressures, a lack of clarity, lack of confidence, and lack of belonging. These beliefs resulted in what I described as professional disorientation, a state of professional vertigo that destabilizes their sense of identity. In this study, professional identity

formation was defined as the process through which individuals develop a sense of self in relation to their professional roles. Noyen et al. (2023) argued that investigating PIF brings two central questions to the forefront: “Who am I?” and “What do I do?” When a profession lacks a clear definition, however, answering these questions and developing a sense of self become more challenging. Bamberg (2011) noted that professional identity exists between how professionals perceive themselves and when they identify as members of a profession. Noyen et al. (2023) found that professionals can typically anchor their identity to their profession when asked to explain their work. In contrast, while the participants in this study could describe their roles, they struggled to connect their identity to a clearly defined profession.

Participants described their professional identity not as a set of specific characteristics but instead as an aggregate of co-existing realities. Identity composition considers several factors, including the meaning derived from sharing lived experiences (Henderson & Bigby, 2019). As the participants shared their stories, they used their words to articulate difficult truths. Each participant’s lived experience was unique, and the ways in which they shared these experiences connected to the themes that emerged from the research. Professional identity formation focuses on the process by which individuals develop and internalize the norms, values, beliefs, behaviors, and ethical standards of their profession (Halverson et al., 2022; Hotho, 2008; Iserson, 2019; Janke et al., 2021).

Becoming a non-clinical CME professional does not require specific prior experience, recognized credentials, or formal training. The lack of a universal and classifiable non-clinical CME professional identity was evident as most participants struggled to articulate the depth and breadth of their work (Janke et al., 2021). I chose the term professional disorientation to describe the overwhelming feelings of confusion, uncertainty, awkwardness, and embarrassment that

participants consistently reported. The participants often followed their stories with questions like,

- "Is that good?" (Dylan)
- "Does that answer the question?" (Otis)
- "Is that what you were looking for?" (Riley)

These questions, of course, emphasized their uncertainty. As they continued sharing, it became clear that in an industry known for regulatory pressures and fear-based practices, their professional identity was disclosed selectively rather than spontaneously in a stream of consciousness (Bamberg, 2011).

All participants identified elements of fear during their interviews. They linked their professional disorientation to their fear, feelings of isolation, and imposter syndrome. They expressed fears of failure, exposure, job loss, and limited opportunities for career advancement. Additionally, all participants reported feelings of isolation, primarily related to professional dynamics. They described a persistent sense of disconnection from their organizations and the broader professional community. Many struggled to articulate how their isolation deepened their loneliness and led to a loss of meaning in their work.

Co-Existing Realities in the Field

The theme of imposter syndrome emerged during the analysis when participants shared that although they possessed impressive credentials and professional experience, they were always worried that they would be exposed as a fraud, that their success would be deemed undeserved, even though this was contradictory to their lived experience (Sakulku & Alexander, 2011). Imposter syndrome was also identified through the participants sharing experiences that highlighted feelings of inadequacy. Despite being highly accomplished professionals with

diverse backgrounds and significant academic achievements, many participants felt intensified imposter syndrome due to their lack of clinical credentials. These co-existing realities took place at the social, personal, and professional levels as the participants worked to authenticate their sense of self and describe how they see themselves as a member of a largely undefined profession. Their ability to define their professional identity became more challenging to articulate as they explained that they did not feel anchored to any singular word or phrase. Rather, they defined their identity through their experiences, their challenges, the resources available or unavailable to them, while crediting external factors for amplifying their resolve.

The courageous work to combat their professional disorientation, fear, and feelings of isolation were tethered to empowerment, resilience, mentorship, and a community of support. If professional disorientation was the cancer, then empowerment, resilience, mentorship, and community of support were the cure. These themes described how the participants embraced their authentic selves, overcame their fear, and experienced empowerment to become a professional worthy of being identified as such.

The perceptions the participants had about this revealed the strong connection between external influences that contributed to their development and their meaning-making processes. The impact of professional disorientation on their perception of their development was notable, marked by confusion, lack of guidance, and reactivity. The combination of the themes of resilience, mentorship, empowerment, and community of support enriched the study and when aggregated together revealed how the participants described their perception of their development of their professional identities.

The participants explained how their challenging and often isolating professional environments were in contrast to the supportive relationships they had with their mentors and

peers. The field of medicine is founded in hierarchy and prescriptive professional paths that lead to achievements by association. In a profession that lacks prescriptive paths and prerequisites, the findings revealed that resilience, mentorship, and empowerment surfaced as key developmental factors.

Transforming Defeats into Achievements

According to Di Fabio and Palazzeschi (2015), resilience plays a vital role in supporting an individual's well-being. Resilience was a prevalent theme that resonated strongly with all 11 participants. They shared stories of transforming their defeats into achievements, and strategically choosing to use the adversity they experienced and the hardships they endured as opportunities to grow, adapt, and persevere (Garza et al., 2014). Southwick et al. (2014) explained that when defining resilience, making the distinction on how it is being viewed is fundamental. In this study, resilience was not one dimensional and emerged as a process to maintain emotional well-being. Participants referenced how most clinical disciplines have resources available for managing stress, burn out, and well-being. Yet, in their profession, those same resources were not available to them, which made the cultivation of resilience a survival technique (Wicks, 2005).

Manne et. al. (2015) described resilience through the positive behaviors one displays in response to challenges and the resulting bounce back leaves one stronger than before. Similarly, participants explained that overcoming the challenges they experienced required them to adopt innovative coping mechanisms and embrace flexibility which is particularly difficult given the governance and oversight by an internal and external regulatory board. Participants struggled with knowing when to be flexible and adaptable, and knowing when to be the “CME police” (Otis). In alignment with the compliance related deliverables of their work, risk taking emerged

as a sub-theme of resilience, with participants recounting experiences where they reached an impasse and had to take a leap forward to overcome barriers. This often involved applying for jobs they believed they were not qualified for. Many described multiple instances that showed taking risks was essential for growth and development.

Developing Self-Agency

Bloom (2020) shared that "empowerment is the result of caring more than others think wise, risking more than others think safe, dreaming more than others think practical, and expecting more than others find possible" (p. 6). Empowerment was a prominent finding that highlighted the role of risk taking, mentorship, and community of support in shaping the participants' professional identities. Critical empowerment cognitions, as described by Koberg et al. (1999), were evident as participants described experiencing empowerment as both deeply personal and foundational to their sense of identity. They also recognized that their professional empowerment was still evolving. The participants believed both in their inherent abilities and their determination to take control of their work environments.

Koberg et al. (1999), conceptualized empowerment both as a relational and motivational construct. The relational aspect involves power dynamics, specifically the sharing and transmitting of power and control to others. The motivational aspect, however, is characterized as the cognitive and psychological investment in one's work. Koberg et al. (1999) posited that empowerment is about believing in oneself—specifically, believing that one can motivate oneself, use mental resources effectively, and take action to control situations. The authors described empowerment as having the confidence that one's efforts will lead to successful results. The participants' stories reflected these dual aspects of empowerment. Some described it in terms of self-agency, which led to feelings of control over their environment and decisions,

which led to a higher sense of personal authority and confidence in decision-making as described by Valoura (2011).

Feeling “undervalued" (Theo) played a crucial role in shaping his identity, a notion that aligns with Wald's (2015) view that professional identity formation involves not only the integration of knowledge, skills, values, and behaviors but also the connection of these professional capabilities with personal identity and core values. They described how empowerment was integral to their meaning-making process, as discussed in the literature (Beijaard et al., 2004; Brown, 2014; Goldie, 2012; McMains et al., 2023; Wald, 2015).

Empowerment was not solely derived from external support, but rather from an internal process of self-recognition and confidence in their professional capabilities. Participants linked empowerment to their ability to overcome challenges, take initiative, and grow through self-directed learning and reflection. While empowerment was influential in their professional identity formation, it was not the sole factor; it was one of several influences that collectively contributed to their ongoing development as professionals. Participants credited mentorship for helping them navigate challenges, build confidence, and foster resilience. Describing mentorship not only as guidance and support structures, but also as an essential tool to succeed. Mentors were portrayed as "champions," "coaches," and "cheerleaders," who advocated for and encouraged their mentees to overcome self-doubt.

Mentors were highly regarded and viewed as role models who encouraged their mentees to anchor their concept of professional identity to the larger healthcare ecosystem (Gibson, 2013). Mentorship also inspired participants to become mentors themselves, with a focus on diversity and inclusion. Overall, mentorship was a fundamental influence on the professional growth and identities of the participants. Closely connected to mentorship was the community of

support referenced consistently by the participants. The community of support offered validation, camaraderie, and belonging in a field lacking clear identity markers. Supportive networks helped combat isolation and fear, while providing emotional and professional guidance. Although some faced challenges in establishing these connections due to competitive dynamics, the community of support was essential for navigating careers and fostering inclusivity. This network was important in their professional growth, identity formation, and job satisfaction. Participants who felt alone often contrasted those experiences with stories of community. They believed that their potential was unlocked through their mentors, supportive communities, and the recognition that they were not alone.

Implications for the Field

This section examines the implications of this study for non-clinical CME professionals and their professional practice. The findings from this study are valuable for fields beyond healthcare where career paths are unclear and professional identities remain vague. The findings of this study broaden the existing research on PIF by providing distinct insights into the experiences of non-clinical CME professionals. The current body of knowledge on PIF is exhaustive, and yet, a critical gap remains regarding this population of professionals. Particularly, the implications could guide future practice for the following stakeholders: continuing education (CE) and continuing professional development (CPD) professionals, CE regulatory boards, mentoring programs, and researchers using PIF as a theoretical framework in their research.

Non-Clinical CME Professionals

When considering the implications of this study to the field, it is important to note the diversity of professional environments where non-clinical CME professionals are employed.

This research has profound implications for non-clinical CME professionals who may work in health systems, hospitals, academic medical institutions, medical affairs, and medical education companies. In the realm of healthcare, these findings illustrate the critical importance of representation. The findings of this study offer valuable insights to professionals who may find themselves struggling with feelings of uncertainty, confusion, and frustration as they attempt to articulate their professional identities, responsibilities, and contributions to the field. For the non-clinical CME professional, forming a professional identity related to an undefined profession is a unique and multifaceted experience, particularly given the lack of a formalized educational pathway into the career.

The existing body of literature on PIF among non-clinical CME professionals is notably limited. No other study with a focus on this population exists. The findings establish a connection between the lived experiences of non-clinical CME professionals, the formation of their professional identities, and the processes through which they construct their identity. These findings contribute to a more comprehensive understanding of the unique challenges and opportunities faced by this group of professionals and add context to how a lack of representation and belonging influence PIF. For non-clinical CME professionals, the findings suggest the need to adapt, despite being in a profession known for its rigor, structure, and rigidity. Sharing of best practices, transparency, and succession planning would serve to enhance knowledge, cultivate community early on, establish belonging at the starting line, and foster a path to professional advancement at the onset rather than five years into the role.

Continuing Education and Continuing Professional Development Professionals

This study has implications for CE and CPD professionals who arrive at this field from a variety of disciplines and careers in other fields. In the field of healthcare, CE and CPD represent

professionals committed to the maintenance and improvement of professional competence. Although there are still many clinical professionals in these roles, the findings suggest that the experience is markedly different for the non-clinical professionals. Clinical professionals often have a prescriptive path, a respected hierarchy, and non-administrative responsibilities that allow them to showcase their clinical prowess and rely on their non-clinical staff to lift an administrative burden. The findings from this study can provide clinical CE and clinical CPD professionals with an alternative way of recognizing that their non-clinical peers are, in fact, their peers. The non-clinical staff may not be a part of the fraternal order of medicine, but their contribution to healthcare is not without merit.

Non-Clinical CE and CPD Professionals. Outside of healthcare, non-clinical CE and CPD professionals might not have the opportunity to cultivate a professional identity that connects them to their role as a professional in this field, and they may find themselves in similar situations where they feel impeded by co-existing realities. These professionals could find themselves feeling isolated if their title connects them to a particular department, but their job descriptions reflect a list of non-conforming deliverables. For example, they might be working in the human resources department, yet find they are responsible for conducting live and virtual trainings. Alternatively, they could be in a situation where their title denotes one classifier, and yet their day-to-day responsibilities are managing a learning management system. These factors may separate the professionals from their departments and their actual responsibilities.

When developing onboarding curriculum in the fields of continuing education, these findings could serve as a reminder that representation is not just an intermediary step, it is a critical one. Without a roadmap that expressly showcases how the CE and CPD professional is represented in their organization, these professionals may experience feelings of self-doubt and a

lack of belonging, which ultimately could negatively contribute to the development of their professional identity.

Continuing Education Regulatory Boards

This study has implications for the criteria, standards, and policies administered by accredited regulatory boards. The findings indicate that the pervasive nature of the various regulatory boards contribute to an environment of fear, confusion, uncertainty, and embarrassment. Many participants associate their fear with the intersection of their roles and the external regulatory boards that govern their practices. The regulatory board mentioned most frequently by the participants was the Accreditation Council for Continuing Medical Education (ACCME). The ACCME is an organization that continuously revises, renews, and re-establishes guidance and criteria for providers of accredited education to maintain. A set of standards and criteria ensure that accredited providers are in alignment with producing and disseminating scientifically rigorous content that meets the needs of physicians in a quantifiable way (Cervero, 2003).

Although the ACCME primarily focuses on the physician learner, the partnership between clinical and non-clinical professionals often leads to roles being misinterpreted, with non-clinical professionals being relegated to serving administrative functions. Non-clinical CME professionals must work to ACCME criteria and the policies of their individual organizations. They are tasked with ensuring the content seeking accreditation is relevant, scientifically rigorous, and contextualized to a given specialty area. The non-clinical CME professional is responsible for taking the initiative to learn and design a process for accreditation that sustains their departments which many find challenging, as there is no formal onboarding or training programs available locally. Thus, the findings from this study suggest that the various regulatory

boards should understand that representation is key for professional identity development of non-clinical CME professionals.

Mentoring Programs

The findings from this study reveal the deeply personal and grounding experience that mentorship provides for newcomers to the field. When participants struggled with the fundamental question of "Why am I here?" their mentors provided a clear path forward. Participants spoke with affection and pride about the benefits of mentorship, chief among them the ways they felt supported, included, and validated in their professional choices. The findings suggested that tailored mentorship was a key to opening doors many did not know existed. Mentors provided a safe space for participants to express their sense of professional disorientation.

The participants attributed a lot to their mentors, specifically how they clarified parts of their professional identity they could not yet articulate due to not having the language, tools, or resources to do so. The stories about mentoring experiences suggested that professional identity is formed through multiple avenues, including on-the-job-experiences, mentorship, and the space to fail forward. In this context, mentorship programs could be enhanced if there was special attention paid to the discovery and development of professional identity. For example, mentorship programs for non-clinical professionals might incorporate specific activities or discussions centered around PIF enhancing communities of support.

Researchers Using PIF as a Theoretical Framework in Their Research

The findings suggest that despite the plethora of empirical research on PIF, there is still a need for a deeper understanding of how the theory applies in diverse contexts. The process of PIF involves how individuals develop a sense of self in relation to their professional role. Kim et.

al (2020) stated that “professional identity centrally includes the attitudes, values, knowledge, beliefs, and skills that are shared with others within that profession” (p. 161). Professional identity formation integrates personal values, beliefs, and experiences with the norms, values, and expectations of a professional community. It is a dynamic and continuous process that evolves as individuals gain experience and encounter different professional situations (Kim et. al., 2020). Janke et al. (2021) said that “professional identity influences how a professional perceives, explains, presents and conducts themselves” (p. 1128). This study builds on the core components of PIF and provides further understanding of the iterative nature of professional identity development. Researchers using PIF can provide further insights into how professional identity progresses, as the findings from this study suggest that the process is in continuous flux and is undergoing constant iteration, refinement, and transformation.

Recommendations for Future Research

There are numerous opportunities to expand this research and further explore PIF of non-clinical CME professionals. The narrow focus of this study opens the door for many avenues for future research. One recommendation is a longitudinal study that examines the evolving nature of PIF. A deep analysis investigating PIF of non-clinical CME professionals from professional entry to retirement could significantly contribute to the body of knowledge related to PIF.

Further research might also consider using a questionnaire to expand the sample size, using open-ended questions that would allow for expanded qualitative data analysis. The highly specialized field is complicated further by the prevalence of regulatory boards and there is room to explore the professional identity formation of those who have gone through an accreditation cycle versus those who have not. These cycles are frequently viewed as monumental tasks within the field and could be another area to investigate. Future research could focus on other

professions with undefined paths of professional entry, a perceived lack of resources or support, and perceived barriers to advancement, such as a “glass ceiling” or “paper ceiling”.

Additionally, a quantitative study could increase the sample size and provide demographic data that would examine a wider range of variables such as gender, age ranges, geographic region, and experience level. A unique finding from this study was the arts-based background of many of the participants. This interesting finding could generate future research that investigates the intersection in the field between art and science. Future research could investigate the complexities of how these previous professions held by the population may impact their professional identity formation.

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Appendix A - IRB Participant Recruitment

Dear (Name Redacted for Anonymity),

You are invited to participate in a research study. The purpose of this study is to explore professional identity formation (PIF) among non-clinical professionals in the field of continuing medical education (CME). If you agree to participate, you will be asked to participate in one interview that will take approximately 60-90 minutes of your time.

Risks that you may experience from participating are considered minimal. There are no costs for participating. Your information collected for this study is completely confidential and no individual participant will ever be identified with his/her research information. Data from this study will be saved on a password protected computer and destroyed after the study is completed.

Your participation in this study is completely voluntary, and you may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study if you choose to do so. You are not under any obligation to answer questions you may be uncomfortable answering.

To voluntarily agree to take part in this study, you must be 18 years of age or older. By signing the consent form, you are giving your consent to voluntarily participate in this research project.

Attached to this email, you will find both an informed consent form and a criterion for inclusion form. Both forms provide additional details regarding the nature of my study, designed with the utmost care to ensure clarity and transparency.

1. Informed Consent Form: Please review, complete, and affix your signature to the attached Informed Consent Form.
    a. This document ensures that you are fully aware of the study's scope, procedures, and your rights as a participant.
2. Criteria for Inclusion Form: Please fill out this form to confirm your eligibility and willingness to participate in our study.

Upon completing these documents, please email them back to me. Additionally, when you send them back to me, it would be great if you could include in your response a few dates and times that you have available for a 60-90-minute interview. My goal is to complete these interviews before May 30th.

If you have questions about the study or study procedures, you are free to contact the investigator via email or phone number below.

Thank you,
Stacy Weiss

KANSAS STATE UNIVERSITY
University Research Compliance Office

Appendix B - IRB Participant Consent Form

Consent to Participate in a Research Study Kansas State University
Professional Identity Formation Among Non-Clinical Professionals in the Field of Continuing Medical Education
Principle Investigator: Stacy Weiss, PhDc
Co-Principle Investigator: Susan M. Yelich Biniecki, Ph.D.

Introduction: You have been asked to participate in a research study. Before you agree to participate in this study, it is important that you read and understand the following explanation of the study and the procedures involved. Please take as much time as you need to read this consent form. If you have any questions about the study or your role in it at any time, be sure to call or email the investigators.

You may contact the investigators at:

- Stacy Weiss
  Phone: 813-230-1155
  Email: stacygweiss@ksu.edu

- Dr. Susan M. Yelich Biniecki
  Phone: 785-532-5535
  Email: susanyb@ksu.edu

Your consent will provide permission to be involved in the study by selecting "I consent" found at the bottom of this page and adding your signature. Taking part in this study is entirely your choice. If you decide to take part but later change your mind, you may stop at any time. If you decide to stop, you do not have to give a reason, and there will be no negative consequences for ending your participation.

Purpose of this Study: The purpose of this basic interpretive qualitative study is to explore professional identity formation among non-clinical professionals in the field of continuing medical education (CME).

Your Participation: You are being asked to participate in a research study. Your participation is completely voluntary. You do not have to participate if you do not want to. If you agree to be part of this study, you will be asked to:

- Complete two 60-minute interviews with the researcher that will be recorded via Zoom. Video recording is not necessary for this study; therefore, participants may choose to not be on camera and only be audio recorded during the interview.

Artifacts: The purposeful artifacts in this study will include job descriptions, and professional documents that the participants are comfortable sharing. Artifacts will be reviewed and analyzed for symbolic meaning and information from the artifacts will be analyzed thematically and coded to achieve a deeper and more textured analysis.

Participation risks: The potential risks for participating in this study are minimal – no greater than what you would experience in your everyday life. It is possible that talking with the researcher and sharing artifacts will stir up some emotions, bring up difficult memories, or cause you to feel embarrassed about your experiences. Participants have the right to skip any question or to pause their involvement at any point, should they feel discomfort or distress. Additionally, if you are uncomfortable sharing your job description or your professional documents you do not need to do so.

Participant Termination: Although rare and extremely unlikely, the researcher might have to end a participant's involvement in the study if it seems to be the safest option. This isn't a decision taken lightly. Reasons for participant termination could include health risks that become apparent because of the study, problems with following the study's rules in a way that could alter the results, or unexpected situations that might pose risks to the participant or others. If it ever becomes necessary to make the decision to terminate a participant, the researcher will explain everything clearly and provide any needed support and guidance. Offering transparency, respecting participant autonomy, and upholding the highest ethical standards throughout the research process is a fundamental component of this study.

Participation benefits: There are no benefits to you as a result of participating in this study.

Confidentiality: The information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies. The results of this study will be confidential and only the investigators will have access to the information. All digital data for this research will be stored on a secured server that is password protected.

Privacy: At no time will your name or personal identifying information be used in any written reports of this research. You have the option to choose to use a pseudonym and may select your own pseudonym if you choose or have the researcher create a pseudonym for you. Data collected from you for this study (i.e. informed consent forms, interview transcripts, and artifacts) will not be shared with anyone outside the research project or used for future research studies and will be destroyed at the end of the project.

Voluntary participation and withdrawal: Your participation in this study is voluntary, and you may decline to participate or withdrawal from the study at any time. Your decision to participate or not to participate will have no effect on your status as a Non-Clinical Professional in the Field of Continuing Medical Education.

Compensation: You will receive a $10 gift card for each interview as a thank you for participating

Who to call with questions, concerns, or complaints: If you have more questions about this study at any time, you can contact:

- Stacy Weiss
  Phone: 813-230-1155
  Email: stacygweiss@ksu.edu

- Dr. Susan M. Yelich
  Biniecki Phone: 785-532-
  5535
  Email: susanyb@ksu.edu

- Lisa Rubin, IRB Chair, Committee on Research Involving Human
  Subjects Phone: 785-532-3224
  Email: rubin@ksu.edu

- Brad Woods
  Associate Vice President for Research
  Compliance Phone: 785-532-3224
  Email: brwoods@k-state.edu

- Institutional Review Board
  University Research Compliance
  Office Phone: 785-532-3224
  Email: comply@ksu.edu

If you choose to participate in the study, the researcher will email you a copy of this consent form and collect it prior to the date of data collection.

Consent to Participate:

By selecting "I consent" with a check mark and signing your name, you consent to participating in this research study and agree to the following:

- You have read and understand the information in this form.
- Your participation in the study is voluntary.
- You are 18 years of age.
- You are aware that you may choose to terminate your participation at any time, for any reason.

I consent to participating in this study_____

Print Name:_____Signature: _____.

Appendix C - Criteria for Inclusion Verification form

Questions to Verify Criteria
for the Study

Thank you for agreeing to participate in my research study. My research is limited to exploring professional identity formation among non-clinical professionals in the field of continuing medical education (CME). The criteria for inclusion in the study are listed below. Please answer the questions below and indicate if you meet the criteria for the study by selecting yes or no to questions 5, 6, & 7. Please return this form via email to stacygweiss@ksu.edu.

1.	Name:	
2.	Email:	
3.	Phone Number:	
4.	Please list days and times that work best for you to participate in interviews	
5.	Have you been working in non-clinical CME longer than five years?	☐ Yes ☐ No
6.	*Advanced training is defined as training or education over and above the basics required for the core qualifications of a position.* (*Definition: Advanced Training from 10 USC § 2101(3) | LII / Legal Information Institute*, n.d.) Given this definition, have you had any advanced training in the field of non-clinical CME?	☐ Yes ☐ No
7.	Do You believe that you have limited professional opportunities to advance in your career.	☐ Yes ☐ No

Thank you,

Stacy Weiss

Stacy Weiss

stacygweiss@ksu.edu

Doctoral Candidate

Kansas State University

Appendix D - IRB Participant Debriefing form

Title: Professional Identity Formation Among Non-Clinical Professionals in the Field of Continuing Medical Education
Principle Investigator: Stacy Weiss, PhDc
Co-Principle Investigator: Susan M. Yelich Biniecki, Ph.D.

Thank you for participating in this research study. Introduction: For this study the researcher informed you that the purpose of the study is to explore professional identity formation among non-clinical professionals in the field of continuing medical education (CME). We would like your permission to keep your data for research purposes. You are free to withdraw your data and not let the researcher use it in the study analysis. If you decide to withdraw your data, you will still receive your $10 dollar gift card for participation. If you have any questions about this research, please feel free to contact the principal investigator at:

Stacy Weiss Phone: 813-230-1155 Email: stacygweiss@ksu.edu	Brad Woods Associate Vice President for Research Compliance Phone: 785-532-3224 Email: brwoods@k-state.edu
Dr. Susan M. Yelich Biniecki Phone: 785-532-5535 Email: susanyb@ksu.edu	Institutional Review Board University Research Compliance Office Phone: 785-532-3224 Email: comply@ksu.edu
Lisa Rubin, I RB Chair, Committee on Research Involving Human Subjects Phone: 785-532-3224 Email: rubin@ksu.edu	

Research conducted at Kansas State University involving human participants is carried out under the oversight of the Institutional Review Board in the University Research Compliance Office.

This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact the Institutional Review Board at 785-532-3224.

I have read this debriefing form and I agree to allow the use of my data for research purposes. Please indicate if you give permission for the use of your research data (please select):

- Yes, you may use my data in the research.
- No, I do not want my data used in the research.

Thank you again for your participation.

Print Name: _____
Signature: _____

Appendix E - Interview Protocol

Thank you for agreeing to participate in this research study that is exploring professional identity formation among non-clinical professionals in the field of continuing medical education (CME). I have received your Verification of the Criteria for Inclusion Form, and I can confirm that you meet the criteria for inclusion. To reiterate, participation in this study is completely voluntary, if at any point during the interview you change your mind and decide to discontinue your participation, we will stop immediately. The interview will be recorded and stored on a password protected computer.

Shall we begin?

1. What three words would you use to describe yourself as a CME professional?
2. What is your current professional title?
3. Tell me about your current position.
4. How do you describe your current position to someone else not in the field?
5. What was the catalyst that provided you with the pathway to apply to your first role in this field?
6. What was your journey to get here? Can you describe your professional experiences prior to entering this field?
7. When thinking about the term "professional identity" How do you describe your own professional identity to someone else?
8. What role does your professional identity play in your overall sense of self?
9. How have you become the professional you are now?
10. Can you walk me through the key milestones in your career so far and describe how they have influenced your professional identity?
11. In your own words, what are the roles and responsibilities of a non-clinical CME professional?
12. What factors or influences along the way have played a significant role in shaping how you professionally think about yourself?
13. Were there any times where you have felt like an outsider in the field or felt excluded?
14. Conversely, have there been situations in the workplace where you felt "at home", comfortable or included?
15. How does being part of a professional community influence your sense of identity?
16. Think back to before you got the job what did you imagine a career in this field would be like?
17. How has your perception of your professional identity changed over time?
18. How many different individuals would you say enabled you to progress in your professional positions?
19. Can you describe relationships in your work that have shaped who you are professionally?
20. Think about the different positions you have had. Were there individuals who helped or hindered you while you were in each position?
21. Who helped you and how did they help you?
22. Who hindered you and how did they hinder you?
23. What are examples of positive support you experienced?
24. Can you tell me about a time when you overcame a significant obstacle in your career?
    a. How did this experience change your approach to your profession?

25. What, if any, other professions, options, or alternatives did you have in mind before working in CME?
26. How would you describe the culture of our profession?
27. Do you feel like the culture is one that is established and thriving or one that is non-existent and detrimental?
28. How strongly do you identify with non-clinical CME professional culture?
29. Do you feel that your professional identity impacts how you are perceived by others?
30. To what degree do your moral beliefs and values algin with the field?
31. At what point in your career as a non-clinical CME professional did you realize you had progressed/learned a lot of information in the field?
32. When did you start to have confidence in your expertise?
33. In what ways do you believe your work makes a difference?
34. How much professional autonomy would you like to have, if at all?
35. Do you believe that in your current role you have access to sufficient tools to fulfill your job responsibilities?
36. How do you see your professional identity evolving in the future?
37. If you were asked to provide a recommendation about how to improve your profession, what would be your recommendation(s)?
38. Potential closing: Is there anything else you would like to add about our discussion of CME and professional identity?

Appendix F - Research Questions and Related Interview Questions

Research Questions	Related Interview Questions
Research Question #1: How do non-clinical CME professionals define professional identity? ?	1. What three words would you use to describe yourself as a CME professional? 2. What is your current professional title? 3. Tell me about your current position. 4. How would you define professional identity? 5. How do you describe your current position to someone else not in the field? 6. What was the catalyst that provided you with the pathway to apply to your first role in this field? 7. What was your journey to get here? Can you describe your professional experiences prior to entering this field? 8. In your own words, what are the roles and responsibilities of a non-clinical CME professional? 9. How many different individuals would you say enabled you to progress in your professional positions? 10. Think about the different positions you have had. Were there individuals who helped or hindered you while you were in each position? a. Who helped you and how did they help you? b. Who hindered you and how did they hinder you? 11. What, if any, other professions, options, or alternatives did you have in mind before working in CME? 12. How would you describe the culture of our profession? 13. How strongly do you identify with non-clinical CME professional culture? 14. To what degree do your moral beliefs and values algin with the field? 15. When did you start to have confidence in your expertise? 16. In what ways do you believe your work makes a difference? 17. Do you believe that in your current role you have access to sufficient tools to fulfill your job responsibilities?
Research Question #2 : How do non-clinical CME professionals perceive their professional identities?	1. When thinking about the term “professional identity” How do you describe your own professional identity to someone else? 2. What role does your professional identity play in your overall sense of self? 3. How have you become the professional you are now? 4. Can you walk me through the key milestones in your career so far and describe how they have influenced your professional identity? 5. What factors or influences along the way have played a significant role in shaping how you professionally think about yourself? 6. Were there any times where you have felt like an outsider in the field or felt excluded? 7. Conversely, have there been situations in the workplace where you felt “at home”, comfortable or included? 8. How does being part of a professional community influence your sense of identity? 9. Think back to before you got the job what did you imagine a career in this field would be like? 10. What are examples of positive support you experienced? 11. How has your perception of your professional identity changed over time? 12. Can you describe relationships in your work that have shaped who you are professionally? 13. Do you feel like the culture is one that is established and thriving or one that is non-existent and detrimental? 14. Do you feel that your professional identity impacts how you are perceived by others? 15. At what point in your career as a non-clinical CME professional did you realize you had progressed/learned a lot of information in the field? 16. How much professional autonomy would you like to have, if at all? 17. How do you see your professional identity evolving in the future? 18. If you were asked to provide a recommendation about how to improve your profession, what would be your recommendation(s)?

Appendix G - IRB Approval Letter

KANSAS STATE UNIVERSITY | University Research Compliance Office

TO: Susan Yelich Biniecki
Educational Leadership
Manhattan, KS 66506

Proposal Number IRB-12135

FROM: Lisa Rubin, Chair
Committee on Research Involving Human Subjects

DATE: 03/27/2024

RE: Approval of Proposal Entitled, "Professional Identity Formation Among Non-Clinical Professionals in the Field of Continuing Medical Education."

The Committee on Research Involving Human Subjects has reviewed your proposal and has granted full approval. This proposal is **approved for three years from the date of this correspondence.**

APPROVAL DATE: 03/27/2024

EXPIRATION DATE: 03/26/2027

In giving its approval, the Committee has determined that:

No more than minimal risk to subjects

This approval applies only to the proposal currently on file as written. Any change or modification affecting human subjects must be approved by the IRB prior to implementation. All approved proposals are subject to continuing review, which may include the examination of records connected with the project. Announced post-approval monitoring may be performed during the course of this approval period by URCO staff. Injuries, unanticipated problems or adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB and / or the URCO.

Electronically signed by Lisa Rubin on 03/27/2024 2:43 PM ET

203 Fairchild Hall, Manhattan, KS 66502 | (785) 532-3224 | fax: (785) 532-3278

Appendix H - Sample page from researcher's reflective journal

Date: 04/23/2024

As I listened to the participants' stories I found it unsettling that they were unable to articulate their roles in their organization, and the impact they have within their departments. It was as if they were explaining the erosion of their identities rather than the way in which they were formed. The human and very personal stories the participants are sharing are inspiring me to continue to move forward and to do so with vulnerability and clarity. When Dylan mentioned being a translator of her world, I was really hearing her call out for validation. She wanted me to know that her professional identity was about being seen, being heard, being validated, and not having to translate her worth. She was longing to belong, to be welcomed with open arms, to find a place to thrive, not just to survive. Having to constantly justify her value, was frustrating for her and was a way for her to adopt a survival tactic that was the gap needing to be bridged with Her determination was evident, and her desire to be helpful even in the face of her fear was what truly mattered to her. I am noticing a consistent pattern across the participants that I am finding alarming, as they all seem to be struggling with feelings of confusion, and for the most part are unable to articulate their profession, their professional identities, and seem to be experiencing some sort of disorientation of sorts.