

The Hidden Process of Positive Doctor Role Modelling

ABSTRACT

Background

Role modelling has been highlighted as an important phenomenon. The aim of this research study was to explore the process of positive doctor role modelling.

Methods

This study used focus group interviews with fifty two medical students, semi structured interviews with twenty five consultants and interviews after clinics with five consultants and five medical students. A qualitative methodology using the grounded theory inquiry approach of Strauss and Corbin was then used to generate an explanation of the process of modelling.

Results

Role modelling is an important process that involves conscious and subconscious elements and consists of an Exposure Phase followed by an Evolution Phase: The Exposure phase involves demonstration of the professional attributes by the doctor role models. The Evolution phase begins with observation of the role model by the modellee, following which the modellee makes a judgement whether or not to trial the observed behaviours of the role model; when the decision to trial is reached, this then leads to a Model Trialling Cycle.

Conclusion

This research study has generated a detailed explanation of the process of doctor role modelling in clinical practice. It is aspired that this can now be incorporated in medical curricula worldwide to enhance the development of the doctor role model and the professional development of the modellee.

Introduction

Role modelling has been highlighted as an important phenomenon in medical education (Skeff and Mutha 1998). The importance of role modelling in the professional development of learners has been illustrated by medical educators' worldwide (Passi et al.2010) and over the past decade there has been a growing body of literature on doctor role modelling in medical education (Irby 1986; Cruess et al.2008; Cote and Leclere 2000; Ricer 1998; Paice et al.2002; Passi et al.2013; Kenny et al.2003; Wright 1996; Wright and Carrese 2001). Role models have been defined as 'individuals admired by their ways of being and acting as professionals' (Cote and Leclare 2000). Role models in medical education are different from mentors as they influence and teach solely by example whereas mentors have a formal relationship with the student (Ricer 1998).

Role modelling has been described by Irby as the process in which 'faculty members demonstrate clinical skills, model and articulate expert thought processes and manifest positive professional characteristics' (Irby 1986). Role modelling has been described as a powerful educational strategy and one especially suited to the apprenticeship system of instruction in medicine occurring in all educational environments and throughout undergraduate and postgraduate medical education (Irby 1986).

A recent systematic review looked in detail at the evidence currently available on doctor role modelling worldwide (Passi et al. 2013). This review highlighted that most of the current literature on role modelling focuses on the attributes of the positive role models illustrating how role models demonstrate high standards of clinical competence, good teaching ability and set of personal attributes (Kenny et al. 2003; Wright 1996; Wright and Carrese 2001), but provided very little insight into what is happening when effective role modelling takes place and, as a consequence, how this process might be influenced.

If we are to maximise the potential of role modelling as a teaching strategy we need to understand in much more detail what is happening during this enigmatic process. Therefore, the aim of this research study was to explore the process of doctor role modelling. Whilst recognising that role modelling can be positive or negative (Paice et al. 2002), as a first step in developing a deeper understanding of the process of role modelling, this study focused solely on positive role modelling with the aspiration that this could ultimately lead to strategies to improve positive role modelling in clinical practice.

METHODS

Study design

A qualitative methodology using the grounded theory inquiry approach of Strauss and Corbin was used to generate a general explanation (a theory) of the process of role modelling based on the views of participants (Strauss and Corbin 2008). The epistemological stance of this study is analogous to that of Strauss and Corbin (2008). The intent of this grounded theory method is the development of a theory, 'grounded' in the data which enables understanding of the process under study (Strauss and Corbin 2008). This systematic, analytical approach uses iterative sampling, conceptual memoing and the simultaneous collection and analysis of data (Strauss and Corbin 2008). The research protocol, participant information sheet and consent forms were subject to external peer review and were subsequently granted institutional ethics committee approval.

Participants and sampling

The study was conducted in one Medical School in the UK. The study involved three different methods to ensure a detailed exploration into the process of role modelling with triangulation of the data, participants and settings: focus groups with final year medical students; semi-structured interviews with consultants; and semi-structured interviews with medical students and consultants immediately after clinics. The third method was used to investigate the immediate impact of role modelling and thereby address the risk of recall bias.

An iterative purposive sampling technique was used to recruit volunteers and the recruitment was voluntary. Participants were students in the final year at a graduate entry medical school and consultants invited to cover the main range of clinical specialities. All participants were given participant information sheets and asked to sign informed consent papers. Participant recruitment was maintained until data saturation was achieved (Morse 1995).

Data collection and analysis

The interviews lasted up to one hour. The focus group questions and semi structured interview questions explored aspects of the doctor role model and the role modelling process and are shown in Appendix 1. All the data from the interviews were audiotaped and transcribed by the principal researcher. N-Vivo version nine reference management software was used to facilitate the organisation of all the data systematically into themes (QSR

International). In line with the grounded theory approach, data analysis proceeded at the end of the interviews, prior to conducting the next interview (Strauss and Corbin 2008).

A constant comparative approach was used to determine the breadth and characteristic of each category. Using the systematic approach of Strauss and Corbin (2008), open coding, axial coding and selective coding methods were employed to reveal the processes involved in role modelling which are described and illustrated in a coding paradigm diagram in the results section (Figure 1).

RESULTS

The study involved 25 consultants interviews representing a total of 17 specialities (ten medical specialities, six surgical and general practice), with no more than three representative from one speciality. The study involved fifty two, final year medical students in twelve focus groups; there were 21 male and 31 female students (reflecting the gender composition of the year group). The focus groups sizes ranged from four students to eight students. In addition, the study involved interviews with five consultants and five medical students immediately after outpatient clinics.

The four components of the Strauss and Corbin (2008) Grounded Theory Methodology (central phenomenon, causal conditions, strategies and consequences) that were generated in the study are outlined below: -

- The central phenomenon: This is the category that held the most conceptual interest, is most frequently discussed by participants in the study and is most saturated with information. The central phenomenon in this study was the doctor role model.
- The causal conditions: these are the factors that influence or cause the central phenomenon to occur. Participants described six main attributes demonstrated by the positive doctor role model: clinical expertise, relationship with patients, colleagues and students, personality factors and inspirational characteristics.
- The strategies: These are the specific interactions or actions that are dependent on the central phenomenon. The participants described seven actions: - observation, judgement, assembly, emulation, experimentation, adaptation and assimilation.
- The consequences: These are the outcomes of the strategies. Three main outcomes of role modelling were identified – the development of professional behaviours, the

development of professional identity and the shaping of career aspirations. These are described in detail in a forthcoming paper on ‘the impact of doctor role modelling.’

In axial coding, the four components are portrayed in a Coding Paradigm/ Logic Diagram, which forms the basis of the theoretical model developed in grounded theory and is illustrated in Figure 1. As shown in Figure 1, the theory emerging from this analysis has two phases (an ‘Exposure Phase’ and an ‘Evolution Phase’) which are described in detail below. The transcripts illustrating the themes are presented in Tables 2 and 3 in the Appendix.

THE EXPOSURE PHASE

Clinical Expertise

The importance of modelling clinical expertise, confidence and competence was emphasised by the medical students and consultants. The importance of maintaining high standards of ‘*diagnostic and clinical skills*’ and of a ‘*comprehensive approach to management, treatment and investigations,*’ were highlighted. The consultants and medical students described role modelling occurring in all educational environments and throughout the curriculum.

Relationships with Patients

The importance of maintaining excellent relationships with patients was highlighted and consists of four main sub- themes: The first sub-theme was altruism, described as the importance of ‘*going the extra mile,*’ for the patient. The second sub-theme was the importance of maintaining ‘*compassionate care,*’ and a predominant observation was the importance of physical contact to comfort patients. The third sub-theme was the importance of ‘*patient satisfaction with their care*’. The final sub- theme was ‘*patient reaction to the doctor*’ in which the students were impressed by doctors who were clearly popular with patients.

Relationship with Colleagues

The importance of establishing and maintaining good relationships with colleagues was highlighted. The transcripts illustrate particularly well how the students observe the importance and impact of maintaining good relationships with colleagues, as they stated that ‘*in the future... I would prefer to be seen to be welcoming to all,*’ and how ‘*looking at how someone interacts with the rest of the staff and students makes a massive difference*’.

Relationship with Students

The positive role models welcomed the students and made them feel a valued, important member of the team. In addition, both the consultants and students stated that the role models explicitly described their clinical actions and decisions to the students which was particularly important when the consultation had not gone well. Role models were described as having an important influence on ‘*shaping*’ the personal and professional development of the modellees. Finally, the participants highlighted the importance of the quantity of time spent with the role model to observe the role model in different educational environments.

Personality

There was a consensus between both the doctors and the medical students that personality plays a large part in the modelling process, in that a student will emulate a doctor who they perceive is similar to them. It does not mean that they do not admire other people, but that in developing their own identity, students prefer to emulate someone who is similar to themselves. Medical students throughout their training are developing their professional identity and they are observing people who they feel that they ‘*could be like in the future*’.

Inspirational Characteristics

The medical students and consultants vividly described their inspirational role models. A synthesis of all the participants’ definitions would be ‘*a doctor role model is someone whom you admire and aspire to be like in the future.*’ An important feature was the role models’ *passion for medicine and love of their work*. The medical students were keen to be like the inspirational models as stated ‘*if I could be a doctor exactly like him then I would be happy.*’

THE EVOLUTION PHASE

Observation

As modelling is known to apply to a wide range of settings, in this paper we use a new term, ‘**the modellee**’ to describe the individual being influenced by the modelling process. The observation stage involves the observation of the role model by the modellee. The participants described how they observed the role models’ professional behaviours in clinical settings. The medical students emphasised that they were very inspired when observing humanistic qualities such as respect, compassion, good body language and empathy. A

consultant succinctly summarises that *'there is no substitute for seeing in action and doing in practice....you can't teach experience and role modelling is the same sort of thing.'*

Judgement

During this stage, the modellee makes a judgement whether or not to trial the observed behaviours of the role model. The judgement is based on whether the observed behaviour was perceived as positive or negative. There was consensus between medical students and consultants regarding the importance for the modellee to see both positive and negative behaviours and then make their own judgement. The medical students commented that the negative experiences *'stick out in your mind more,'* than positive experiences. However, the medical students highlighted how the negative modelling had a positive effect because they made a judgement on how not to behave.

THE MODEL TRIALLING CYCLE

Following the judgement phase participants described a range of subsequent actions. These took the form of a cycle termed here as the 'Model Trialling Cycle.' During this cycle, the modellee seeks to incorporate behaviour, style or attribute which has been exhibited by the role model and test its utility. The model trialling cycle involves the processes of assembly, imitation, experimentation, adaptation and assimilation.

Assembly

The assembly stage involves the modellee gathering up many professional behaviour, styles and attributes from different role models throughout their training. The notion of *'picking up'* behaviours and actions was described by both the medical students and consultants. The students noted that *'it was often the small things that you pick up'* like shaking hands. The assembly stage was noted to occur consciously and subconsciously and often described as a type of *'osmotic effect'* or occurring by *'diffusion'*.

Emulation

During this stage, the modellee imitates the professional attributes, behaviours and styles of the role model. It involves the process of acting *'in a similar way to get the same responses that the person would produce.'* The process was described as *'imitating,'* *'mimicking'* or *'mirroring'* the actions of the role models. The emulation stage was noted by participants to often occur subconsciously, for *'you notice people and you see people as an example'*.

Experimentation

During this stage, the modellee chooses via trial and error which professional attributes, behaviours and styles they prefer to utilise in practice. The importance of this stage was exemplified as the modellees describe how they try different things and '*see what works*'. The students appreciated that there are different ways of doing things and so they could trial the different approaches of several role models. This experimental process was described as an '*iterative process*,' in that the modellee will try something in practice and if it does not work well they will trial an approach from another model.

Adaptation

This stage involves the modellee adapting the professional behaviours, attributes and styles and incorporating them into their own personal style. This stage is important because '*everyone is so different in their personal styles*,' and so if it is '*not with your natural style it will sound artificial*'. The importance of '*incorporating it into your own style*' was noted. This Adaptation stage was noted to occur both consciously and subconsciously for it was noted that '*subconsciously you start to adapt styles*.'

Assimilation

This stage involves the modellee assimilating all the professional attributes, behaviours and styles to become a unique doctor. During this stage, the modellees are incorporating the behaviours from all the role models and then '*putting it together to practise in an effective way*'. The end result is that '*you have pieces from everyone*,' so that '*by the time you are a consultant you are a mixture of several different people*'. It was noted that '*role modelling is constantly evolving and we model ourselves on behaviours and skills that we have seen*'.

The Impact of Doctor Role Modelling

The impact of doctor role modelling is in the development of medical professionalism, the development of professional identity and the influences on career choices. These will be considered in detail in a separate paper.

DISCUSSION

Role modelling has been identified as an important influence in medical education (Skeff 1998; Passi et al.2010; Irby 1986; Cruess et al.2008; Cote and Leclere 2000; Ricer 1998;

Paice et al.2002; Passi et al.2013; Kenny et al.2003; Wright 1996; Wright and Carrese 2001). Role modelling in clinical education is an enigma. Whilst modelling is an important feature of two widely respected learning theories - Bandura's social learning theory (Bandura 1977) and cognitive apprenticeship (Brown et al. 1989), little is known about the process whereby doctor role modelling occurs, and what is known is that the process is frequently subconscious with the influence occurring more by example than direct action.

This research offers an explanation of what is happening in the doctor role modelling process. It can be summarised as a process that involves conscious and subconscious elements and consists of an Exposure Phase followed by an Evolution Phase: The Exposure phase involves demonstration of the professional attributes by the doctor role models; The Evolution phase begins with observation of the role model by the modellee, following which the modellee makes a judgement whether or not to trial the observed behaviours of the role model; when the decision to trial is reached, this then leads to a Model Trialling Cycle which involves five stages (assembly, emulation, experimentation, adaptation and assimilation).

There are several strengths of this study: the methodology used (the systematic grounded theory model of Strauss and Corbin) was rigorous; the sample size ensured the saturation of the emerging themes; and there was a breadth of specialities represented. A potential limitation of the study was that it was conducted in only one centre although this is mitigated to some extent by the inclusion of a range of consultants who had been trained in very diverse range of settings in the UK and the students had clinical rotations in four different hospitals.

The existing literature on modelling focuses on the attributes of the doctor role models rather than the process (Wright et al. 1998; Kahn 2008; Joubert et al.2006; Weissmann et al.2006; Althouse et al. 1999; Elzubeir and Rizk 2001; Wright and Carrese 2002; Yazigi et al. 2006; Mclean 2006). The findings of the exposure phase of this study are consistent with those from a recent systematic review that identified clinical attributes, teaching skills and personal qualities as the key attributes of doctor role models (Passi et al. 2013). However, the findings in this study expand our understanding of these attributes highlighting in particular the importance for positive doctor role models of maintaining good relationships with patients, students and colleagues, having unique personalities and inspirational characteristics.

With regard to the personality factors, previous studies have described the personality profiles of role models (Magee and Hojat 1998; Hojat et al. 1999). However, this study raises

a somewhat different finding in that modellees selected for role models who had similar personality traits to themselves. This means that modelling should not be considered to be restricted to specific personality types; indeed it highlights the importance of there being a wide range of possible role models available to maximise the opportunities for successful matching.

The Judgement stage is pivotal as it marks the transition from exposure to evolution. Students often mentioned that they remembered negative modelling rather than positive modelling. Whilst this may be an illustration of ‘negativity bias’ (the psychological phenomenon (Haizlip et al. 2012) in which humans pay more attention to negative rather than positive experiences), negative modelling is frequently highlighted in the literature (Cruess et al. 2008; Cote and Leclaire 2000). However, this study confirmed that negative modelling could have a positive effect as the students make judgements about what they had observed and could thereby learn how not to behave. This finding provides strong justification for medical educators to support students to develop their ability to discriminate between positive and negative behaviours.

When the decision to trial is reached, this leads to the Model Trialling Cycle which involves five stages of assembly, emulation, experimentation, adaptation and assimilation. Participants described how the Assembly stage took place in all educational environments and throughout training. The next stage, Emulation, emphasises the ancient (Aristotelian) virtue of role models leading by example (Kristjansson 2006). The Experimentation and Adaptation stages offer a potential future focus for workplace based learning in which students trial different attributes modelled in clinical practice. The final stage, Assimilation was noted to continue throughout the journey to becoming a professional doctor; this highlights the potential impact of role modelling beyond the initial years as a medical student. Three main outcomes of role modelling were identified – the development of professional behaviours, the development of professional identity and the shaping of career aspirations.

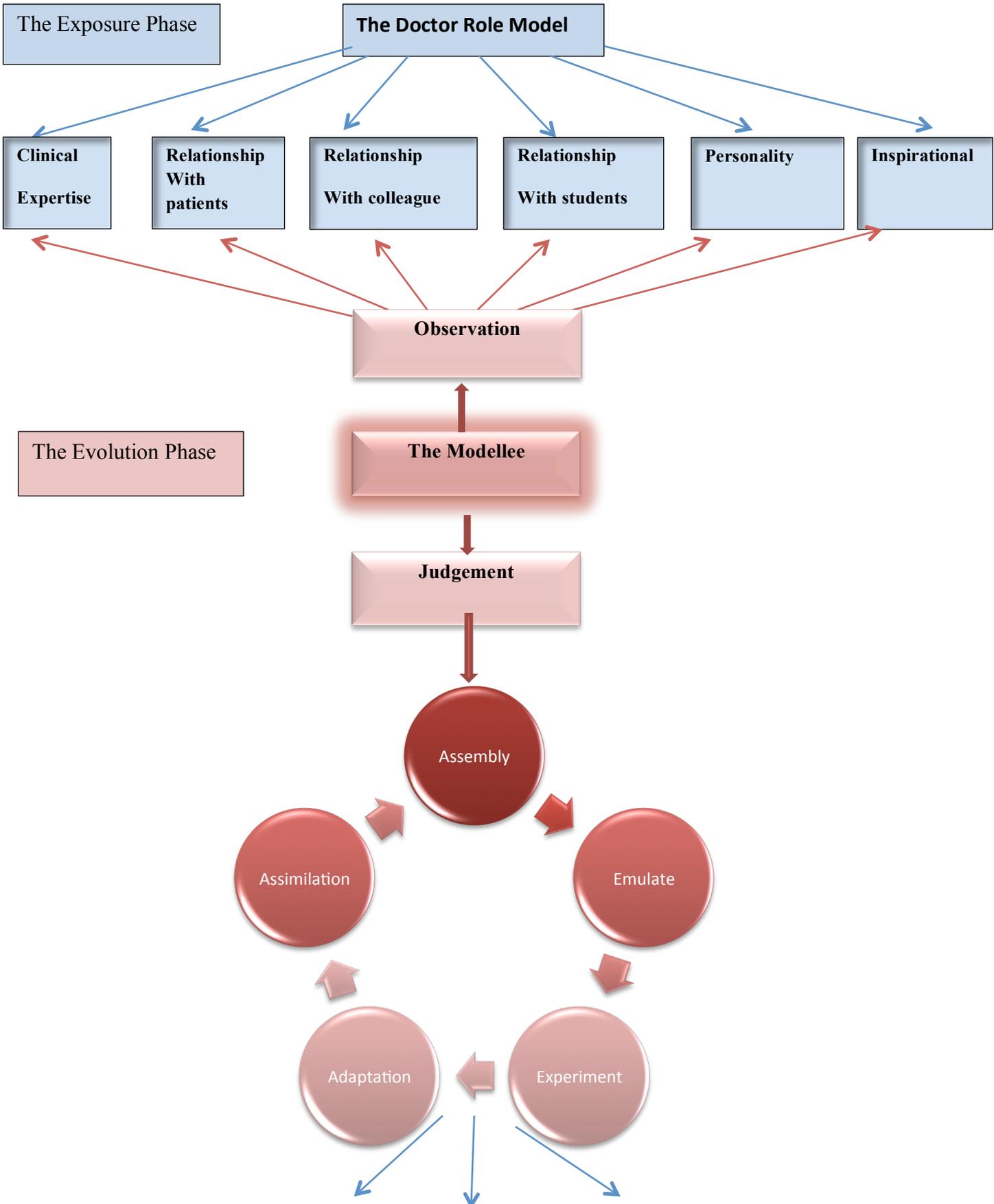
CONCLUSION

This research study has unveiled the complex process of positive doctor role modelling illustrating that it is a conscious and subconscious process that is highly dependent on the attributes of role models and the judgements made by the modellee. Role modelling occurs in the formal, informal and hidden curriculum and throughout the continuum of medical

education. The relationship between the role model and modellee is quite unique in medical education as it is dependent on the choice made by the modellee.

The implications for medical educators are important: First, faculty development initiatives must support the professional development of their clinical teachers as future role models. Second, all clinical teachers need to develop a conscious awareness of being a role model - demonstrating high professional standards in all learning environments and making their implicit actions more explicit for the students. Third, this study provides strong justification for medical educators to support students to develop their ability to discriminate between positive and negative behaviours. Finally, students need to develop effective strategies to make the best use of role modelling and this paper argues for greater emphasis on the active engagement of learners in the modelling process. This study paves the way for enhancing role modelling worldwide as an innovative teaching and learning strategy.

Figure 1: The Hidden Process of Positive Doctor Role Modelling



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Professionalism

Professional Identity

Career Choices

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Author Contributions

Dr Vimmi Passi was the lead researcher who made the main contribution to the study design, data collection, data analysis, data interpretation and writing of this article.

Professor Neil Johnson was the lead supervisor who advised on the study design, data interpretation and writing of this article.

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Appendix: Tables 1-3 are illustrated below.

Appendix 1: The Interview Questions

<p>Student Focus Group</p>	<ul style="list-style-type: none"> • Have you had many doctor role models during your training? • How many role models have you had in your training? • What were the characteristics of these doctor role models? • What are the influences of doctor role models? • Where does role modelling take place? • At what stages of training does role modelling occur? • How does the actual process of role modelling occur? • How important is role modelling in developing professionalism? • How would you define the term doctor role model? • Any other thoughts or reflections on role modelling?
<p>Semi Structured Interview Consultant Interviews</p>	<p>Looking back to your own undergraduate and postgraduate training : -</p> <ul style="list-style-type: none"> • Have you had many doctor role models during your training? • How many role models have you had in your training? • What are the characteristics of these doctor role models? • What are the influences of doctor role models? • Where does role modelling take place? • At what stages of training does role modelling occur? • How does the actual process of role modelling occur? • How important is role modelling in developing professionalism? • How would you define the term doctor role model? <p>In your career as a Consultant / Educator : -</p> <ul style="list-style-type: none"> • Do you consider yourself a doctor role model? • Do you think about and use ‘role modelling’ during clinical practice? • How important is role modelling in your current educational role?
<p>Interview after Clinics</p>	<p>Interview questions for medical students immediately after clinic : -</p> <ul style="list-style-type: none"> • What positive role modelling did you observe in clinic? • How did the consultants model this? • Which aspects will you model in the future? • Are there any characteristics of the doctor that you would model? • Any other thoughts on the process of doctor role modelling? <p>Interview questions for consultants immediately after clinic :</p> <ul style="list-style-type: none"> • What positive role modelling did you demonstrate in clinic? • How did you model this? Where you thinking about the modelling process? • What aspects would you like the student to model in the future? • What characteristics of a positive doctor role model did you demonstrate? • Any other thoughts on the process of doctor role modelling?

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Table 2: The Exposure Phase

Exposure Phase	Transcripts (C1,C1, C2 etc denotes the consultant and G1M1 denotes focus group one, female student etc).
Clinical Expertise	<ul style="list-style-type: none"> • Confidence and capability.. the main thing is confidence in that you know what you are doing. (G1M2). • Competence and confident – these are two things that you notice most. (G1M3). • Diagnostic and clinical skills and their comprehensive approach to management, treatment and investigations. (C2).
Relationship with Patients	<ul style="list-style-type: none"> • They want to help patients - they want to go the extra mile for the patient – that is what impresses me. (G2F3). • Really caring ...every time he goes to see a patient in their bed he will kneel down so he is on their level and hold their hand,' (G6F3). • Another influence is that you can see the patient is satisfied. (G5F1). • The one I aspire to be ... is when the patients say 'wasn't he really good' as they come out of the consultation. (G1F1). • He was really passionate about what he was doing The patients adored him' (G6F3).
Relationships with Colleagues	<ul style="list-style-type: none"> • Looking at how someone interacts with the rest of the staff and students makes a massive difference. (G1F1). • In the future I would prefer to be welcoming to all – I like the way that the consultant gave time to everyone and treated everyone the same. (G3M1). • Role modelling is important how doctors interact with patients and colleagues. (G4F2).
Relationship with Students	<ul style="list-style-type: none"> • I think being welcomed into the field and being made to feel part of the team is very important. (C5). • You sometimes afterwards have to explain to the student why you did it in that way. (C6) • I personally after a consultation explore with the student why it did not go well.. it is an important learning opportunity.' (C17). • How that shapes you.. how that encourages you. (C9). • The better ones are more willing to spend time with you to teach you and so it is two way really. (G2F2).
Personality	<ul style="list-style-type: none"> • You take off bits which you can identify with your own personality (G5F2). • A lot of role models are people that I have seen and I think that I could be like that in the future...people who have a similar personality to me. (G12F2). • Personality does have a big impact on your choice of role model. (C19).
Inspirational Characteristics	<ul style="list-style-type: none"> • He was so inspirational – he showed me the path of how to become a neurosurgeon – I took his advice. (C11). • But if you find someone who is particularly inspiring – then you may be inclined to take more of what they do.' (C3). • I was impressed by an endocrinologist – if I could be a doctor exactly like him then I would be quite happy...he was friendly with patients ...quite happy to sit on the bed and discuss the situation with them ...he would draw diagrams to help them understand the condition.. (C12M1). • Someone can just say something in a slightly different way and it is just like a light bulb has come on or a whole planet has just become available. (C13).

Table 3: The Evolution Phase

Evolution Phase	Transcripts
Observation	<ul style="list-style-type: none"> • It is important to follow professionals and see how to do things (G7F1). • She often sits on the end of the bed to be at their level and has good body language...often touches their shoulder to reassure. (C11F1). • As a medical student You are in quite a unique position because you will sit in the clinic and just observe (G3M2). • There is no substitute for seeing in action and doing in practice....you can't teach experience and role modelling is the same sort of thing.' (C26).
Judgement	<ul style="list-style-type: none"> • Role modelling is really important.....to see good and bad things. (G3F2). • You need to see both positive and negative behaviours. If you see only good behaviour – there is no judgement involved (C4). • It is always easier to consider bad examples – as those are the ones that stick out in your mind more.' (G2F1). • Negative influences me in a more positive way – I do not want to do that.' (G1M1).
Assembly	<ul style="list-style-type: none"> • One tries to take the bits of people you work with and inculcate that in your own practice. (C17). • Some doctors shake hands with the patients and spend time with themIt is often the small things that you pick up from a good role model. (G7F1). • Picking up interactions is often subconscious. (G6F1). • I think you pick up techniques, mannerisms, strategiesfrom people you work with ...a type of osmotic effect. (C24).
Emulation	<ul style="list-style-type: none"> • Emulation ... a role model is someone I would like to beto act in a similar way....to get the same responses that person would produce. (G10F1). • Speaking personally ... there are some doctors that I have thought that I would like to be like and so it feels more like imitation (G4F2). • I mirror how I see other people do things (C5M1). • A lot of it is subconscious ...if I spend a lot of time with someone I start mimicking them automatically. (G9M2). • I have modelled myself on certain individuals ...not consciously but I suppose subconsciously... you notice people and you see people as an example.' (C18).
Experimentation	<ul style="list-style-type: none"> • It is worth trying things out yourself to see what works and what does not work. (G5M1) • It is an iterative process ...sometimes you try something out that you thought worked well. (C1M1). • We try different things and see what works. (G7M2). • It is vital – there are some many different waysso one consultant does it one way and the other consultant does it another way – but both are equally goodI would try both. (C1F1).
Adaptation	<ul style="list-style-type: none"> • Incorporating into your own style rather than just imitatingblend it in with your own style.' (G5F1). • Because everyone is so different in their personal stylesit is important to see how it would work in your own stylebecause some things do not just sound right. It takes a while to realise that you can't just take what other people are doing and imitate it. ' (G5F2). • I think subconsciously you start to adapt styles. (G11M1).
Assimilation	<ul style="list-style-type: none"> • Modelling is really important ...as it is fine having the knowledge but you

	<p>have to put into practice in an effective way. (G1M1).</p> <ul style="list-style-type: none">• Role modelling is really important ...by the end of it you have pieces from everyone. (C26).• By the time you are a consultant – you are a mixture of different people. C22• Role modelling is constantly evolving and we model ourselves on behaviours and skills that we have seen.’ (C2).
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