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Navigating Roles: How Specialist Physicians Perceive Their Leadership and Peer Positions in Interprofessional Healthcare Teams

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Abstract

This qualitative exploratory study investigates the identity work of specializing physicians (SPs) in interprofessional (IP) teams, focusing on how they define their professional roles and relationships through the framework of positioning theory. The analysis is based on 65 self-reflective essays authored by SPs as part of their mandatory leadership training. The positioning analysis revealed five distinct physician roles—peer, coordinator, leader, medical expert, and decision-maker—and identified two key storylines describing teamwork: one emphasizing communication and the other highlighting organizational performance. The diversity of roles demonstrates the flexible and dynamic ways SPs integrate leadership into their professional identity. The findings suggest that future research should examine how SPs actively construct the dimensions of their professional identity, rather than merely confirming its presence.

Keywords: Interprofessional communication, Leadership, Residents, Formation, Positioning theory, Professional identity

Introduction

Specializing physicians (SPs) are frequently expected to take on leadership roles within interprofessional (IP) teams [1]. Leadership in these teams is crucial, as IP collaboration has been shown to organize expertise within healthcare (HC) teams efficiently [2], benefiting both patients and healthcare professionals [3]. However, Roten *et al*. [4] note that working in IP teams can pose identity challenges for SPs, who may struggle to reconcile their managerial and leadership responsibilities with their professional roles. While the formation of professional identity (PIF) begins during medical school [5], specialization training is when SPs gain a deeper understanding of interprofessional interdependence and begin to acquire the leadership and administrative skills their roles demand [4]. This process can create what Berghout *et al*. [6] call a dual-identity challenge, as SPs may find it difficult to integrate a leadership identity into their professional identity [7–9]. Understanding how SPs perceive their position in IP teams is therefore essential for supporting effective teamwork and high-quality patient care.

Physician professional identity formation and interprofessional teams

PIF is widely used to study the development of physicians' professional roles during training and throughout their careers [10]. It is often portrayed as a linear process, in which medical students enter with pre-existing personal identities and aspirations to join the physician community, gradually acquiring professional values, behaviors, and goals [11, 12]. Traditional PIF models describe stages of development in a pyramid structure (knowledge, competence, performance, and action) [13, 14]. In contrast, this study emphasizes the interactional and dynamic nature of identity formation, adopting a sociocultural or socio-constructionist

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perspective [7, 13, 15]. Professional identity is not a static trait obtained at graduation but is continuously negotiated through interactions with colleagues and organizational contexts. Consequently, we aim to explore how PIF develops within the context of IP team interactions.

Physician identity is firmly anchored in the physician–patient relationship [6]. Physicians may perceive leadership and managerial duties as potential threats to their professional autonomy [16]. Walraven *et al*. [17] highlight that SPs often feel underprepared to participate in or lead IP team meetings actively, suggesting that specialization introduces a complex identity shift that can be stressful and challenging [4]. Despite this, SPs are expected to assume leadership early in their careers [4]. To examine how SPs navigate their evolving professional identities within IP teams, positioning theory provides a helpful framework.

Theoretical background: positioning theory

Positioning theory (PT) is a socio-constructionist framework that views communication as a dynamic process that shapes identities [18]. It focuses on how individuals actively and mutually position themselves relative to others during interactions, thereby expressing and negotiating their professional and social identities [19, 20]. Central to PT is the idea that identities are socially constructed and gain meaning through the distinction between similarity and difference [21, 22]. Within this framework, a "position" refers to the relational stance one adopts toward others, outlining the distribution of interactional rights and responsibilities that guide what is considered appropriate behavior in social contexts [23].

PT is organized around a triangular model consisting of positions, speech acts, and storylines [18]. Positions delineate the scope of acceptable actions and the corresponding rights and responsibilities within interactions [20]. For example, a specializing physician (SP) may simultaneously occupy roles such as peer, novice, or leader within an interprofessional (IP) team, each with distinct interactional expectations. Speech acts are the communicative behaviors through which individuals assert and negotiate these positions [19, 24], such as asking clarifying questions to other team members, which contextualize and socially define their actions. Storylines provide the situational and organizational context that shapes which positions are possible or appropriate [25], such as norms governing communication during regular team meetings.

In this study, we use PT to examine SPs' professional identity work by analyzing how they position themselves in relation to colleagues within IP team interactions. Specifically, we explore how SPs perceive the distribution of rights and responsibilities and how these perceptions shape both their own participation and that of other team members in patient care. We focus on identity positions—how SPs interpret and enact their role within the team—without investigating the underlying factors, such as gender or specialty, that may influence these positions. Our goal is to capture the full spectrum of positions that emerge from SPs' experiences. This leads to our research question:

RQ: What leadership positions do specialized physicians construct within interprofessional teams as part of their professional identity?

Materials and Methods

Research design

This study employed a qualitative, theory-driven design to explore how specializing physicians (SPs) describe their positioning within interprofessional (IP) teams. The aim was to gain insights into communication patterns in IP teams and contribute to understanding leadership development in medical education. The study focused on broadly describing the spectrum of possible identity positions rather than examining differences by specialty or demographic characteristics. Data consisted of 65 individual essays written by SPs as part of a communication module in a specialist training program at a Finnish university. While participants drew on experiences from diverse health care settings, no observational or facility-specific data were included.

The analysis was guided by positioning theory (PT) [18], focusing on positions, speech acts, and storylines expressed in the essays. While PT is most commonly applied to naturally occurring interactional data, it has also been successfully used to study monologic texts such as diaries [26, 27] and interviews [28]. Applying PT to self-reflexive essays represents a novel extension of the framework.

Participants

In Finland, specialist medical training is a postgraduate program offered across five medical faculties. Completion typically spans 5–6 years (300–360 ECTS), combining clinical practice, nine months in primary health care centers, theoretical coursework, management

studies, and a national written examination [29, 30]. Each program includes 10 ECTS of mandatory management courses covering leadership, organizational management, human resources, workplace communication, healthcare economics, legislation, and data management, with optional electives available for up to 20 ECTS.

During specialization, SPs complete mandatory leadership studies while working in public health care clinics across Finland, typically once per month. The communication module emphasizes leadership, workplace communication, and media-related competencies and requires pre-reading, lectures, and submission of a reflective essay. The timing of courses is flexible, and participants come from diverse specialties, resulting in varying levels of experience and expertise.

All participants reported working in both hospitals and primary health care centers, with many having experience in both environments. The essays reflect 16 different specialties, including psychiatry, anesthesiology, surgery, neurology, and pediatrics. Due to the limited number of participants per specialty, meaningful specialty-based comparisons were not feasible. Participants described a range of IP team experiences, highlighting the centrality of collaboration, teamwork, and communication in their professional roles.

Data collection

The study utilized learning assignments completed as part of a lecture led by the fourth author, who coordinated the communication module. Participants received instructions on how to write the essay and how to provide consent if they chose to participate in the study. The essays asked specialized physicians (SPs) to reflect on their experiences with interprofessional (IP) teamwork and leadership, encouraging them to share personal observations and insights. The guidance was intentionally broad, allowing participants to describe experiences from any of their current or previous workplaces. Consequently, the essays included a wide range of team types, encompassing collaboration with nurses, nurse practitioners, physiotherapists, psychologists, ward clerks, and physicians from other specialties.

No strict page limit was imposed, but participants were recommended to write at least three pages. Essays were submitted within two weeks after the lecture sessions, formatted as 2–5 A4 pages, single-sided, with 1.5 line spacing and a 12-point font. Completing the essay was a required component of the module, but contributing to the research study was entirely voluntary and had no impact on course or program progression. All participants were eligible, regardless of specialty, prior experience, or background, and there were no exclusion criteria. Essays were submitted digitally through the Moodle platform. Although the instructions referenced IP collaboration, most participants emphasized "teamwork," highlighting the interchangeable way the terms are used in practice. The analysis, therefore, centered on teamwork as described by the SPs.

Data analysis

The essays were examined using a framework inspired by positioning theory (PT), which considers positions, speech acts, and storylines to understand how individuals situate themselves within social interactions [18]. This approach allowed us to analyze how SPs describe their roles and responsibilities in relation to other team members. Atlas.ti software supported the coding and organization of the data.

Analysis began with the first author reviewing all essays multiple times to achieve a thorough understanding. Relevant passages concerning interprofessional interaction, teamwork, leadership, and the physician's role were extracted to create a targeted dataset. Following PT, the first step involved identifying speech acts, which in these written essays were interpreted as "meaning units" [31]. A meaning unit was defined as a coherent section of text where an SP described how they positioned themselves within the IP team—for example, "I feel responsible for supporting both my colleagues and the patients with respect." Coding decisions and interpretations were regularly discussed among co-authors to ensure accuracy and consistency.

Coding and analysis of meaning units

Once the essays were segmented into meaning units, these units were coded according to how SPs positioned themselves within the interprofessional team. Positions were inferred through personal pronouns and statements reflecting relational stance, such as "…as a physician, I trust that the nurses ensure my safety too…" or "…I don't direct anyone; instead, we discuss decisions together…". In these examples, "others" refers to fellow IP team members and colleagues in health care organizations. As SPs described their own roles, they simultaneously

constructed positions for other team members. Across all essays, over 600 speech acts were initially identified.

The first round of open coding suggested eight tentative identity positions: peer, coordinator, chairperson, leader, professional, medical expert, unsure, and decision-maker. Due to overlap among some codes, the team collaboratively refined and consolidated them into five distinct categories representing how SPs perceived themselves relative to the IP team. Notably, multiple positions could coexist within a single essay, reflecting the situational and context-dependent nature of positioning.

After defining these five identity positions, the first author revisited the essays to confirm the consistency and validity of the coding. Subsequently, storylines were derived by examining the relationships among the positions. Two primary storylines were identified: one framing IP teamwork as a communicative process among team members, and the other emphasizing teamwork as a functional, organizational mechanism. Detailed descriptions of the positions and storylines are presented in the Results section.

Ethical considerations

The study adhered strictly to the Finnish National Board of Integrity and the Finnish Code of Conduct for Research Integrity. Participants received detailed information about the study and provided written consent for their essays to be used for research purposes. All personal identifiers, including names and contact information, were removed before analysis to ensure confidentiality. While some essays mentioned the participants' specialties, this information was retained in anonymized form, as it did not allow identification of individual SPs.

Results and Discussion

Analysis revealed five clear identity positions among SPs: peer, coordinator, team leader, medical expert, and decision-maker. These categories reflect how SPs perceive their roles within IP teams and their relationship with colleagues. In addition, two overarching storylines emerged: teamwork as a communicative activity and teamwork as an organizational tool. SPs demonstrated fluid movement between these positions, highlighting the dynamic nature of professional identity in practice. The findings are particularly novel in framing physician leadership as emerging through interaction within the team and in applying positioning theory as an analytic lens to capture this relational and dynamic perspective—a methodological approach not previously used in this context. **Table 1** summarizes the identity positions and storylines from both the SPs' perspectives and their interpretations of the viewpoints of other team members.

Table 1. Distribution of rights and responsibilities in SPs' leadership positions and the storylines constructed by these positions in Finland i**n** 2018

Position/storyline	Specializing in physicians' rights	Others' rights	Specializing in physicians' responsibilities	Others' responsibilities
Peer: The storyline of teamwork as communication is dominant	… to participate in processes that impact patient care.	… to participate in processes that impact patient care.	… to ensure the shared IP team goal of quality patient care. … to report one's actions to the IP team.	… to ensure quality patient care. … to report one's actions to the IP team.
Coordinator: The storyline of teamwork as communication is emphasized	… to participate in and coordinate the processes that impact patient care. … to make informed decisions regarding patient care.	… to coordinate the team's shared expertise.	… to ensure the shared IP team goal of quality patient care with effective team processes and outcomes.	… to participate in processes that impact patient care. … to ensure quality patient care. … to report one's actions to the IP team.
Team leader: The storyline of teamwork as an organizational tool gets introduced	… to lead processes that impact patient care. … to answer to their own supervisor.	… to make informed decisions regarding patient care.	… to ensure the team's performance regarding the quality of patient care and teamwork.	… to assist in processes that impact patient care. … to assist the physician with processes that impact patient care. … to report one's actions to the physician.

Medical expert: The storyline of teamwork as an organizational tool gets emphasized	… to utilize the IP team in processes that impact patient care and the right to decide how these processes are executed. … to consult other members of the IP team and determine whose expertise is essential. … to make decisions regarding patient care.	… to consult other members of the IP team and determine whose expertise is vital.	… to ensure the team's and its members' performance and outcomes. … to avoid errors in processes that impact patient care.	… to assist in processes that impact patient care if one has the knowledge and skills. … to assist the physician with processes that impact patient care. … to report one's actions to the physician.
Decision maker: The storyline of teamwork as an organizational tool is dominant	… to utilize or dismiss the IP team in processes that impact patient care. … to consult other members of the IP team and to gather information from them. … to supervise and give instructions or orders to others on the IP team. … to make decisions on behalf of others regarding patient care.	… to consult other members of the IP team and to gather information from them. … to supervise and give instructions or orders to others on the IP team.	… to be accountable for the performance and outcomes of patient care. … to answer to their own supervisor. … to ensure effective processes that impact patient care.	… to assist in processes that impact patient care processes if one has the knowledge and skills. … to assist the physician with processes that impact patient care. … to gather information for the physician. … to report one's actions to the physician.

Peer position

When SPs adopt the peer stance, they view their responsibilities and authority as equal to those of other team members. The focus is on shared accountability, with every professional regarded as an essential contributor to patient care. In this position, all team members are encouraged to participate in discussions, decision-making, and clinical assessments, offering their expertise. SPs deliberately cultivate a low-hierarchy environment where everyone's perspective matters. Communication emerges as the primary tool for collaboration, aligning with a storyline that frames teamwork around dialogue. The shared goal of patient-centered care justifies this equitable distribution of responsibilities.

Extract 1 illustrates this perspective:

"The physician's role in interprofessional communication is, in my opinion, the same as every other profession that participates in communication: to work for the patient's wellbeing on their behalf." (SPO16).

Even though SPs recognize their hierarchical position due to medical responsibility, they consciously promote inclusivity and joint decision-making. By inviting contributions from all members, they reduce hierarchical barriers, emphasizing interaction over authority. Extract 2 highlights this approach:

"An important shift happens from the point of interprofessional leadership. Instead of traditional hierarchy, a coordinated and equal team-based collaboration emerges, like, 'We are jointly responsible for our patients, and we lead the care processes together.'" (SPO04).

Coordinator position

In the coordinator role, SPs take on the responsibility of guiding team processes to improve efficiency and outcomes. They facilitate discussions, organize information flow, and actively seek input from other professionals. Unlike the peer position, coordinators assume a more structured role, directing the team's activities without acting as supervisors. While care responsibilities remain shared, SPs in this position ensure smooth coordination, helping the team function effectively. Extract 3 exemplifies this approach:

"This does not mean that the SP is the supervisor of these professions. Mainly, I think that the role of a physician is more about keeping all the strings in one's hands and piloting with open discussions. Because leadership matters to the other professions, they can plan their own work better." (SPO16).

Coordinator role

In the coordinator role, SPs focus on organizing team interactions and ensuring discussions flow effectively. They recognize the unique expertise each team member brings and take responsibility for identifying whose input is most relevant in a situation. This sometimes means

making decisions without consulting the entire team, though they always strive to remain informed of all pertinent information. The emphasis in this role is on facilitating communication rather than exercising hierarchical power. Even though responsibility for patient care is shared, the SP acts as the primary guide, summarizing progress and ensuring tasks are completed efficiently. Coordination depends heavily on mutual trust and collaborative dialogue, as illustrated in extract 4:

"You have to listen, negotiate, and respect viewpoints you might not agree with. Often, physicians end up coordinating the situation—summarizing, organizing follow-ups, and keeping the team on track." (SPO29).

Team leader role

As team leaders, SPs assume formal responsibility for the performance and oversight of the entire IP team. They operate within the broader hierarchy of the healthcare organization and are accountable to both their supervisors and the team members they manage. Unlike the coordinator role, which emphasizes facilitation within the team, the team leader role situates the SP within an organizational framework, linking team performance to institutional goals.

Even in this leadership capacity, patient care is a collective endeavor. Team members are expected to contribute their expertise to decisions, and SPs balance directing processes with respecting professional autonomy. The narrative shifts slightly here: while communication remains essential, teamwork is also framed as a key organizational tool for achieving efficient operations. Extract 5 highlights this perspective:

"Physicians are often seen as the leaders in interprofessional teams. They take responsibility for the overall picture and clinical decisions, but they do not dictate to other professionals how to do their work." (SPO42).

SPs in the team leader role guide the workflow and ensure that tasks align with both patient needs and organizational requirements, without overstepping into micromanagement of other professionals' roles.

Medical expert role

In the medical expert role, SPs center their identity on their professional expertise and responsibility for patient care. Here, they align more closely with their medical specialty and supervising physicians than with the IP team as a collective. Legal and professional accountability is a defining feature of this position: the SP bears ultimate responsibility for the patient's outcomes. While input from the team is welcomed and can inform decision-making, the SP retains authority over how, when, and whose contributions are considered. In this sense, the team functions primarily as a resource or tool rather than as a collaborative partner, making the "teamwork as an organizational tool" storyline dominant. Unlike roles that emphasize equal participation, the SP in this position may function more as an external overseer rather than a fully engaged team member.

Other team members contribute only when specifically consulted or when they provide information relevant to the case. Because the SP carries full accountability, they often monitor or verify the work of others, ensuring patient safety and quality of care. This responsibility can create professional isolation, as illustrated in extract 6:

"At the top of the food chain, physicians' position is quite lonely when making the final decisions and taking responsibility for everything, even the accomplishments of supportive groups." (SPO10).

The medical expert role is shaped mainly by organizational expectations rather than negotiated interactions within the team. SPs have limited flexibility to redefine their responsibilities; the organization mandates their leadership and decision-making authority. Even if reluctant to assume this role, the SP must fulfill it in practice, which can be demanding, as noted in extract 7:

"Responsibilities weigh young physicians down when multiple things must be taken care of very independently. At the end of the day, responsibility for everything, including the big picture, lies upon them. This role is not easy; in fact, it's even ruthless." (SPO10).

For early-career SPs, balancing patient care responsibilities with leadership demands can be especially challenging. Some may feel unprepared or overwhelmed when expected to direct interprofessional collaboration immediately, as captured in extract 8:

"The physician might end up as a leader straight out of medical school, even as the youngest and most inexperienced of the team and one who holds no interest or competence in leadership." (SPO60).

Decision-maker role

In the decision-maker role, SPs position themselves as the ultimate authority within the IP team, bearing full responsibility for patient outcomes. In this position, the SP has discretion over when and how to involve the team, which primarily functions as a resource to support the

SP's decisions. The storyline of teamwork as an organizational tool dominates here, with the team operating under the physician's direction rather than as an equal participant. Other professionals are primarily responsible for gathering information or performing supportive duties, and they do not participate in the core decision-making process.

This role reflects a hierarchical structure aligned with organizational norms. SPs are not expected to justify their decisions to team members, and only occasionally to supervisors, resulting in a top-down, physician-centered approach. Decision-making relies heavily on the SP's clinical judgment, as illustrated in extract 9:

"The physician gathers prerequisites from the patient or next of kin, makes the clinical status, assesses the big picture, consults colleagues about the situation, and gives the patient the follow-up treatment plan." (SPO09).

The SP in this role has the authority to direct the team while also carrying the responsibility for overall performance and efficiency. Unlike the medical expert position, where SPs may question imposed leadership responsibilities, the decision-maker position reflects acceptance of hierarchical authority within the healthcare organization.

SPs monitor team actions closely to ensure accurate decision-making during patient care processes, delegating more straightforward or routine tasks to other members to allow focus on critical clinical judgments. Extract 10 highlights how SPs, while acknowledging the complementary contributions of different professionals, maintain traditional hierarchical boundaries in this role:

"Even though the job description and areas of expertise of physicians and nurses are partly clearly different and partly complementary, the physicians' job entails giving direct instructions to nurses." (SPO06).

This study explored how SPs construct their professional and leadership identities within interprofessional (IP) team interactions by analyzing how they position themselves relative to other team members. Analysis revealed five distinct identity positions: peer, coordinator, team leader, medical expert, and decision-maker, grounded in positioning theory [19]. Individual essays often reflected multiple positions, highlighting the situational and flexible nature of SPs' leadership practices. In the Finnish specialist training context, leadership education is integrated into clinical practice, offering structured opportunities for shared learning across specialties, which further emphasizes the context-dependent nature of physician leadership.

The identified positions aligned with two overarching storylines: teamwork as communication and teamwork as an organizational tool. These positions span a continuum—from approaches that prioritize team-centered collaboration and shared decision-making to models where leadership is physician-centered with hierarchical control. Importantly, these positions do not represent formal professional authority or legal responsibilities, nor do they diminish the expertise of other team members. Instead, they capture how SPs and their IP teams negotiate decision-making and accountability in practice.

Five leadership positions

The diversity of identity positions demonstrates that SPs develop their professional and leadership identities in multifaceted ways, adapting to the expectations of their training and clinical work. Conflicts can arise when SPs' situational default positions differ from the leadership role expected of them—for example, not assuming a decision-making role in urgent cases or failing to consult the team during collaborative problem-solving. These observations support the view that identity positions are not static roles but flexible tools that SPs use to navigate the complex leadership demands of IP teamwork [18].

The positions identified should not be interpreted as hierarchical; no single position is inherently superior. Effective medical leadership depends on adapting one's approach to the situation rather than maintaining a fixed leadership role [28, 32-35]. Across essays, SPs frequently adopted multiple positions, often shifting between them within the same narrative. This fluidity mirrors findings from Williams *et al*. [28], who reported that residents transition between leadership positions as they develop their professional roles. Overall, these results highlight that SPs' relationships within IP teams are dynamic and negotiated, shaped continuously through interactions with colleagues rather than determined solely by formal roles.

Two storylines

Analysis revealed two dominant storylines connecting the different identity positions: IP teamwork as communication and IP teamwork as an organizational tool. Similar patterns have been reported in earlier medical studies [28, 36], and they resonate with the heroic and collaborative narratives described by Berghout *et al*. [6]. These storylines illustrate the ongoing tension in medical practice between collaborative,

interprofessional work and the traditional hierarchical structures of healthcare organizations.

In the teamwork-as-communication storyline, all team members engage actively in discussions about patient care and collaboratively shape how the team functions. Echoing this view, Williams *et al*. [28] found that SPs' learning is strongly influenced by interactions with patients, nurses, and supervisors, emphasizing the value of teamwork over hierarchy. While tasks are not uniformly shared, each team member has opportunities to influence decisions and contribute to the team's functioning. A similar emphasis on equality was observed by Møller *et al*. [36], who highlighted how traditional morning reports in healthcare promote shared input and team engagement.

In contrast, the teamwork-as-organizational-tool storyline positions the SP as the primary holder of decision-making authority, particularly in the decision-maker role. Here, SPs shape both teamwork and care processes according to their judgment, bearing responsibility for both their own actions and the outcomes of the team. This approach reinforces hierarchical structures, consistent with previous studies that have shown hierarchy is maintained through interaction [28, 36]. For instance, Møller *et al*. [36] noted that morning reports often serve to preserve hierarchy and make the chain of command explicit, reflecting this organizational perspective.

Team-centricity vs. physician-centricity

The five identity positions form a continuum from fully team-focused roles, where rights and responsibilities are shared, to strongly physician-centered roles, characterized by exclusive authority. This spectrum highlights the tension between collaborative and hierarchical approaches, observed in both organizational and professional contexts. Organizational meanings pertain to formal leadership responsibilities within IP teams, while professional meanings reflect the SP's medical expertise and authority. Mapping this continuum demonstrates a progression from shared, team-oriented positions to physician-centered positions with exclusive decision-making powers. The relationship between the two storylines, the five identity positions, and this continuum is illustrated in **Figure 1**.

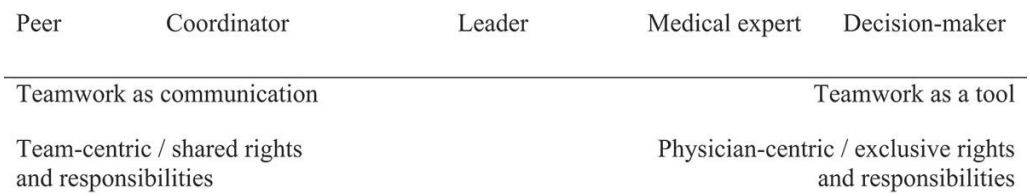

Figure 1. The continuum of the two distinct storylines and how responsibilities and rights are distributed across identity positions

When SPs adopt team-focused identity positions, both they and their teams prioritize delivering optimal patient care. In contrast, physician-centric positions expand the SP's responsibilities beyond patient care to include managing the team and overseeing care processes. This contrast reflects the tension between organizational hierarchy and collaborative practice within IP teams, as highlighted by the study's storylines and prior research [6, 28, 36]. Importantly, even in physician-centric positions, patient-centeredness remains central, with SPs maintaining ultimate responsibility for patient outcomes across all positions.

Organizational structures can reinforce both approaches. For example, strict protocols in high-stakes situations (such as resuscitation) naturally support physician-centric roles, whereas policies and routines that encourage interprofessional communication promote team-centricity. However, these positions are not mutually exclusive; recognizing their interplay is essential. Effective physician leadership, therefore, requires balancing and transitioning between collaborative and physician-centered positions depending on situational demands and leadership expectations within the IP team.

The dual-identity perspective

The variety of identity positions demonstrates that SPs construct their professional identity flexibly and dynamically, finding ways to enact leadership during specialization training [4, 37]. This aligns with previous claims that professional identity is fluid and evolves [38-40]. Earlier studies have framed the challenge as a "dual

identity" problem, highlighting the difficulty physicians face in integrating leadership into their professional role [6–9, 17]. However, our findings suggest the issue is less about accepting or rejecting leadership and more about how SPs incorporate it into their identity. Within IP teams, SPs experiment with different ways of exercising leadership by navigating multiple identity positions.

Viewing leadership as a flexible element of professional identity avoids oversimplifying the dual-identity problem. By understanding their own positioning, physicians can actively shape how they relate to their teams—choosing to act as a leader, an organizational representative, or a peer depending on context. This perspective frames leadership identity as dynamic, relational, and communicative rather than fixed. It also broadens the concept of physician identity to include adaptable leadership capabilities, enabling physicians to foster inclusive and collaborative interprofessional communication, even when formally assigned to lead a team.

Physician education

Prior research has consistently indicated that SPs often feel underprepared for the leadership responsibilities expected of them in clinical practice [4, 17]. Even though management and communication topics are included in the medical curriculum, some SPs reported that their training did not adequately equip them for the real-world challenges of leading interprofessional teams, highlighting a potential gap between educational content and practical demands. Our findings suggest that medical education should recognize SPs' professional identity formation as a complex, dynamic process in which leadership identity is actively constructed. Consequently, it is crucial to consider how medical leadership is introduced, reinforced, and integrated throughout the continuum of medical education. Adopting a socio-constructionist approach to professional identity and PIF may help SPs manage the pressures associated with leadership roles, as this perspective emphasizes identity construction through discourse and positioning, focusing on interactions rather than solely on individual traits [7]. Additionally, the importance of communication, teamwork, and management within collegial relationships should be highlighted alongside the traditional focus on the patient–physician relationship.

The development of leadership identity should be integrated into SPs' professional identity from the beginning of their medical training. This entails incorporating topics such as interprofessional communication, teamwork, and leadership throughout undergraduate, residency, and specialization stages. Leadership identity cannot simply be appended at the end of training. Since professional identity formation occurs through interactions and team-based communication, developing strong interprofessional communication skills must be a continuous focus across all phases of medical education.

Strengths and limitations

This study provides a detailed snapshot of SPs' professional identity formation, particularly how they construct their leadership identity as part of their overall professional identity. The analysis is transparent and thorough, with positions and storylines clearly traceable to multiple speech acts, supporting the robustness of the findings. The data are strengthened by the inclusion of SPs from a wide range of specialties, including psychiatry, surgery, and primary care, and represent perspectives from both hospitals and primary healthcare settings. Recruitment was inclusive, allowing all students in the communication module to participate, increasing the representativeness of the dataset. The alignment of identified positions and storylines with previous studies suggests potential transferability of findings to other SPs in Finnish medical education. Furthermore, the research team's expertise in leadership programs and qualitative methodology adds credibility to the analysis.

A limitation of this study is the reliance on reflective essays rather than direct observation or naturally occurring interactions. While positioning theory and analysis were applied [18], the essays provide a "snapshot" of SPs' perspectives at a single point in time rather than a complete view of actual interactions. The findings reflect the SPs' own views and may not fully capture the dynamics of real-life team interactions. Nevertheless, this approach offers a clear perspective on how early-career physicians perceive their roles within interprofessional teams, providing a valuable foundation for future studies that could include observations or input from other team members.

Another limitation is the lack of analysis based on individual participant factors, which might influence interpretations of leadership positions and interactions. The dataset reflects responses from a single semester of students, limiting longitudinal or comparative insights. Additionally, systematic background information about the participants was not collected, which restricted

opportunities for more nuanced analyses. Finally, while all students in the module were invited to participate, self-selection or non-participation may have introduced bias. Future research could benefit from more controlled or stratified sampling to improve representativeness and reduce potential selection bias.

Conclusion

The findings of this study illustrate that leadership among specialized physicians within interprofessional teams is not static but highly adaptable, shaped by multiple identity positions: peer, coordinator, team leader, medical expert, and decision-maker. Each position reflects different emphases on collaboration or physician authority and represents a spectrum from shared responsibilities to more exclusive control, influenced both by organizational context and professional knowledge. Leadership is better understood as relational and communicative, negotiated continuously within daily team interactions, rather than as a fixed hierarchical role. The notion of a dual-identity struggle is reconsidered here: SPs do not merely accept or reject leadership; they actively develop it as a flexible, integral part of their professional identity. The two main storylines – teamwork as dialogue and teamwork as an organizational instrument – highlight the ongoing balancing act between collaboration and hierarchy in clinical practice. These insights point to the importance of integrating leadership, communication, and teamwork skills throughout the entire span of medical training, fostering identity development through interaction and social construction.

For future studies, it is recommended to investigate how physicians handle competing leadership demands in real-world settings and how these affect their professional identity development. While previous research has explored perceptions of teamwork [41], there is a need to focus on authentic interactions. This could involve ethically guided observations, recordings with consent, or anonymized analysis of team discussions. Additionally, examining how physicians' leadership and communication approaches evolve over the course of medical education would provide valuable insights. In practice, structured reflection, simulation-based interprofessional training, and mentorship programs can support physicians in managing leadership challenges and improving collaborative communication within teams.

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