

What counts as training capacity? Professional identity and educational readiness for postgraduate medical training expansion in Ireland: a qualitative multistakeholder case study

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Research Article

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Abstract

Background

Expanding postgraduate medical training requires decisions about what constitutes credible training capacity, which educational resources should be prioritised and how agreement can be reached across organisations with different responsibilities. This study examined how professional identity influenced these aspects of strategic renewal in Irish postgraduate medical education.

Methods

An interpretive embedded qualitative case study was conducted using 35 semi-structured interviews with senior stakeholders, documentary analysis and participant cognitive maps collected across three waves between 2023 and 2025. Reflexive thematic analysis and pattern matching addressed the study's three research questions: how professional identity shaped decision-making during renewal; how identity commitments influenced prioritisation and resource allocation; and how identity conflicts underpinned or inhibited consensus across stakeholders.

Results

Sites experiencing the greatest workforce pressure could present the strongest service case for additional trainees while having the least capacity to provide supervision and protected learning time. Professional identity shaped what stakeholders counted as credible expansion. Policy and service actors emphasised numbers, deployment and deliverability; clinician-educators, training bodies and trainees emphasised supervised learning, progression and the quality of the training environment; and regulatory actors emphasised standards, accountability and public protection. These identity commitments directed attention and resources towards different elements of training capacity and generated tension over speed, quality and assurance. Consensus became possible when stakeholders connected rather than displaced these responsibilities. Six educational-readiness domains made that negotiated position operational: supervised participation; breadth and continuity of learning opportunities; protected educational time; educator and assessment capacity; trainee support and wellbeing; and organisational alignment with regulatory assurance.

Conclusions

Expansion of postgraduate medical training is an identity-structured process as well as a workforce and educational intervention. Professional identity influences how stakeholders interpret capacity, legitimate priorities and acceptable evidence. The Educational Readiness Framework translates the negotiated outcome of those perspectives into practical conditions for expansion while retaining the distinct

responsibilities of policy, service, education, regulation and trainees. A funded training post should not be treated as equivalent to educational capacity.

Background

Health systems across Europe are seeking to increase specialist medical capacity in response to workforce shortages, demographic change and growing service demand. [1–7] In Ireland, workforce policy has also been shaped by persistent problems of doctor retention and migration. [8–12] Increasing the number of doctors entering specialist training is an understandable response. Yet the number of funded posts is an administrative measure. It does not show whether the settings in which those posts are located can provide the learning required for specialist practice.

Postgraduate medical education (PGME) is delivered mainly through participation in patient care. The clinical learning environment determines whether trainees can observe expert practice, undertake progressively demanding work, receive feedback, develop professional judgement and assume responsibility with appropriate oversight. [13–17] Its educational capacity therefore depends on the relationship between clinical activity and learning. A service may have unmet workforce need and available salary funding while lacking enough supervisors, appropriate case mix, continuity, protected educational time or assessment capacity to support another trainee.

This distinction becomes important when training expansion is used as a workforce intervention. If workforce demand is translated directly into posts, expansion may increase intake without increasing the conditions through which competence develops. Supervisors may carry more learners without additional time; training experiences may become diluted; assessment systems may face greater volume; and trainees may be deployed primarily to fill service gaps. Nominal capacity can therefore rise while educational capacity remains static or falls.

Existing medical education research describes many components of a high-quality clinical learning environment. Irish stakeholders have identified engagement with senior doctors, learning during patient care and the organisation of work as central to postgraduate learning.[13] Realist synthesis shows that supervised workplace learning depends on entrustment, observation, modelling, meaning-making and feedback, all of which are influenced by local and system conditions.[14] Reviews of educational supervision point to variation in how supervisory roles are defined and enacted.[15] Residents and supervisors also describe recurring tensions among clinical work, formal education and feedback.[16] More recent scholarship treats the clinical learning environment as a system shaped by organisational pressures rather than as an isolated teaching setting.[17, 18]

These studies explain how learning is supported, but they provide less guidance on how a health system should decide whether a service, site or programme is ready to absorb additional trainees. Workforce plans commonly count entrants, posts, completions and vacancies. Educational quality processes commonly review programmes or sites after training is established. Between these functions lies a practical planning question: what evidence should be available before expansion is approved?

Ireland is a useful setting in which to examine this question because responsibility for PGME is distributed. The Department of Health influences policy and funding; the Health Service Executive employs and deploys much of the workforce; postgraduate training bodies design curricula and assessments; the Medical Council regulates standards and accreditation; and clinical services provide the workplace in which training occurs. Trainees encounter the combined effects of decisions made across these organisations. No single actor controls all the resources or assurances required for expansion.

Professional identity refers to the values, beliefs, expectations and responsibilities through which individuals understand their professional roles and judge appropriate action. [19, 20] In multistakeholder settings, different professional identities can direct attention towards different problems, priorities and forms of evidence. Identity therefore shapes sensemaking by influencing how stakeholders interpret proposed change, and it shapes legitimacy by influencing which decisions and claims they regard as credible or defensible. Because strategic renewal requires stakeholders to determine priorities, allocate resources and sustain agreement across organisational boundaries, professional identity may both enable and constrain that process. The study consequently examined three questions: how professional identity shapes decision-making during strategic renewal; how identity commitments influence prioritisation and resource allocation; and how identity conflicts underpin or inhibit consensus across stakeholders.

These identity dynamics are especially relevant when doctors move into educational, clinical or organisational leadership roles. Leadership development research has often concentrated on individual knowledge and skills, while reviews have identified a need for greater attention to system-level outcomes and the contexts in which leadership is enacted.[21] Studies of clinical managers show that doctors can experience difficulty reconciling professional and managerial roles, with clinical identity remaining an important source of meaning and legitimacy.[22] Medical leadership may therefore involve identity work as clinicians learn to interpret organisational, financial, regulatory and political demands alongside responsibilities for patient care and professional standards.[23–25] In PGME, these demands converge in decisions about training capacity: clinician-leaders may need to span boundaries between the educational requirements of professional formation and the organisational realities through which those requirements are resourced and delivered.

Within those questions, the paper focuses on decisions about expansion and develops the Educational Readiness Framework as a practical synthesis of the findings.

Methods

Study design and research questions

An interpretive embedded qualitative case study was conducted within an abductive methodological orientation. The case was a system-level reform process concerned with PGME and medical workforce

development in Ireland.[26, 27] The embedded units included organisations and stakeholder groups involved in policy, service delivery, specialist training, regulation and trainee representation. The design was appropriate because professional identity and strategic renewal were produced and negotiated across organisational boundaries rather than controlled by a single institution.

The study examined how professional identity influenced strategic renewal. It addressed three research questions: (1) How does professional identity shape decision-making during strategic renewal? (2) How do identity commitments influence prioritisation and resource allocation? (3) How do identity conflicts underpin or inhibit consensus across stakeholders? This paper applies those questions to stakeholder accounts of postgraduate training expansion and the educational conditions required to make expansion credible.

Participants and sampling

Participants were selected purposively because of their experience, formal responsibilities, informal influence or system-level visibility within PGME and workforce reform. Invitations were issued by email with a participant information leaflet describing the study, the researcher's role, voluntary participation, confidentiality and the intended use of findings. The final sample comprised 35 senior stakeholders from postgraduate training bodies, the national health service employer, the medical regulator, government and policy roles, clinical education and other relevant positions, including trainee representation. Sampling sought variation in institutional location, professional role and seniority. Four individuals declined because of time constraints; where necessary, an alternative participant from the same organisation was approached. Data collection continued until later interviews produced diminishing new insight into the case.

Data collection

The author conducted semi-structured interviews across three waves between 2023 and 2025. Interviews lasted approximately 45 to 55 minutes, were conducted one-to-one in person, online or by telephone, and were audio-recorded with consent. The semi-structured interview guide was developed specifically for this study and included a cognitive sorting and mapping exercise followed by open questions exploring participants' professional backgrounds and identities, experiences of strategic decision-making, sources of influence, areas of agreement and conflict, and perspectives on change and future priorities (Supplementary File 1). Reflexive field notes and a research diary were maintained. Documentary material included policy and strategy documents, meeting records, reports and professional communications relevant to the reform process.

Analysis

The sole author conducted the analysis using NVivo 15. Reflexive thematic analysis followed the phases of familiarisation, coding, theme development, review, definition and analytic writing.[28] Initial coding remained close to participants' accounts of professional roles, reform priorities, decision criteria, resources, standards, areas of agreement and contestation. Subsequent analysis examined how identity commitments shaped sensemaking, legitimacy judgements and causal reasoning about training expansion.

Codes were compared across stakeholder groups to address the three research questions. For decision-making, the analysis examined how actors defined the problem of capacity and what evidence they treated as credible. For prioritisation and resource allocation, it examined which educational and operational conditions stakeholders protected, deferred or regarded as non-negotiable. For consensus, it examined how differences among policy, service, educational, regulatory and trainee identities generated conflict or enabled negotiated agreement.

Cognitive maps and documentary material were used for pattern matching. The maps showed how participants linked workforce numbers, supervision, clinical exposure, protected time, assessment, wellbeing, standards and service pressure as causes, constraints or outcomes. The analytic synthesis identified six educational-readiness domains that captured the conditions around which stakeholder priorities converged. The framework is therefore presented as an outcome of identity-structured decision-making and negotiation, not as a separate research question.

Credibility was supported by prolonged engagement across three waves, triangulation among interviews, documents and cognitive maps, a recorded audit trail, reflexive memo-writing and examination of divergent accounts. Transcripts were not routinely returned to participants, and formal respondent validation of the final framework was not undertaken.

Researcher position and reflexivity

At the time of the study, the author was a doctoral researcher at Aston University and a senior leader in Irish postgraduate medical education. This insider position provided access and contextual knowledge but created a risk that familiar policy language or organisational assumptions would be accepted without sufficient examination. Participants were informed of the researcher's role and reasons for undertaking the study. Reflexive memos recorded assumptions, role-related tensions and alternative interpretations. Reporting uses broad stakeholder categories to reduce deductive identification within a small senior stakeholder community.

Ethics

Ethical approval

was granted by the Aston University College of Business and Social Sciences Research Ethics Committee in September 2023 (reference BSS21085). Participants received written study information

and provided informed consent. Participation was voluntary, withdrawal was permitted during the interview and for 21 days afterwards, and participants consented to the use of anonymised quotations.

Reporting and relationship to other manuscripts

The study is reported with reference to the Consolidated Criteria for Reporting Qualitative Research and broader standards for reporting qualitative research. [29, 30]

Use of generative AI

Generative AI was not used to collect data, conduct interviews, code the source data, generate findings or make research decisions. Generative AI was used during manuscript preparation to assist with journal-specific restructuring, literature-search support and language refinement. The author reviewed and verified all AI-assisted text and takes full responsibility for the content of the manuscript.

[Table 1 near here]

Table 1
Study design and analytic scope

Component	Description	Purpose in this analysis
Design	Interpretive embedded qualitative case study of Irish PGME reform	Examined educational capacity across organisational boundaries
Participants	35 stakeholders across policy, service, training, regulation, clinical education and trainee representation	Captured different responsibilities for planning and delivering training
Interviews	Semi-structured interviews conducted in three waves from 2023 to 2025	Explored priorities, constraints, influence and implementation
Documents	Policy, strategy, meeting and professional records	Located stakeholder accounts within formal arrangements
Cognitive maps	Participant-defined factors and causal relationships	Tested how educational conditions were connected
Focused analysis	Examined identity shaped decision making, prioritisation and consensus in relation to educational capacity.	Distinguished funded posts from educational readiness

Results

The findings revealed three mechanisms through which professional identity shaped the expansion of postgraduate medical training. First, professional identity determined what stakeholders recognised as credible evidence of training capacity. Second, identity commitments directed attention and resources towards different service, educational and regulatory priorities. Third, consensus depended on

integrating these different legitimate priorities rather than eliminating disagreement. The interaction of these mechanisms identified six connected conditions of educational readiness. Weakness in any one condition could turn a nominal training post into a predominantly service post.

Professional identity determined what counted as credible evidence of capacity

Policy and service participants tended to make workforce pressure visible through numbers, vacancies, deployment and throughput. One participant described the prevailing demand directly: "At the end of the day, the Department wants numbers - how many doctors we are training, how quickly we can get them into the system." This framing reflected responsibilities for supply and service delivery. It supported action because it produced targets that could be funded and monitored, but it compressed several questions into one measure: whether a post existed, whether it was filled and whether it provided a viable education.

Clinician-educators, training bodies and trainees interpreted the same decision through responsibilities for professional formation, progression and patient care. Their accounts asked what the trainee would do, who would supervise, whether the experience matched the curriculum and whether service conditions permitted feedback and progression. A clinician-educator located legitimacy in the educational outcome: "everything comes back to the patient. You can redesign curricula, move trainees around, introduce new assessment tools, but the real question is whether it makes them better doctors."

Professional identity therefore influenced the decision by shaping what each group noticed and what it regarded as credible evidence. The difference was not whether expansion was needed. It concerned what had to be true before expansion could be called successful. Participants' accounts shifted the unit of analysis from the funded post to the post-in-context: the learner, supervisor, clinical work, curriculum, assessment system and organisation had to function together.

Educational implications for supervised clinical participation

Participants treated supervision as more than the formal allocation of a named trainer. Educational readiness required supervisors who were clinically available, understood the programme, could observe performance and had enough continuity with trainees to judge development. High clinical activity could provide valuable exposure, but volume alone did not create learning. Experience became educational when trainees could participate at an appropriate level, discuss decisions, receive feedback and take progressively greater responsibility.

This distinction exposed a potential contradiction in expansion. Sites under the greatest workforce pressure could appear to have the strongest case for more trainees because they offered abundant service activity. The same pressures could reduce senior availability and make trainees more likely to work as service substitutes. In the cognitive maps, supervision, staffing and service demand frequently

appeared as connected causes rather than separate variables. Adding a trainee could relieve an immediate rota gap while increasing the supervisory load borne by the same clinicians.

Participants therefore understood supervisor capacity as a finite educational resource. Readiness depended on the number and availability of suitable supervisors, the distribution of supervision across teams and shifts, and the organisation's ability to protect observation, feedback and review. Formal trainer recognition was necessary for assurance but insufficient as evidence that supervision could occur in practice.

Educational implications for breadth continuity and progression

A second domain concerned the content and sequence of workplace learning. Participants referred to clinical exposure as a condition of training quality, but their accounts indicated that exposure involved more than case numbers. Educational value depended on breadth of case mix, access to required procedures and decisions, continuity across stages of training and opportunities that matched the learner's level. A site could be clinically busy yet provide a narrow or repetitive experience.

Readiness was therefore specialist training programme specific. The same clinical service might offer strong learning opportunities for one stage or component of a curriculum but not for another. Expansion decisions needed to consider the complete training pathway, including rotations and dependencies on other sites. Where learners competed for a limited set of cases, procedures or supervisors, increasing numbers could dilute individual opportunity even though total service activity remained high.

Participants also linked learning opportunities with patient care and standards. The purpose of clinical exposure was not to accumulate activity but to support competent, safe practice. This made progression important: trainees required an appropriate balance of participation, oversight and autonomy. Expansion was educationally credible when the clinical environment could preserve that balance for both existing and additional trainees.

Identity commitments directed the allocation of educational resources

Protected educational time revealed how identity commitments influenced resource allocation. Service and education drew on the same people and working day, but stakeholders valued that time through different responsibilities. Participants described pressure on both trainee learning time and educator time. Teaching, feedback, portfolio review, assessment and remediation could be displaced when clinical demand intensified. Expansion without explicit time allocation increased the volume of educational work while leaving its temporal resources unchanged.

The effects were cumulative. Reduced time limited observation and feedback weakened the quality of assessment and made difficulties harder to identify early. It also changed the trainee's experience of the programme: formal curriculum requirements remained, but the practical opportunity to meet them

narrowed. Participants did not treat this simply as a scheduling inconvenience. They connected it with competence, morale and retention.

The prioritisation question was therefore practical rather than rhetorical. A post could not be considered ready solely because a rota could accommodate another doctor. Protecting training required workforce and service plans to allocate time to the learning processes that justified designating the position as a training post.

Educator and assessment capacity

Participants also identified capacity beyond the immediate supervisor-trainee relationship. Programmes depended on educators, assessors, programme directors, administrative support, faculty development, learning infrastructure and processes for reviewing progression. These resources were less visible than funded posts but determined whether increased learner volume could be managed without weakening standards.

Assessment capacity was particularly important because expansion increased the number of observations, judgements, reviews and decisions required. The data did not support treating assessment as a final checkpoint that could absorb unlimited volume. It was part of the learning process and relied on timely, credible judgement. Where educators lacked time or training, assessment could become episodic or documentary rather than a meaningful account of performance.

Readiness therefore included the programme's ability to recruit and develop faculty, distribute assessment work, maintain consistency and respond when a trainee needed additional support. These functions required planning before numbers increased. Retrofitting them after expansion transferred risk to trainees, educators and patients.

Trainee support and wellbeing

Trainee wellbeing was described in relation to workload, learning, morale, professional development and the likelihood of remaining in the system. Participants did not reduce wellbeing to individual resilience. They linked it to the conditions under which trainees worked and learned. When service pressure repeatedly displaced education, the programme's promise of specialist development became less credible.

In this sense, trainee experience served as information about educational capacity. Difficulty accessing supervision, persistent loss of learning time, excessive service dependency and weak continuity could appear first as dissatisfaction or distress before becoming visible in completion or retention data. Expansion that ignored these signals risked scaling the conditions producing them.

A readiness assessment therefore needed to consider both support structures and evidence of the existing trainee experience. Formal access to occupational or wellbeing services was relevant, but it did not compensate for a learning environment whose routine organisation generated avoidable strain.

Trainee voice was important because system-level actors could otherwise infer capacity from posts and activity while missing how the environment functioned in practice.

Consensus required the integration of different legitimate priorities

The organisations that authorised, funded, delivered and assured training worked from different professional and institutional mandates. A training body participant characterised cross-system discussion as "talking different languages". A senior manager described the practical task as learning to "speak three languages: the clinical, the political and the regulatory." These differences affected which evidence each organisation regarded as sufficient and could inhibit consensus when one identity claim displaced the responsibilities of another.

Regulatory participants emphasised standards, accreditation, accountability and defensibility. One stated: "We're not here to rubber stamp ideas. Our job is to ensure standards are met and maintained." This identity commitment could be experienced as a constraint on speed, but it also supplied public and professional legitimacy. Consensus did not require the regulator, employer or training body to abandon its mandate. It required stakeholders to recognise how standards, educational quality and operational feasibility depended on one another.

No organisation controlled all six readiness domains. The employer could fund posts and organise services but did not own the complete curriculum or regulatory standard. Training bodies could specify educational requirements but depended on clinical services for time, cases and supervisors. The regulator could accredit and set standards but did not deploy staff. Consensus became actionable when these identities were connected through aligned decisions and shared evidence. Without that integration, approval in one part of the system could precede the resources or assurance required in another.

Educational Readiness Framework as negotiated synthesis

These three identity mechanisms produced the six-domain Educational Readiness Framework for PGME Expansion presented in Table 2. The framework is therefore the practical synthesis of the findings rather than a separate set of findings. It integrates the conditions that different stakeholders considered necessary for legitimate expansion: workforce supply, service feasibility, professional formation, trainee experience, regulatory assurance and patient protection. It is intended as a prospective planning and monitoring tool. It does not produce a single universal threshold because curricula, specialties and sites differ. Instead, it requires decision-makers to state the evidence for readiness in each domain, identify dependencies and agree how risk will be monitored after expansion.

The framework also changes the timing of quality assurance. Accreditation remains essential, but a readiness review should occur before or alongside decisions to increase numbers. It should then be repeated when material service changes alter staffing, case mix, supervision or trainee experience. Readiness is therefore a condition to be maintained, not a one-off designation.

Table 2
Educational Readiness Framework for PGME Expansion

Readiness domain	Evidence to examine before expansion	Risk if weak
Supervised clinical participation	Available and trained supervisors; continuity; observation; feedback; appropriate graduated responsibility	Service substitution; limited feedback; unsafe or delayed progression
Breadth continuity and progression	Case mix; procedural and decision-making opportunities; stage-appropriate experience; rotation dependencies	Narrow or diluted exposure; competition for learning; curriculum gaps
Protected educational time	Time for teaching, feedback, study, portfolio work, review and remediation in job and service plans	Education displaced by service; delayed identification of difficulty
Educator and assessment capacity	Faculty numbers and development; assessor workload; administrative support; progression and remediation processes	Superficial assessment; inconsistent decisions; faculty overload
Trainee support and wellbeing	Workload; access to support; continuity; trainee feedback; indicators of morale, retention and avoidable strain	Burnout; attrition; reduced engagement and learning
Organisational alignment and assurance	Agreed responsibilities, funding, accreditation, data sharing, implementation sequence and monitoring	Posts approved without resources; fragmented accountability; loss of trust

Discussion

This study found that professional identity shaped postgraduate medical training expansion through three connected mechanisms: it determined what stakeholders counted as credible evidence of capacity, directed the allocation of educational resources and influenced how competing priorities were integrated into legitimate decisions. These mechanisms help explain why stakeholders could agree that expansion was necessary while disagreeing about whether a particular site or programme was ready. The six-domain Educational Readiness Framework is the practical synthesis of those findings, translating different service, educational, trainee and regulatory responsibilities into conditions that can be assessed before expansion.

The first research question concerned decision-making during strategic renewal. The findings show that identity operated through sensemaking: stakeholders interpreted the same proposal for expansion through different mandates and professional responsibilities. Workforce demand justified why more specialists were needed, but educational identities questioned whether a particular setting could train them. Regulatory identities asked whether the arrangement remained defensible against standards. Decision quality therefore depended on making these different criteria explicit rather than treating headcount as a complete account of capacity.

Supervision illustrates this identity-structured decision process. Counting recognised trainers or assigning a named supervisor provided formal assurance. Clinician-educators, however, interpreted supervision through availability, continuity, observation and meaningful interaction. A similar issue arose with clinical exposure. High service volume signalled opportunity to service planners, while educators considered case mix, access, progression and competition among learners. Neither perspective alone was sufficient for a credible expansion decision.

The second research question concerned prioritisation and resource allocation. Protected time made these commitments visible because service and education competed for the same workforce resource. Previous research identified time to learn during patient care and protected educational time as central challenges in clinical learning environments.[13] The present findings show how decisions about time expressed underlying priorities. If additional posts increased teaching and assessment workload without changing job plans or service organisation, the system expanded demand for education rather than its capacity to provide it.

Trainee wellbeing was one way in which the consequences of resource decisions became visible. When service pressures repeatedly displaced supervision, protected learning time and access to support, trainees experienced greater workload strain and fewer opportunities for professional development. Two systematic reviews have reported a high prevalence of burnout among postgraduate medical trainees. [31, 32] In Ireland, a longitudinal multicentre study found an association between junior doctor burnout and self-reported error.[33] The framework does not treat wellbeing as an instrument for workforce retention or as a substitute for educational quality. It treats recurring strain, loss of learning time and weak support as evidence that the clinical learning environment may already be operating beyond sustainable capacity. Trainee experience should therefore inform readiness and monitoring, rather than being considered only after expansion.

The third research question concerned identity conflict and consensus. Regulatory assurance demonstrated that conflict did not arise only from poor communication. Stakeholders were accountable for different outcomes and used different standards of legitimacy. European specialist training varies in structure, duration, curriculum and assessment.[34–38] Within this variation, consensus became possible when actors treated standards, educational quality and operational feasibility as interdependent. Early engagement among regulators, training bodies, employers, educators and trainees allowed disagreement to inform design rather than emerge after commitments were made.

Implications for medical leadership development

The findings also have implications for how medical leadership is developed. The participant who described cross-system work as learning to "speak three languages: the clinical, the political and the regulatory" captured a form of boundary-spanning that was central to the case. Clinicians moving into leadership roles did not cease to reason as professionals; rather, their professional commitments shaped which evidence they trusted, which risks they regarded as legitimate and which compromises

they considered acceptable. At the same time, credible system leadership required engagement with organisational resources, workforce constraints, regulation and policy priorities that could not be resolved through clinical reasoning alone.

This interpretation is consistent with research describing medical leadership as an identity challenge and clinician-manager roles as hybrid positions in which professional and managerial identities must be negotiated.[22, 24] Berghout and colleagues further show that leadership development can support physicians in moving from relatively detached or individualistic understandings of context towards a more collaborative identity in which organisational conditions are adjusted with others.[23] The implication for medical education is that leadership development should not be limited to generic competencies or technical management knowledge. It should also create opportunities for clinicians to examine how professional identity shapes sensemaking, legitimacy judgements and responses to financial, political, regulatory and organisational constraints.

This does not mean weakening clinical identity. In this study, professional commitments to supervision, progression, standards and patient care were essential safeguards against treating funded posts as educational capacity. The developmental task is instead to build reflexive and boundary-spanning capability: retaining the normative strengths of professional identity while learning to work across the institutional logics that determine whether educational priorities can be implemented. Reviews of physician leadership development similarly suggest that individual skill acquisition alone is insufficient and that development needs to connect physicians with organisational context, networks and system-level outcomes.[21, 25] For PGME, leaders capable of this translation may be particularly important because educational capacity is produced collectively across organisations rather than controlled by a single actor.

The framework has practical implications for national and local decision-making. A proposal for additional posts should include an educational readiness statement addressing all six domains. Evidence might include supervisor-to-trainee arrangements, educator time, expected clinical opportunities, assessment workload, trainee experience data, rotation capacity, accreditation status and the resources required from participating organisations. The purpose is not to create a uniform numerical score. A single composite score could conceal a critical weakness, such as unavailable supervision. The review should identify minimum conditions, dependencies and mitigations for the specific programme and site.

Readiness should also be monitored after implementation. Expansion can change the environment it assesses: more learners alter access to cases, supervision and faculty workload. Service redesign, vacancies or changes in case mix can subsequently reduce capacity. A staged approach allows systems to test whether expected learning opportunities and supervision are being realised before adding further posts. Measures should combine administrative information with educational indicators such as access to supervision, completion of workplace assessment, progression, rotation experience, trainee feedback and faculty workload.

The framework is relevant beyond Ireland because distributed responsibility is common in PGME. Ministries, employers, regulators, universities, professional bodies and clinical educators often control different parts of the training pathway. The exact institutional arrangement will vary, but the planning problem remains recognisable: the body that funds a post may not control the educational resources that make it viable. The framework offers common questions around which these actors can organise evidence and accountability.

The paper retains the research questions and interpretive design of the wider study while making a specific contribution to medical education. It explains how professional identity shaped decisions about educational capacity, resource priorities and consensus during training expansion. The Educational Readiness Framework is the practical synthesis of those findings and distinguishes this contribution from the related manuscript's emphasis on health workforce policy.

Strengths and limitations

The study brought together perspectives from policy, service delivery, training, regulation, clinical education and trainees and combined interviews with documents and cognitive maps. This supported analysis of identity-structured decision-making, prioritisation and consensus across organisational boundaries, while also identifying the educational conditions around which stakeholder perspectives converged.

Several limitations apply. The framework was developed from one national case and should be adapted rather than transferred unchanged to systems with different governance, resources or training structures. The sample was weighted towards senior system stakeholders; trainee representation was included, but direct observation of learning environments and a larger trainee sample could have produced further detail. Patient and public perspectives were limited. The framework has not yet been prospectively tested against outcomes following expansion, so it should be regarded as an empirically grounded planning framework rather than a validated measurement instrument.

The researcher's insider role supported access but may have shaped what participants chose to disclose and how familiar concepts were interpreted. Reflexive records, triangulation and attention to divergent cases reduced but could not remove this influence. Cognitive maps captured participants' perceived causal relationships; they are interpretive data and not objective models of system behaviour.

Conclusions

Professional identity shaped postgraduate medical training expansion by determining what stakeholders counted as credible evidence of capacity, which resources and standards they prioritised and how they negotiated consensus. Health systems risk mistaking workforce need for educational capacity. Indeed, the sites with the most urgent service case for additional trainees may be least able to provide the supervision, protected learning time and support required for effective training. Expansion therefore requires evidence not only that additional doctors are needed, but that the clinical learning environment

can convert service participation into supervised progression towards specialist competence. The six-domain Educational Readiness Framework provides a practical means of assessing these conditions before expansion and monitoring them afterwards. These findings also suggest a leadership-development implication: clinicians who lead PGME reform need opportunities to develop the reflexive and boundary-spanning capacity to work across clinical, educational, organisational, regulatory and political contexts without losing the professional commitments that protect training quality.

Abbreviations

COREQ

Consolidated Criteria for Reporting Qualitative Research

PGME

Postgraduate medical education

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the Aston University College of Business and Social Sciences Research Ethics Committee in September 2023 (reference BSS21085). The research was conducted in accordance with Aston University's Research Integrity Policy and applicable institutional research ethics and governance requirements. Participants received written study information and provided informed consent before participation.

Consent for publication

Not applicable.

Competing interests

The author declares that he has no competing interests.

Funding

No funding was received for this study.

Author Contribution

MM is the sole author and conceived the study, collected and analysed the data, interpreted the findings, wrote the main manuscript .

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The author thanks the study participants for sharing their time and perspectives.

Data Availability

The datasets generated and analysed during the current study are not publicly available because participants were senior stakeholders in a small professional governance system and release would create a material risk of deductive identification. Further information about the analytic process may be available from the corresponding author where ethically permissible.

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