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Exploring Professional Identity Formation of Community Preceptors as Medical Educators

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Abstract

Purpose

A sense of professional identity as a medical educator nurtures self-efficacy, commitment, job satisfaction, and motivation to engage deliberately in teaching which are essential in becoming an effective teacher. Engagement in communities of medical educators may foster the formation of a teacher identity. For community preceptors who practice in settings away from the medical school the formation of professional identity as educators is less understood. This study aimed to explore the formation of community preceptors' sense of self-identity as medical educators.

Method

Semi-structured interviews were conducted with community preceptors from two medical schools from May to July 2022. Transcripts were analyzed using open coding. Cruess et al. *Professional Identity Formation* framework was used to organize codes into categories and themes.

Results

Eleven community preceptors practicing in rural settings were interviewed. Participants reported feeling isolated, and lacking contemporary role models. They identified teaching faculty during their medical school and residency training as role models. Opportunities to socialize with other medical educators and engage in faculty development were limited. Clinical demands, time constraints, and practice location hindered their engagement and sense of belonging in the community of medical educators. Their self-confidence as educators was founded on their self-assessed competency as clinicians. They perceived clinical competency as most important in their ability to teach. They acknowledged the value of teaching in their professional growth and patient care.

Conclusions

Community preceptors had limited opportunities for socialization with other medical educators, faculty development, and engagement with the medical school. They attributed their self-confidence as medical educators to their self-assessed clinical competency. Teaching was valuable to their professional growth and patient care. More research is needed to better understand the factors influencing the formation of an educator identity in community preceptors to develop strategies for their successful integration into the community of medical educators.

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Clinical training in community settings has become essential in preparing medical students for the practice of medicine.[1,2] More than half of US medical schools use community-based clinical sites for student training, and some schools depend entirely on community physicians (e.g., community preceptors) to train their students.[3-5] While these community-based physicians are highly skilled in the practice of medicine, many may have limited or no formal training in education, and may lack confidence as medical educators.[6] Preceptors in rural communities have expressed concerns about lack of support from the medical school and feeling undervalued and less prepared in their teaching roles.[7] Community preceptors in family medicine who felt competent about their teaching skills and connected with the medical school were more motivated to teach.[6] However, best practices on how to engage and prepare community preceptors for their role as medical educators are lacking.[8,9] Faculty development (FD) for community preceptors has focused on teaching skills, but little is known about its impact on learners and community preceptors' development of a teacher identity.[10] A sense of self-identity as a medical educator (e.g., teacher) is important, influencing a physician's decision to teach and pursue FD opportunities which may improve their confidence and skills as educators.[11]

Professional identity formation is a dynamic process that encompasses how individuals understand themselves, interpret experiences, choose to present themselves, wish to be perceived by others, and are recognized by the broader community.[12] Social and individual factors, roles, memberships, and context influence the way individuals self-identify.[13,14] For new teachers, the school environment, the nature of learners, the impact of colleagues and school administrators, and their own experiences influence their teaching practices and how their teacher identity is shaped overtime.[15,16] A sense of professional identity contributes to teachers' self-efficacy, commitment, job satisfaction, and motivation to engage deliberately in teaching which are essential in becoming an effective teacher.[17-19] Furthermore, professional identity formation relates to agency; as teachers begin to construct their identity as educators, their ability to imagine future actions within their teaching practice increases as does their participation in contexts that will enable them to practice effectively.[20]

Thus, professional identity formation is a relational process that results from a synergistic interaction of internal-external factors and takes place in various contexts.[21] Teachers in health professions education may have more than one professional identity. For some, being a teacher is the most important part of their identity, but for others being a clinician or researcher may be more central in their self-sense of professional identity.[22] Additionally, individuals may adopt different identities depending on the context or adopt a unique combination of different identities.[23] Through active engagement in the community of medical educators (e.g., communities of practice),[24] teaching physicians develop a sense of belonging in the community of medical educators,[25,26] *access competence* and gain a sense of *meaning* as educators.[24,27-29] Teachers who are not successful in connecting with a community of educators may have difficulty in self-categorizing themselves as teachers, find themselves in professional isolation, and may be less informed in their teaching practice which can affect quality of teaching.[30]

Theoretical Framework

In this study, we used Cruess et al.[27] framework on *Professional Identity Formation* (PIF) to explore the process of community preceptors' professional identity formation as medical educators. This framework builds on Kegan's[31] constructive-developmental theory of *Social Maturity* that posits individuals construct their experiences through stages and make meaning in any given situation by building upon previously acquired knowledge.[32] Cruess et al.[27] adapted Kegan's[31] *Imperial* (e.g., individual's awareness of their own and others' experiences), *Interpersonal* (e.g., more mutual relationships become possible), and *Institutional* (e.g., understanding of systems and greater autonomy become possible)[31] stages of identity formation to describe the development of PIF in medicine. This framework[27] has been used to understand the process of PIF in medical students and residents,[27,33] and in basic science and clinical teachers in international academic settings.[29,34] We deemed this framework relevant to teaching physicians in community settings. This is the first study to our knowledge using this framework to

explore teacher identity formation in community preceptors. The research question that guided our study was:

What is community preceptors' sense of self-identity in becoming a preceptor/ medical educator?

Our findings may be helpful to faculty developers and medical schools in designing programs that support the formation of a teacher identity in community preceptors.

Methods

Setting

We conducted a qualitative descriptive study[35,36] to investigate a topic that is less studied but important. We chose the descriptive approach considering that we used a theoretical framework (e.g., PIF) to explore further the study findings and characteristics of the PIF phenomenon in the context of community preceptors. The descriptive approach allows researchers to provide a detailed "summary of an event in the everyday terms of these events" by exploring the meanings participants attribute to that event (e.g. teaching medical students in a community setting).[37] We applied a "grounded theory overtone"[36] to our approach to explore a topic less studied, but our aim was not to produce a theoretical rendering for the phenomenon.[38] We followed the Oxford Equator Network Guidelines[39] and Standards for reporting qualitative research[40] in our approach and to report our findings.

In our study, community preceptors were affiliated with two public medical schools that had different characteristics, including organizational structure, location, and student class size. *Medical School A* was community-based and located on the US-Mexico border with a class size of 120 students. *Medical School B* was located in the Pacific Northwest with a class size of 270 students who were dispersed at campuses across five states. The main campus was an academic medical center, while the four regional campuses were community-based. Community preceptors affiliated with *Medical School B* were from the same regional campus.

Participants

We defined a community preceptor as a practicing physician (i.e., MD or DO) who taught medical students, residents, fellows, and other health profession students in a community-based clinical setting and held an affiliate clinical faculty appointment or served as a volunteer at the partnering medical school. In our study, participants were practicing in underserved rural communities (except for one preceptor practicing in an underserved urban setting). The community preceptors varied in characteristics, such as specialty (e.g., family medicine, internal medicine, pediatrics), type of practice (e.g., solo, group, or hospital-owned), and years of experience as physicians and as preceptors. We identified the participants after input from each school's leadership overseeing medical student preceptorship experiences. We followed a maximum variation sampling[41] approach by selecting a small number of participants with diverse characteristics from each school to ensure broad representation and optimize data sources relevant to the research question.

Data Collection and Analysis

We contacted participants via email and conducted semi-structured interviews over video conference from May to July 2022; interviews were forty-five minutes to an hour in duration. We developed the interview questions (Supplemental Digital Appendix A) through an iterative process with participation of all the co-authors and assessed their face validity based on our experience as researchers and educators. The interview questions broadly explored how community preceptors perceived themselves in their dual role as practicing physicians and medical educators. In addition, the questions explored opportunities for FD, mentorship and role models, and the role of socialization with peers and clinician-educators from the medical school in the formation of the community preceptors' identity as medical educators. This work expanded on our previous work that examined the perceptions of community preceptors about their teaching roles.[42]

IA transcribed the interview narratives verbatim, replaced any identifying information with pseudonyms, and collated the final transcripts into a single document. Each of the co-authors used open

coding independently to conceptualize the data and axial coding to connect open codes into categories, and subsequently performed independent thematic analysis to identity themes and subthemes.[43] We used Morse[44] definition of category as "a collection of similar data sorted into the same place" to identify and describe the characteristics of each category and compare it with the other categories. Our use of themes reflected a meaningful "essence" that ran through the data.[44] We held consensus meetings to discuss our findings from the analysis and agreed on codes, categories, and constructed themes. We resolved any disagreements after discussion until we reached consensus. We used Cruess et al.[27] PIF framework to organize codes into categories and themes. Specifically, the PIF framework considers different stages of professional identity formation in medicine. The first is "imperial", which posits individuals can assume professional roles, but are primarily motivated to follow rules. "Interpersonal" is the second stage, suggesting individuals assuming professional roles are keen on seeking out role models. In the "institutional" stage, an individual starts to identify with the profession and internalizes professional values.

Trustworthiness

To ensure trustworthiness, we engaged the participants in the process of member checking. Additionally, we conducted peer debriefing by engaging outside peer researchers with expertise in this field in giving feedback on the interpretation of transcripts and quality of interview process. We used maximum variation sampling approach to optimize representation of community preceptors in answering the research question.[45] Through reflexivity, we acknowledged our own biases and assumptions as educators (IA, RB, AK, GBD, JS) and preceptors (IA). Within the context of the study, we considered how our professional background, experiences, and prior assumptions may have influenced our interactions with the participants (IA) and data (IA, RB, AK, GBD, JS). IA is a clinician-educator who has previously served as a preceptor and conducted the study as part of her doctoral dissertation under the guidance of the co-authors who are non-clinician educators and researchers with expertise in qualitative methodology and education. As an interviewer, IA was introducing herself as a doctoral student, setting aside her own views and reactions, and listening from the perspective of the researcher. The study was approved as exempt by the University's Institutional Review Board as research involving the use of educational tests (e.g., interviews) and obtaining information in a manner that human subjects cannot be identified (Category 2, §46.104).[46]

Results

Eleven community preceptors participated in the interviews that explored their sense of self-identity in becoming a preceptor/medical educator. Four preceptors (Drs. P, A, S, and C) were affiliated with *Medical School A* and seven (Drs. B, M, J, R, T, F, D) with *Medical School B.* Seven preceptors were practicing Family Medicine, three Internal Medicine, and one Pediatrics. Four preceptors were male and seven female; gender was self-identified. Female participants were more likely to mention work-life balance and making adjustments in their teaching or clinical practices to manage priorities. The clinical practice locations were rural (30 minutes to 6 hours distance from the medical school); one practice was in an urban underserved area. Eight preceptors were in a group practice and three were practicing solo. Teaching experience ranged from 2-29 years (Table 1).

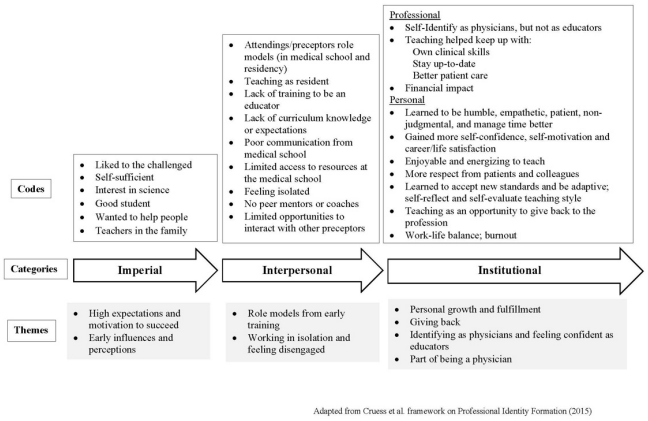
Table 1: Community Preceptors' Specialty, Preceptorship and Teaching Experiences, and Engagement in Faculty Development

Name	Medical School	Specialty	Years in Practice	Years as Preceptor	FD Development	Other Opportunities to Connect/Engage
Dr. P	*A*	FM	15	15	None	Syllabus with expectations sent from the medical school Attends workshops offered by state FM organizations
Dr. A	*A*	FM/Sports Medicine	6	2	Once a year lunch lecture at regional site	None
Dr. S	*A*	FM/OB	3	2.5	None	None
Dr. C	*A*	FM	35	6	None	Academic Fellowship after residency training
Dr. B	*B*	IM	28	9	Sporadic 1-day retreats	Occasional dinners organized by the medical school
Dr. M	*B*	IM	36	22	None	"Bullet points" sent from the medical school on expectations
Dr. J	*B*	Pediatrics	16	7	None	Preceptor Dinner (on hold due to pandemic)
Dr. R	*B*	FM	25	10	None	None
Dr. T	*B*	IM	34	29	None	Attended workshops at main campus in past role as site-director Dinner for preceptors (1-2 times per year)
Dr. F	*B*	FM/OB	5	3	None	1-2 training workshops for role as student mentor
Dr. D	*B*	FM	21	21	None	Appreciation Dinner (annually)

FD: Faculty Development; FM: Family Medicine; FQHC: Federally Qualified Health Center; IM: Internal Medicine; OB/GYN: Obstetrics/Gynecology

Through open coding, we analyzed the data, and subsequently connected open codes into categories.[44] These categories were based on the stages of the PIF framework which allowed us to construct themes.[27] Figure 1 displays the open codes, categories, and themes. The arrows represent the continuous and sequential stage development of a community physician into a medical educator.

Figure 1: Themes with Their Respective Codes and Categories



Adapted from Cruess et al. framework on Professional Identity Formation (2015)

Supplemental Digital Appendix B provides additional representative community preceptors' comments not included below.

Imperial

In this category, individuals consider views of others, but their decisions are predominantly driven by their personal needs, interests, and goals.[27] At this stage, the lens individuals use to "make sense" of the world (e.g., career path) does not enable them to see the limitations and biases,[32] but their decision is mainly driven by emotions and desire to follow the rules and maximize personal rewards. In this category, codes included "self-sufficient" and "liked to be challenged." Figure 1 illustrates all of the codes.

High Expectations and Motivation to Succeed

Community preceptors reported that they liked to be challenged and wanted to be self-sufficient.

"I always wanted to be completely self-sufficient. I liked things that sounded like they would be difficult." (Dr. M)

Early Influences and Perceptions

At a young age, some participants considered teaching as a career while they were trying to "make sense" of the world, growing up in families with teachers. But later in life, they changed their mind and decided to pursue a career in medicine.

"I enjoy explaining things to people, and that's one of my primary satisfactions in being a doctor. I just felt it would be enjoyable to have students." (Dr. B)

Interpersonal

In the Interpersonal stage, individuals tend to seek out role models, are self-reflective, and prioritize obligations over self-interest. Codes falling into this category included "attendings/preceptors role models," "teaching as a resident," and "limited opportunities to interact with other preceptors" (Figure 1).

Role Models from Early Training

Community preceptors identified teaching attendings from medical school and residency as their role models. Learning from these faculty inspired them to teach and emulate their teaching approach. Some participants highlighted the value of their learning experiences from rural community preceptors, and the impact of these experiences on their decision to practice primary care in an underserved setting. Some participants even returned after residency to practice in the rural communities where they trained as students and joined the preceptors they worked with as students.

"I couldn't ask for a better residency program; so bringing some of those pieces along, and some of the things they had taught me. I wouldn't be here if it wasn't for some of them (teaching attendings), for sure." (Dr. S)

Working in Isolation and Feeling Disengaged

Preceptors felt isolated and lacked knowledge of the medical school curriculum or expectations from them. They reported limited to no interactions with medical educators from the medical school or feedback on their teaching performance. One participant reported "mostly operating in the dark." (Dr. R). Participants also commented on how their

work as practicing physicians in a clinic can be "lonely" (Dr. T) or "solitary work" (Dr. B)

"I am so distant from the mothership, so I don't really know how students do other rotations. I just know what students have told me and the reason why they like to come to where I'm at." (Dr. C)

"As a community preceptor, I feel I interact with other people very little. And I get a little bit of feedback from one of the directors over there (medical school), but more just kind of offhand." (Dr. M)

Participants reported limited FD opportunities available to them. Some preceptors had attended sporadic workshops, but most were unable to because of clinical duties or other responsibilities. Some participants learned by doing.

"But in terms of teaching my medical student preceptees, I actually had no formal teaching at all, and have made it up as I go along." (Dr. M)

In addition, there were limited opportunities to socialize with medical school faculty or other community preceptors. One preceptor participated in the White Coat ceremony putting the white coat on the student they worked with which gave "a glimpse of the relationship that was built." (Dr. T) Some preceptors were invited to an appreciation dinner, although some could not attend such events due to family responsibilities.

"You did get to see who else does this (precepting). But I don't remember actually reaching out to anybody or collaborating. So that's probably not very good. It wasn't really to mingle and interconnect; it was kind of a fancy presentation." (Dr. D)

Community preceptors working in a group practice were interacting and learning from their clinic partners who were also preceptors.

"I wouldn't say there's any formal mentorship. At our practice, it's kind of a shared value that we teach medical students." (Dr. F)

Preceptors found it difficult to access the medical school's resources and had to go through a tedious application process to obtain a clinical faculty appointment.

"And eventually, after jumping through hoop after hoop, I got volunteer faculty status. It ended up getting me nothing. It brought about a bunch of annoying emails and things that they wanted me to do that were irrelevant to my position." (Dr. M)

Institutional

At the Institutional stage, individuals have embraced and internalized the values of their profession; they are able to understand relationships in terms of values, expectations, and standards.[27] Codes falling into this category included "learned to accept new standards and be adaptive", "identify as physician", and "teaching as an opportunity to give back to the profession" (Figure 1).

Personal Growth and Fulfillment

The participants found teaching to be enjoyable, meaningful, energizing, and fulfilling. Being a medical educator required organization and time management skills, and willingness to share their patients.

"I feel good about being involved in teaching, and having that, I get good feedback from my patients and my students which makes me feel good about my career and myself." (Dr. B)

Teaching kept community preceptors sharp and up to date in their specialty because "students a lot of times would come up with questions." (Dr. A) Participants commented on how students' enthusiasm helped their own motivation and increased their job satisfaction. Dr. C noted how teaching gave "a sense of purpose and legacy" and "sharing your wisdom for the next generation of doctors that are going to be taking care of you and your family." Their teaching role also motivated them to self-reflect and "do more than in their ordinary schedule." (Dr. B)

"It's been an amazing blessing to my practice (teaching), to me individually, personally, professionally, and it's really paid dividends to my community. I view what I do as a force multiplier to try and advocate for rural health and care of the vulnerable." (Dr. P)

But having a student in the clinic slowed participants down and had a negative financial impact. Balancing patient care and teaching was challenging. Teaching taught them to be patient and non-judgmental when students were lacking knowledge or skills.

"I think humility to learn from your trainees and empathy that they're not finished with school yet, and so they can't be expected to know all the diagnosis, physical exam skills and treatments." (Dr. P)

Giving Back
Community preceptors felt obligated to give back to the profession and hoped to inspire medical students to pursue careers in primary care.

"I recognize that there are not many doctors that do it (teaching), and if we want to encourage students to be primary care doctors, we have to train them." (Dr. C)

Identifying as Physicians and Feeling Confident as Educators
Participants reported being passionate about both medical education and primary care. They felt confident in their role as medical educators, and identified themselves as physicians.

"My primary identity is as a physician. And I consider that I have the privilege to teach medical students. I would not want to give up my primary profession because I find it very satisfying." (Dr. B)

Community preceptors highlighted their strong commitment to patient care that was taking precedence over teaching. Some participants noted that being medical educators "made them better doctors." (Dr. T)

"I really see hosting trainees as a way to learn more. I learned from trainees, probably more than they learned from me, and I've thought of it also as a better way to take care of patients." (Dr. P)

Participants noted their teaching role gave them more respect and credibility from colleagues and patients. Many preceptors acknowledged their own "doubts" (Dr. T) as educators and appreciated the feedback from students that helped them become more confident as educators.

"I feel as though I'm learning more. I feel that I'm providing better care. I really feed off the enthusiasm of these students, and I hear so much validation from the students about the type of practice that I have." (Dr. P)

Part of Being a Physician
Some preceptors viewed the practice of medicine intertwined with teaching as they often taught their patients how to live a healthy life. Some participants considered it part of being a physician.

"I always knew I enjoyed teaching and I wanted to have it in my life and career as a doctor." (Dr. F)

Discussion

Our study explored rural community preceptors' sense of self-identity in becoming a preceptor/medical educator. Participants felt confident as medical educators, which they attributed to their self-perceived competency as physicians and ability to stay current in their specialty. Patient care often impeded their teaching responsibilities and ability to maximize their performance as medical educators. Work-life balance, especially for female participants, and practice location hindered engagement with and a sense of belonging in the medical education community. The limited engagement with the medical school made them feel isolated and unsupported. Our findings concur with other studies suggesting that competency and relatedness through intrinsic and external rewards (e.g., formal recognition, awards) can propel self-motivation to teach.[6,7,10,32]

In our study, preceptors' identity was influenced early in life by their home environment as they were trying to make sense through their emotions and self-perceptions of rewards (e.g., Imperial Stage).[27,31] Their decision to pursue medicine as a career was driven by their altruism and desire to help others, although they were cognizant of the challenges associated with pursuing a career in medicine. Participants reported clinical demands, time constraints, and other competing responsibilities to challenge their dual role as physicians and educators. However, their desire to

give back to the profession and aspiring role models from their early training propelled and supported their intrinsic motivation to teach. These findings reflect the dynamic process of identity formation where at the Interpersonal Stage[27] individuals continue to shape their identity influenced by role models and prioritize obligations (e.g., teaching, patient care, giving back to the profession) over self-interests (e.g., free time, financial benefits).

Furthermore, our results highlighted the challenges community preceptors face as they try to balance and harmonize the two components of their dual role, often with little support from the medical school. At this stage of their identity formation (Institutional Stage),[27] participants had embraced and internalized the values of their profession, and were trying to exemplify these values through their dual role. Community preceptors had accepted the standards set by the medical school and learned to be adaptive, often perfecting their teaching skills through trial and error. Yet, expectations from the medical school for these teaching physicians were similar to their academic counterparts.

In our study, community preceptors felt isolated and had limited opportunities for formal training in teaching skills through participation in FD. Competing demands, time constraints, and location were additional barriers impeding their ability to engage even when FD offerings were available. Our results illustrate a missed opportunity for medical schools to be more intentional in their efforts to actively engage community preceptors in their educational program and welcome them in their community of educators. Recognizing the value of their contributions to the medical school through engagement and formal recognition (e.g., awards) can go a long way, especially with the increasing physician burnout[47,48] and community preceptors' attrition rates.[8,49] Additionally, creating opportunities for community preceptors to participate in the curriculum in other ways, such as contributing in the development of curricular content, or serving on medical school committees, when possible, can nurture a stronger relationship and a sense of belonging in the medical school and its community of medical educators.

Our findings support the crucial role of socialization in the formation of professional identity. Through socialization, clinicians can move from peripheral to full participation and become members of the community of medical educators which can help them solidify their identity as educators and have a positive impact on their intrinsic motivation to teach, and on their productivity and job satisfaction. In addition, socialization with other medical educators can offer community preceptors opportunities for experiential learning and mentorship, allowing them to transition from a layperson to a fully recognized professional (e.g., medical educator) with a well-defined identity.[29,50-54] In our study, experiential learning occurred primarily during medical school and residency where teaching attendings served as role models. These learning experiences influenced the community preceptors' decision to teach after several years when practicing medicine. Many participants emulated the skills and behaviors they learned from their teaching attendings in their own teaching approach. Yet, their socialization with other practicing physicians in their local community may have nurtured their self-identity as physicians.

In the higher education context, Van Lankveld et al.[22] described five processes in the development of a teacher's identity: a sense of appreciation; connectedness; competence; commitment; and imagining a future career trajectory. In our study, community preceptors did not feel appreciated, but undervalued and isolated, and did not view teaching as a career path, which may explain their lack of self-identification as medical educators. For Browne et al.[55] the increased social capital associated with the medical profession can sway physicians to see themselves as clinicians rather than teachers. Additionally, the degree of engagement and agency in conjunction with mentorship are important factors in the formation of teacher identity.[55,56] In our study, the sense of isolation, lack of contemporary role-models and mentors, and limited socialization with other medical educators may have hampered the formation of community preceptors' identity as medical educators.

Furthermore, our findings may be explained by the fact that volunteer community preceptors' primary career aspiration and responsibility is patient care

while teaching is typically optional and an addition to their clinical responsibilities, playing a smaller role. In contrast, a teaching physician in an academic context may have different career goals and aspirations that could influence their professional identity formation as educators. Additionally, academic clinicians generally have more opportunities for FD and active engagement with other medical educators and mentors in their setting which can affect the relationship between having an identity as a clinician and teacher.[57,58] Teaching physicians constantly try to reconcile their teaching with their clinician identities by juggling the two, finding mutuality between them, or forging merged identities to minimize tensions between their educational and clinical roles.[34]

Existing literature has focused on teaching physicians practicing in academic settings that are generally hierarchical social contexts.[34] Our study suggests that the dynamics in the dual role of clinician-educator may be more complex in non-academic contexts, such as community settings that often have different structures and priorities (e.g., solo practice). Additionally, the process of teacher identity formation in community preceptors may not be fully developed and could be different compared with the process in academic teaching faculty. Whether FD could potentially facilitate the full development of community preceptors' identity as medical educators is less understood,[10] highlighting a need for more research in this area. Considering the differences that may exist in the formation of a teacher identity between academic and community teaching faculty, medical schools should consider personal, relational, and contextual factors in the design of programs for community preceptors, capitalize on mentorship, and offer opportunities for active engagement in the medical school's community of educators.[11,59-61]

Our study had limitations. Our participants were community preceptors practicing in rural areas and affiliated with community-based medical schools located in medically underserved regions in the US. Thus, our findings may not be generalizable to academic clinician-educators, community preceptors practicing in other settings, or medical schools with different organizational structures or locations. A convenience sample of community preceptors was selected which could introduce selection bias. However, we followed a maximum variation sampling approach to ensure broad representation of specialties, types of practice, and levels of experience as preceptors to provide as broad a perspective as possible. Furthermore, we followed a descriptive approach and utilized member checking, peer debriefing, and reflexivity to ensure study trustworthiness.

We used the Cruess et al.[27] framework that provided a useful guide, but may have to some extent narrowed our lens, focusing mainly on the role of socialization in professional identity formation and on academic settings. In community settings, there may be additional factors influencing the formation of a teacher identity, considering that community preceptors are a more heterogenous group with priorities, goals, and needs that may not necessarily align with those of academic clinician-educators. Future research should further explore these factors given the increasing dependence of medical schools on community preceptors for their students' clinical training.

Conclusion

Drawing on Cruess et al.[27] PIF framework, this study explored community preceptors' sense of self-identity in becoming a preceptor/medical educator. Our findings suggest that community preceptors felt disengaged from the medical school and had limited opportunities for socialization with other medical educators. They aligned themselves with established identities in medicine (e.g., clinician) rather than a teacher. Their self-confidence as educators was founded primarily on their self-assessed competency as clinicians, indicating that their teacher identity may not be fully developed. Therefore, it becomes important for medical schools to create environments that support the engagement of community preceptors with their medical educators' communities, and develop FD programs intentionally to cultivate their identity as medical educators. More research is needed to better understand the factors influencing medical educator identity formation in community preceptors to develop strategies for their successful integration into the community of medical educators.

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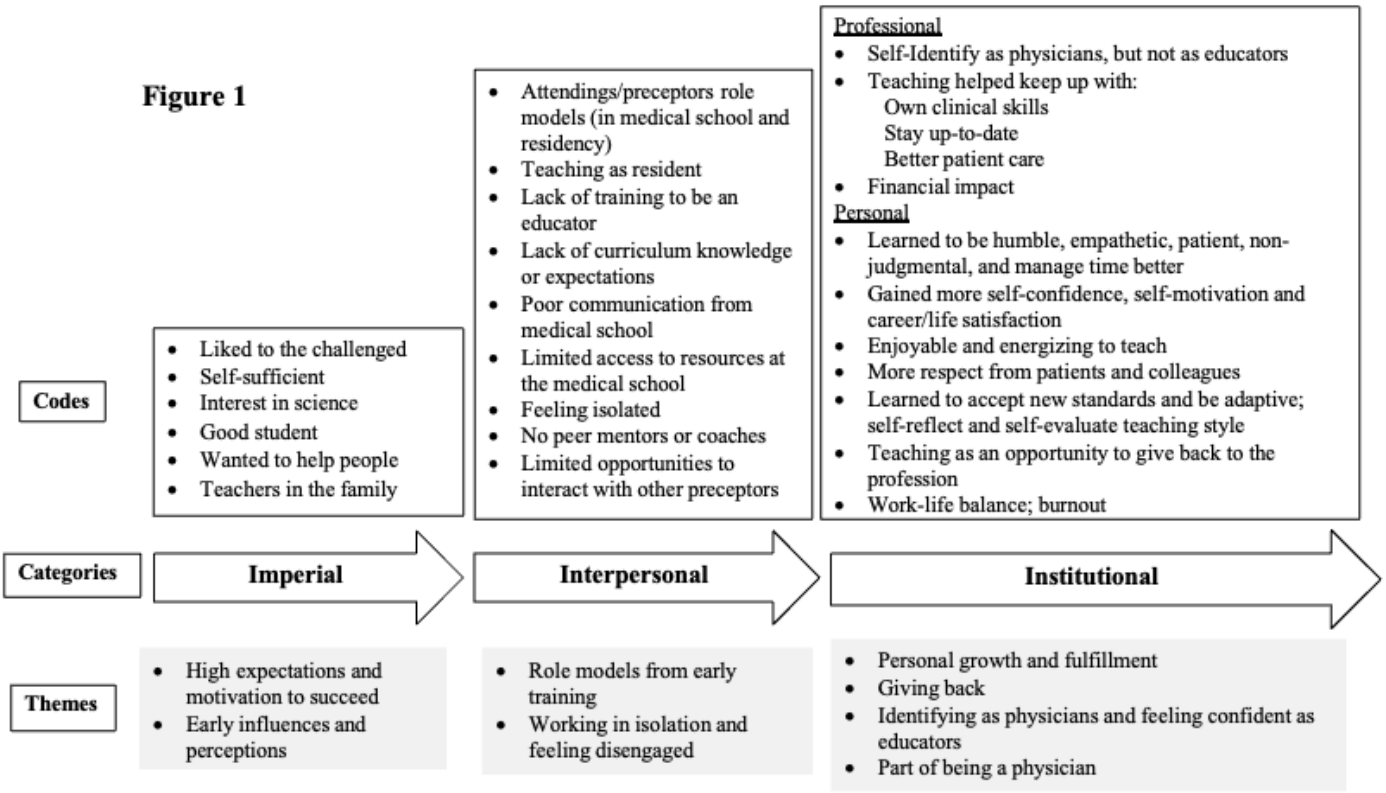
Legends:
Table 1: Community Preceptors' Characteristics, Specialty, Practice Type, Preceptorship and Teaching Experiences
Figure 1: Themes with Their Respective Codes and Categories
Supplemental Digital Appendix A: Interview Guide
Supplemental Digital Appendix B: Representative Comments from Interviews with Community Preceptors

Table 1: Community Preceptors' Specialty, Preceptorship and Teaching Experiences, and Engagement in Faculty Development

Name	Medical School	Specialty	Years in Practice	Years as Preceptor	FD Development	Past or current Opportunities to Connect/Engage
Dr. P	*A*	FM	15	15	None	Syllabus with expectations sent from the medical school Attends workshops offered by state FM organizations
Dr. A	*A*	FM/Sports Medicine	6	2	Once a year lunch lecture at regional site	None
Dr. S	*A*	FM/OB	3	2.5	None	None
Dr. C	*A*	FM	35	6	None	Academic Fellowship after residency training
Dr. B	*B*	IM	28	9	Sporadic 1-day retreats	Occasional dinners organized by the medical school
Dr. M	*B*	IM	36	22	None	"Bullet points" sent from the medical school on expectations
Dr. J	*B*	Pediatrics	16	7	None	Preceptor Dinner (on hold due to pandemic)
Dr. R	*B*	FM	25	10	None	None
Dr. T	*B*	IM	34	29	None	Attended workshops at main campus in past role as site-director Dinner for preceptors (1-2 per year)
Dr. F	*B*	FM/OB	5	3	None	1-2 training workshops for role as student mentor
Dr. D	*B*	FM	21	21	None	Appreciation Dinner (annually)

FD: Faculty Development; FM: Family Medicine; FQHC: Federally Qualified Health Center; IM: Internal Medicine; OB/GYN: Obstetrics/Gynecology; Pandemic: COVID-9 Pandemic; Gender as self-identified; M: male; F: female

Figure 1



Adapted from Cruess et al. framework on Professional Identity Formation (2015)

Supplemental Digital Appendix A

Interview Guide

Welcome and Introductions (5 minutes)
The introduction will set the stage for the interview and serve as an icebreaker. I will begin by welcoming the interviewee, introducing myself, and briefly mentioning the purpose and duration of the interview.
Background Questions (10 minutes)

In the first part of the interview, I will ask a few questions about the participant's background, medical training (e.g., medical school, residency, and any other post-graduate training), and current practice.
Community Preceptors Professional Identity Formation (40 minutes)

This is the central part of the interview. I plan to spend about 40 minutes to explore how community preceptors view the role of medical educator and perceive themselves in that role. I will ask the participants about their experiences, motivations and actions to become educators, challenges they face, and the way they shape their identity as educators while practicing as clinicians.
Reflection and Closure (5 minutes)

I will ask the participants to share any advice they may have and add any closing remarks.
Interview Questions

Welcome and Introductions

- Good Morning/Afternoon Dr._, thank you for taking the time out of your busy schedule to meet with me today.
- My name is... I am conducting a research project at the University of…to better understand how community preceptors view the role of medical educator and perceive themselves in that role. I am particularly interested in understanding how community preceptors develop their professional identity as educators and transition from the role of clinician to the dual role of clinician-educator.
- We have about 60 minutes to talk about your experiences as a community preceptor. The study has received the IRB approval of the University of … and any information gathered from the interview will be de-identified and remain confidential.

Background Questions

- Tell me about yourself.
- What is your specialty?

- What inspired you to become a medical doctor?
- Where did you go to medical school?
- Where did you do your residency?
- How many years have you been practicing?
- How long have you been a community preceptor?
- What caused you to become a community preceptor?

- Have you received training to be an educator?

Community Preceptors Professional Identity Formation

- Tell me how you identify yourself when they ask you "what you do" at social gatherings
- Tell me about any experiences that led you to consider volunteering to teach medical students
- Tell me how important medical educators were for you during your medical training
- How do you view yourself? Do you view yourself as an educator?

- How does your role as an educator affect your professional relationships?
  - How does it affect your clinical practice?
  - How does it affect your satisfaction at work?
- After choosing to volunteer as a community preceptor, describe any steps you took to prepare yourself for this role

o What were some of the challenges?

  - Were there any factors that facilitated your preparation for your role as a medical educator?
  - What skills do you think you need to be a community preceptor?
  - What new skills did you learn to be a good/effective medical educator?
    - If any?
  - How confident do you feel in your role as a medical educator?
  - How satisfied are you with your choice to serve as a community preceptor?
- Were there any people who influenced you as you were developing your own identity as a medical educator?
  - Do you have any mentors and coaches?
    - Tell me about them.
  - Who do you network with?
- Have you attended any professional development sessions on teaching skills?
- What factors do you think would be most helpful in supporting community preceptors in their roles as medical educators?
- How do you think the medical school can help community preceptors who volunteer to teach medical students?

Closing Questions and Remarks

- What else would you like to share?
- What advice do you have for community physicians who consider volunteering to teach medical students?

End of Interview

Thanking the participant for their participation and time.

Supplemental Digital Appendix B

Representative Comments from Interviews with Community Preceptors

Imperial	
High expectations and motivation to succeed	"So, I wanted to have a job that left me financially self-sufficient and able to land on my feet wherever I might end up." (Dr. M) "I was always interested in health, and always interested in science and I was a good student. I looked at a lot of different things going through high school and college trying to figure out what I wanted to do." (Dr. B)
Early Aspirations of Being a Teacher	"I think I like doing it (teaching). I like to teach. If I were not a doctor, I probably would have been a college professor or a coach." (Dr. J) "I wanted to be like my dad (who was an obstetrician-gynecologist) … I guess I thought my other career choice was to be a special education teacher." (Dr. T)
Interpersonal	
Role models from early training	"It's like an apprenticeship process so I certainly know that I was educated and brought along and molded by people who took time from their schedule to educate me and I'm very thankful to them." (Dr. B) "It's kind of in medicine you have the person above you teaching you. If you're a first-year resident, you have a second year resident, and it goes up the line. It's kind of a natural part of medicine teaching those below you in training." (Dr. J) "My residency (program) director was fabulous! And he invested in us academically, spiritually; helped us be well rounded doctors, and helped us see the purpose and what we were doing. And so I would say my residency education was where I learned to be a compassionate doctor, with relationships with your patients, with meaning in your career. That's what I tried to bring to my students." (Dr. C) "And they (teaching attendings) took me in hand

	and taught me amazing clinical skills. So I respect them very highly, and still remember their names and their faces. And how they showed me respect and listened to me and gave me feedback." (Dr. M) "I work at a clinic now in part because I was a third-year medical student here, and I really enjoyed the clinic, and then my main preceptor you know, is part of the practice, and you know she still continues to work here." (Dr. F)
Working in isolation and feeling disengaged	"It's not like there's any central hub to interact with other preceptors." (Dr. J) "There was a dinner that we used to have. But it wasn't mandatory and when my kids were little, I just didn't go, and so then I went towards the end a couple times. I think people that are practicing medicine in general, are not really very good networkers because you have your own home, and you have this job. Maybe you just come in and you do your work. You're personally responsible for your work. And that's it. The professional obligation part. But it's essentially, it's quite solitary work anyway. You know you're not seeing people with your colleagues. You're not, you're doing your own thing. And then if you choose to be a community preceptor, you just have one more day that's even more of a hassle." (Dr. B) "So anything that medical schools can do to make community preceptors fill as they are a valued part of the team, and especially for rural physicians. Limiting the isolation of practicing by yourself." (Dr. P) "That just becomes a little difficult sometimes, so I've just developed ways of working students in so

	and getting them up to speed, which I think sometimes their schools have a different idea of how that will go than is realistically possible." (Dr. R) "I like teaching, and then also as a practice, I mean at some point or other, our pediatricians all taken students. And one of our partners has a third year rotation with a third year student; this is a pediatric rotation at our clinic, so we had a lot of students..." (Dr. J) "No, I don't think so (having any faculty development); just took a deep breath, and learned as I went. …" (Dr. T) "It is difficult for me to be able to get access (to the medical school). The pain part is to go through the main university channel; you are kind at the mercy of people that are in bureaucratic positions at the university that deal with all comers."(Dr. J) "I think, also goes a long ways to showing that there's a commitment from the medical school of helping us as well that it's not just about us receiving the students that there should be something in return and it may be something as simple as an award, or just improved access to education for the preceptor, and improved access to care for their patients. (Dr. P) "I wouldn't say that there's any specific training geared directly towards teaching residents or teaching medical students. I don't think I've had anything like that. But I just had good mentors in medical school, and kind of took some of the things that they've done and that I really liked and then incorporated that into what I do." (Dr. S) "I think it's weird doing it by myself. So, it was different in an educational program where there were other educators. So being in solo practice I'm on my own to begin with, trying to keep up without being in an educational environment myself. I think what we don't have is that educational environment to share." (Dr. R) **"**You have to fill out an endless application to be a

	clinical faculty member, and you have to wait about six months for your faculty membership approval. So, they make it way too hard." (Dr. T)

Institutional	
Personal growth and fulfillment	"But being a preceptor is a way to keep your hand into teaching. And it's fun because the students are very interested, very excited, too." (Dr. B) "Learning to, I guess not be too judgmental and not too fast to react when a trainee does something incorrectly, or has, you know, a very incorrect idea of a diagnosis or treatment." (Dr. P) "You look at yourself, and how you want to do better, or students will ask you. So you will go read something and look it up." (Dr. T) I'm up to date and I think that's part of the reasons I like having students is that forces me to do that. (Dr. R) "There is nothing like having someone look up to you. So you do your job day after day, and it can become a grind. But once someone comes and is in awe of what you do and wants to learn how to do what you do, it's very revitalizing. It gives you new inspiration and recognition that you are doing a job that's valuable." (Dr. T) "Patients come and go, and you can be very confident that you did something good for someone. And then they're gone, and it's over. Teaching feels more lasting." (Dr. T) "My patients respect the fact that I have a job teaching medical students. And I think my colleagues also respect the fact that I have a job teaching medical students, so I can't say that I don't value that. I do value that." (Dr. B)

	"It's a ton of fun, and I always feel like it was much, much more exciting day than it would have been without them." (Dr. M) "And so medical school education is for my own well-being and my own fulfillment and legacy." (Dr. C) "…allow some time for students to try and explore and find their wings. Because I don't think it's a lot of value for students to purely shadow once they're in medical school. So some of that requires loosening the grips of how my exact half day looks with the student compared to when I don't have a student." (Dr. F) "They (community preceptors) need to be patient for one thing, because, having a student with you in your work slows you down; students have a lot of questions." (Dr. T) "I tried many different ways to organize the afternoon so that this would work out well, and it's just difficult to work out well." (Dr. B) "Oftentimes I learn because my students ask questions, and I go, oh, I need to look this up, and sometimes, I learn something I didn't know before." (Dr. R) "It has been a point of pride for me that I have not been an academic physician which allows me to present students a different side than most of my academic colleagues." (Dr. M)
Giving back	"I will help inculcating you the values and interests in ethics and decision-making process that have created the subculture of being a medical doctor." (Dr. B) "Give them (students) an example of somebody who's enjoying their jobs so that they have something to look forward to and also to sort of instill in them some of the values that I have in terms of doing a job well and being kind to patients and enjoying the patient stories." (Dr. M) "…having the opportunity from job shadowing in high school and college to getting to do my rural experience as a student. So kind of paying it forward." (Dr. F) "I worked with some wonderful physicians (in

	medical school) who allowed me to take care of their patients, and I had a great time; really learned from these internists and certainly want to give back." (Dr. M)
Identifying as Physicians and Feeling Confident as Educators	"And, I had decided basically against academic medicine because I wanted to have a family, and that would have all had to take place at the same time period." (Dr. B) "We're saying I'm a doctor and teach you to be a doctor. So you're not saying I'm going to be, I'm a teacher." (Dr. B) "I go in with the student and then still have to do the documentation that I need to do professionally on a patient and to try and arrange that schedule- wise would be extremely challenging." (Dr. B) "I wouldn't say I teach medical students, or whatever that's not something…I don't label myself that way." (Dr. C) "I really don't think I have a hostile learning environment, but you know it's kind of trying to, I guess, evaluate your style." (Dr. B) "I find that it (teaching) causes me to learn things better. One of the things that I do with my medical students is that I will assign them a study to teach me the next time we see each other." (Dr. M) "I think negative feedback would have been interesting but would have also put me off of being a preceptor." (Dr. M) "I just need to demonstrate them, pick enough time to actually demonstrate them to the medical student, but they don't need me to be perfect." (Dr. M) "It is just simply because I think most people who ever are patients they want good doctors, and so they want to know that what they consider good people are educating future doctors." (Dr. D) "I still don't feel like by any means an expert, or that I can't continue to learn and improve. It's like trying to reach infinity, to become a good leader; you can never become the best leader, but you hope that you just keep trying to improve and get

	better." (Dr. P) "I do keep up with my continuing learning, and so that I'm able to teach. But I think it's more for the patients than for my ability to teach." (Dr. S) "I had to understand that I cannot meet the needs of all the students, and I will not be the most popular, but I might make an impact on one person at a time. I think that's how I look at what I did accomplish as a preceptor. I'm mentoring one person at a time, maybe people more like myself than very dramatic goals to be a in the limelight hero sort of doctor." (Dr. T) "I think the more skills you have, the better you are; so the better doctor you are, the more confidence you have, and the better preceptor you'll be." (Dr. M) "And a lot of my colleagues would say the same thing that the students push you; they ask why you do something. They watch what you do. So, you want to be doing your very best when you're demonstrating your work. So, I think it helps you be a much better doctor." (Dr. T) "Well, when a patient seems to have a sentiment, it's always positive; patients always seem to think that's a good thing. They're glad that I'm doing that." (Dr. D) "I don't think of myself as an educator; like in the academia faculty role, like that kind of way." (Dr. F)
Part of being a physician	"I was ready to have my own experience of being the doctor, so I didn't want to go into teaching immediately at that point when I was done (e.g., completing residency training)." (Dr. B)