FACTORS INFLUENCING NOTIONS OF PROFESSIONALISM

INSIGHTS FROM ESTABLISHED PRACTITIONER NARRATIVES

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Abstract

Factors influencing notions of professionalism – insights from established practitioner narratives

The aim of the research is to explore the ways in which the meaning of professionalism is increasingly understood during the process of professional socialisation into medicine. The major work is in the analysis of the accounts of senior doctors and a sociocultural approach looks at their perspectives on the factors in their learning which have impacted on their own practice, on their notions of the meaning of professionalism and on their roles as teachers.

Such an analysis is not without its challenges. Much of the existing literature on professionalism has taken a positivistic turn, for example focusing on developing ‘efficient and effective’ ways to teach and developing instruments to assess traits deemed likely to contribute to professionalism. Conflicts faced by students or new doctors when they encounter professional dilemmas are also extensively studied. From some areas of the literature it is increasingly evident that medical professionalism is a complex and dynamic construct ever-changing in meaning depending upon context. Accordingly, interpretive methods are highly suited to give a rich analysis of the central issues of this thesis. Three separate analyses of the data provide new insights into the meaning of professionalism in medicine and how it may best be passed on to new generations of doctors.

This work adds to the literature on the nature of professionalism by giving a retrospective perspective from established practitioners. In exploring the complexity of the humanistic and broader professional side of medical practice it seemed appropriate to seek the perceptions of senior clinicians. Unlike medical
students or junior doctors, more senior professionals are able to discuss these matters with the benefit of real experience and from a position of relative phronesis. The major educational influences that are investigated are relationships with professional role models, the hidden curriculum and the learning atmosphere.

A central tenet of this thesis is that the current dominance of a positivistic paradigm in medicine and the power relationships inherent in medical education run counter to the humanistic environment needed to nurture the development of characteristics essential to deliver patient-centred medical care. The currently prevailing culture in which medical education is conducted is rule-driven, competitive, self-serving and uncaring. I assert that in order to produce the caring, supportive and collaborative doctors needed by a twenty-first-century global society, a radical change in culture within medical education is needed.
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Publications and Conference Papers Arising from this Research

International Conference Presentations

**Foster K.** and Roberts C., Learning about professionalism – a medical student never forgets. *13th Ottawa Conference*, 2008, Melbourne, Australia (Oral presentation)

**Foster K.** and Roberts C., Heroes, villains and professionalism. *Association of Medical Education in Europe Annual Conference*, 2008, Prague, Czech Republic. (Research presentation)

Publication

**Foster K.** *Learning about medical professionalism – don’t forget emotion!* The Clinical Teacher. 2009; 6: 9-12 (Research paper)
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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABIM</td>
<td>American Board of Internal Medicine</td>
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<tr>
<td>AHS</td>
<td>Area health service</td>
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<tr>
<td>AMC</td>
<td>Australian Medical Council</td>
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<tr>
<td>CoP</td>
<td>Community of practice</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
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<td>EBM</td>
<td>Evidence based medicine</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
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<tr>
<td>JMO</td>
<td>Junior medical officer</td>
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<tr>
<td>MLE</td>
<td>Metaphorical linguistic expression</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse unit manager</td>
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<tr>
<td>OSCE</td>
<td>Objective Structured Clinical Examination</td>
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<tr>
<td>OT</td>
<td>Occupational therapist</td>
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<tr>
<td>PGY</td>
<td>Post graduate year</td>
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<tr>
<td>PIN</td>
<td>Personal incident narrative</td>
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<tr>
<td>RACP</td>
<td>Royal Australasian College of Physicians</td>
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<tr>
<td>RACS</td>
<td>Royal Australasian College of Surgeons</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>RCS</td>
<td>Royal College of Surgeons</td>
</tr>
<tr>
<td>RMO</td>
<td>Resident Medical Officer</td>
</tr>
<tr>
<td>SI</td>
<td>Symbolic interactionism</td>
</tr>
<tr>
<td>SIT</td>
<td>Social identity theory</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WCC</td>
<td>White coat ceremony</td>
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Prologue

*Wherever the art of medicine is loved, there is also a love of humanity*
(Hippocrates ca 460 BC – ca 377 BC)

Introduction

For more than thirty years of my professional life as a doctor I have been actively involved in the education of medical students and junior doctors. Over the course of my career this has included being a clinical supervisor, tutor, mentor, assessor, curriculum designer, teacher trainer and educational consultant both in developed (Scotland, Macedonia, Croatia and Australia) and in developing countries (Vietnam and Timor Leste). This variety of perspectives, including, of course, being an undergraduate medical student, postgraduate trainee in a variety of hospital specialties and a general practitioner, has afforded me the opportunity to reflect widely and deeply on the teaching and learning of medicine. In particular, I have maintained a passionate interest in the concept of ‘medical professionalism’ and the process by which it is learned. Reflexivity is a key element of this thesis and I can think of no better way to start than through my own perceptions of the origins of my interest in professionalism.

Personal reflection

I know that, for me, being a medical student and young doctor was a huge learning experience. Assimilating the necessary scientific content was difficult involving much concentration, note-taking and endless nights of study. Acquisition of clinical skills was mostly fun, either attending fascinating bedside tutorials or
helping the residents and interns in their daily tasks. It was all hard work but relatively straightforward. If I attended classes and clinical placements, paid attention, studied diligently in the evenings and remained calm in examinations I would graduate from the course.

What was much more challenging was making sense of the less tangible elements of being a doctor. On the wards and in clinics I saw a myriad of different ways of interacting with people; as a passive observer I witnessed the reactions of patients to the way that doctors spoke to them – or ignored them. Subconsciously, I registered the traits and behaviours of doctors and the similarities and differences between those traits and behaviours and those of nurses and other health professionals. This type of learning, which occurs outside the more formal curriculum has often been recognised and dubbed the ‘hidden’ and ‘the informal’ curriculum (F W Hafferty, 1998). The term ‘hidden’ refers to organisational and structural influences operating at an institutional level, whether it be university or health service (F W Hafferty, 1998). The ‘informal curriculum’, on the other hand, comprises the often casual, interpersonal interactions happening every day between students, tutors, patients and others and from which learning can occur (Karnieli-Miller, Vu, Holtman, Clyman, & Inui, 2010). At the time, I did not realise that this was an integral part of my medical education. I thought that seeing the humanity in hospital wards and clinics was for nurses and lay people. I thought that to be a ‘good’ doctor I had to repress my natural empathy with distressed, worried or ill people. It seemed to me that in the world of medicine there was little or no place for emotions and feelings. We were taught that we had to be objective in our assessment of a clinical case so that we could dispassionately reach an accurate diagnosis and prescribe the most effective treatment.
Looking back on my own experiences it seems that the formal curriculum aimed to teach me the ‘science’ of medicine, while I learned the ‘art’ of medicine piecemeal from a myriad of experiences throughout life – and from the people I came across along the way. In our privileged positions as medical students and doctors we are close to human suffering and emotion and our day-to-day interpersonal interactions provide a rich learning environment.

Several key moments from my medical education have remained stored in my memory for more than a quarter of a century. What makes them memorable to me is not the seriousness of the patient’s condition or the expertise of the clinical teacher, but the level of emotion I felt at the time and on the occasions I have thought about them since. A link between emotion and memory is recognised in the literature (Levine & Pizarro, 2004) and I will illustrate two of these in the form of personal incident narratives (PINs). That is, I will briefly tell the stories of what happened from my perspective.

Mrs Campbell¹ and the teaching hospital

I still remember a very upsetting experience I had as a fourth-year student. Mrs Campbell, a thirty-five year-old woman had been admitted during the night as an emergency. She had a chronic condition which had flared up acutely. The membranous bag around her heart was very inflamed causing fluid to collect and prevent her heart from pumping effectively. This meant that she was extremely

¹ Name has been changed to provide anonymity
breathless. I was sent to see her with an eminent cardiologist in charge of her ‘case’ who was going to demonstrate how to take an accurate history from a patient with a cardiac condition. Mrs Campbell struggled to breathe as he asked her not just to state her name and address but to spell them too. He said that this was to ensure accuracy in documentation. She was so breathless that she could barely speak. I could hardly bear to watch. Throughout the rest of that day a stream of junior doctors came to examine her as practice for their upcoming examinations. Eventually in the evening Mrs Campbell was transferred to another hospital for lifesaving surgery but she died during the operation. That was the day I learned that, contrary to my understanding of the Hippocratic Oath, doctors can (and do) indeed put their own needs above those of the sick and the vulnerable.

The opening of the new building

Seven years later I was a new partner in a large urban general practice (GP) in a socially deprived area of Scotland. Many of the patients registered with the practice were unemployed and there were high rates of both medical and social problems impacting on health. I had spent three years training in various hospital specialties in a local hospital and one year as a GP trainee in this practice. I was the first female partner the practice had ever appointed as it had been thought too tough an area for women to work in. Through a government finance scheme the partnership had built new premises with a comfortable waiting room, pleasant consulting rooms for doctors, nurses and the other health professionals who made up the

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2 The pledge often taken by medical graduates
primary health care team. In celebration, an opening ceremony was held with the local Member of Parliament presiding and invitations extended to other general practitioners practising in the surrounding area. During the proceedings a young doctor, who was from a neighbouring practice with a predominantly middle class clientele, said to me over his glass of champagne, “I don’t know what you’re wasting your money on your patients for, they’re not worth it.” I felt ashamed that a fellow member of my profession could be so dismissive of other human beings, especially as I knew that most of our patients were decent hardworking folk with as much entitlement to a smart new health centre as anyone. I also knew that those patients who presented a challenge had multiple problems and needed help not judgment. In the years since I have often thought of that moment and pondered how it came about that two recently qualified GPs could have such differing views on society.

At the time, both of these events caused me anger and shame. Now, many years later, and from my position as an experienced doctor I can see a much richer picture. In neither of these situations were the doctors making reportable mistakes but the stories give different perspectives on the range and nature of professionalism. In both cases there was a lack of humanity. In the cardiology story this was shown by the consultant and by the junior doctors, all of whom followed their own agenda rather than considering Mrs Campbell’s needs. The ignorance of the GP in the second story is demonstrated in a few fleeting words. He had little experience of the people he was so ready to condemn but that did not prevent him from voicing an opinion, presumably to a person he assumed would hold the same opinion. These experiences influenced my subsequent thinking and behaviour. The effect of the first was that I studied cardiology only minimally and made a vow to myself never to work in that particular hospital. I felt that I would be tainted with
the values I had seen demonstrated there. The ignorance of the GP in the second story spurred me to advocate for the underprivileged and to promote social accountability in medicine.

Over the years I have often reflected on these and other experiences from early in my own professional socialisation. I have come to the conclusion that, for me, it is the emotional nature of experiences which influenced, and have continued to influence my own view of the meaning of professionalism. It seems to me that professionalism is about the integration of the art and the science of medicine and is a continuing process throughout life. It is not a list of attributes and qualities to be attained and ticked off as present or absent during an assessment. This gave me the idea that undertaking a research project to analyse the stories from other senior doctors could provide a deeper understanding of the nature of professionalism and the process by which it is learned.

**Reframing of the concept of professionalism**

Most of the current literature on the teaching, learning and assessment of medical professionalism is presented in an environment where evidence-based medicine is dominant. This leads to a prevailing view of professionalism as static, residing within the individual in the form of attributes and traits that are measurable (Gauger, Gruppen, Minter, Colletti, & Stern, 2005). The alternative view is that medical professionalism is a dynamic and complex process, context-dependent and emergent from the myriad of interactions between individuals which occur day in and day out (Frederic W. Hafferty & Castellani, 2010). This is a position with which I agree and intend to develop in this thesis. The term ‘phronesis’, or practical wisdom (S. R. Hilton & Slotnick, 2005), has been coined to describe the state of
professional maturity over hundreds of years. We know that the attainment of phronesis is a dynamic process (Cruess, Cruess, & Johnston, 1999), occurring over a number of years. During this process, known as proto-professionalism (S. R. Hilton & Slotnick, 2005), doctors gain experience and knowledge and construct their own professional identities. Much of this thesis is about the process of proto-professionalism. Since the process of gaining phronesis is lengthy, a good way to gain insight into the process is to seek the views of people who have progressed along the path to reaching it. The participants in the research reported here are, therefore, senior doctors. The data consists of their PINs, along with notes, memos and reflections made over two years of in-depth and sophisticated analysis.

The initial research questions are: What does the term professionalism mean to senior doctors? and What factors do senior doctors perceive as influential on their developing views of the meaning of professionalism? I will demonstrate in this thesis that messages about the nature of medical professionalism bombard and potentially impact on medical students and doctors every day, from the moment they start to consider medicine as a career. Even before that decision, our impressions are formed by interactions with doctors or as they are portrayed in the media. Medical students begin their studies with an often already formed set of values and beliefs about how doctors behave. These vary between students depending on their own personal circumstances and experiences. Over the several years of their medical education their personal construct of professionalism is constantly moulded and changed by the myriad of experiences they have and by

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3 Phronesis is discussed in more detail in Section 2.6.3
their reflections on that experience. Many, possibly the majority, of such experiences will be part of the aforementioned hidden or informal curriculum (F W Hafferty, 1998). The informal curriculum is recognised as particularly influential in conveying the prevailing values of the profession and the expected (and accepted) behaviours of doctors (Suchman et al., 2004).

My position as researcher

From childhood I knew that education was all around me. My mother and grandmother were both teachers and I went through the Scottish public education system renowned across the world for its breadth, quality and accessibility (Humes & Bryce, 2003, p108). Learning for me was, and still is, a natural part of life, to be treasured and shared. I know that my background is responsible for the constructivist epistemological position I take in this research and in my educational work.

For more than twenty-five years I have been involved actively in medical education. Initially, as a clinician, my role was to provide clinical supervision and inspiration to medical students and post-graduate trainees as they undertook placements in the Scottish general practice where I was a full-time principal. Later, as General Practitioner (GP) Advisor in Health Promotion, I became involved in curriculum development, delivery and evaluation at postgraduate level, working with the local health authority in collaboration with the Edinburgh University Post-graduate Board of Medicine. This included responsibility for continuing professional development (CPD) courses for primary care teams. When my husband’s job moved us to Australia I took the opportunity to develop my educational expertise and worked as Medical Educator on a multimillion-dollar
national perinatal education project based in Sydney and Macedonia (Jeffery et al., 2004). Since then I have gained considerable experience in planning, delivering, supporting and evaluating clinical teaching, both locally in Australia and in developing countries in South East Asia. I have taken an active role in a major curriculum review at a large Australian medical school and been heavily involved in its implementation. In undertaking a Masters of Education within an education faculty, I have learned a great deal about the social science perspective on education. Currently in an academic position, working with medical students and with clinical teachers and supervisors, I realise that I have an unusual range of perspectives and insights on both medicine and medical education to bring to my research. In my career I have been privileged to have a great variety and depth of experience in medical education and to work with many inspirational people. I am also aware that this means that several different perspectives contribute to my current epistemological position which, in summary, is that learning is an active and continuous process of evolution and development. It is enhanced by participation, interaction and reflection and is ubiquitous, dynamic and infinite. I consider the undertaking of research to be a natural and important progression of my own learning and hope that the broad perspective and experience I bring can enrich the process.
Chapter 1

1 Introduction

1.1 Background

There is an agreed need for professionalism to be reinstated as a core value in medicine (J. J. Cohen, Cruess, & Davidson, 2007) – a professionalism which both doctors and the societies they serve can own and trust in. Until recently the foundation of the social contract (Cruess, Cruess, & Johnston, 2000; Shirley & Padgett, 2006 p30; Matthew K. Wynia, 2008) has been to grant power, influence and autonomy in exchange for an assurance that the medical profession will use its specialist knowledge and skills to provide safe, reliable, ethical and compassionate medical care to those in need. But it appears that the bargain is breaking down. Collectively, doctors are perceived to have overstepped the mark by clinging to power, money and status while neglecting their duty to society (D. H. Irvine, 2004). In the United States the public is suspicious of medicine’s close alliance with the insurance companies and managed care trusts (F. Hafferty, 2006); in the United Kingdom doubts have been raised as to whether an important minority of rogue doctors are adequately dealt with by the profession (Donald Irvine, 2005); and in all developed countries there is disquiet about doctors’ relationship with the pharmaceutical industry (Dubovsky et al., 2010; R. L. Goodman, 2007; Kassirer, 2007).

In response to such allegations there has been a resurgence of interest in professionalism and a vast literature on the topic has appeared over the last thirty years. One problem that emerges is that there is no agreed definition of the term
professionalism. The word has different meanings depending on stakeholder and on perspective. Another problem is that the dominant discourse of medicine currently is as a scientific endeavour where increasingly technologically advanced diagnostic and treatment modalities become available each year. The alternative, humanistic discourse of medicine that emphasises the innate desire in human beings to respond to the needs of other people is less in vogue. While many doctors aspire to blend the two perspectives there remains an uncomfortable prioritising of the scientific over the humanistic. Statistics, politics and money further complicate the situation. Very generally, in my view, professionalism is about bringing humanism and scientific knowledge together to help the sick and the vulnerable. It is about 'goodness'4.

1.2 A specific problem

We know that most students start at medical school with noble values and aspirations befitting their chosen profession (Coulehan & Williams, 2001). We also know that during medical training these attributes are diminished and perhaps even lost (Inui, 2003); (Newton, Barber, Clardy, Cleveland, & O'Sullivan, 2008). This has been medicine's tragedy. Even in recent years, when professionalism has been explicitly taught as part of the undergraduate curriculum, students have found conflict between what they are taught in the classroom and the reality they find in clinics and on the wards (Coulehan & Williams, 2001). The processes by which doctors learn about professional values and behaviours are not yet fully

4 By goodness in this context I mean virtue
explored. My research, conducted within a sociocultural paradigm, uses three distinct analytical methods to contribute to this exploration, especially in relation to medical education. Firstly, a thematic analysis investigates the meaning of professionalism to senior doctors, all of whom are involved in clinical teaching, and the factors they perceive as influential for them in reaching their current understanding. Secondly, the influences of relationships and encounters with role models over time are explored in an analysis of the characterisation of important figures in the life of the participants; and, thirdly, a metaphorical analysis of the cultural environment of medicine is conducted. My three analyses together give a multidimensional picture of the milieu from which professionalism emerges. As I will demonstrate, professionalism is the business of every doctor, whoever they are and wherever they practise.

In the remainder of this chapter the key areas for exploration and the context of the study are introduced, followed by an outline of the structure of the thesis.

### 1.3 Context and setting

This research is set in Australia where academic interest in medical professionalism has grown in the last ten years, mainly in relation to medical students (Gordon, 2003a, 2003b; Monrouxe, Rees, & Hu, 2011; Parker & Wilkinson, 2008; Charlotte E. Rees & Knight, 2007; Thistlethwaite, 2007). Medical education in Australia is based on the United Kingdom model and is similar to that of other Commonwealth countries such as Canada. All students undergo a period of study for a primary medical degree and then enter the workforce as a provisionally registered doctor. On satisfactory completion of an intern year, worked under close supervision, doctors start a further period of training in their chosen specialty. This takes four to six years depending on the
specialty, and requires participation in an approved training program culminating in both written and clinical examinations. As in other countries, there has been a constant evolution of curricula both at undergraduate and postgraduate level, informed largely by the experience of medical schools globally and the emerging evidence based on best educational practice.

1.3.1 Medical student education

In general, Australian medical schools have adopted one of two models. Around half the schools have a traditional five- or six-year undergraduate medical program. The others have a four-year graduate program undertaken after studying for a Bachelor's degree. Some graduate schools achieve diversity among medical students by admitting graduates from a broad range of disciplines, for example from law, economics or arts, in addition to the traditional science-based degrees. Over the last decade several medical schools have introduced a problem-based learning (PBL) curriculum (Schmidt, Rotgans, & Yew, 2011) and an emphasis on early clinical experience (Littlewood et al., 2005). PBL encourages students to work in groups, to solve problems rather than learn by rote and to discuss and debate rather than accept dogma. This pedagogical approach is designed to produce active, lifelong learners with a sound understanding of the principles of medicine and an ability to reason throughout a lifetime of constantly evolving medical practice. The increased small-group discussion involved in PBL curricula also enhances the opportunity for the transfer of attitudes and beliefs about professionalism, either explicitly or implicitly, through interpersonal interaction in a group setting. In addition to basic science and clinical competence, most curricula now include a vertical theme of personal and professional development. In this theme, matters such as ethics, personal development of the individual, and health and illness within the wider context of culture and society are included
(Flinders University, 2009; University of Melbourne, 2009; University of Sydney, 2009). At primary medical qualification level there remains heavy reliance on didactic methods to teach these subjects.

### 1.3.2 Specialty training and professionalism

After graduation, the new doctor moves into a lengthy period of postgraduate training focusing on gaining experience as well as expertise. To ensure quality health service delivery specific criteria have been established to ensure standards are maintained in specialist ranks. These training programs are the responsibility of the professional Colleges which set the curriculum, accredit supervisors and oversee assessment requirements. Political pressure to develop training programs to better service the needs of a modern health service followed several high-profile media reports and official enquiries highlighting the impact of lapses in professional behaviour in doctors (Joint Select Committee on the Royal North Shore Hospital & Nile, 2007; Kennedy, 2001) and has resulted in references to ‘professionalism’ appearing commonly in specialist College training programs.

One example of such a response is the Royal Australasian College of Physicians’ (RACP) multi-level, competency-based comprehensive Professional Qualities Curriculum program introduced in 2008 (Royal Australian College of Physicians, 2008), which articulates expected outcomes for doctors undertaking physician or paediatrician training. This document is sixty-five pages long and very detailed. The College clearly sees the need for action in relation to professionalism and has put much effort into curriculum development on the subject. The program is presented in a framework of nine domains: communication, quality and safety, teaching and learning, cultural competency, ethics, clinical decision-making, leadership and management, health advocacy and the broader context of health.
Each domain contains themes each with defined learning objectives listing assessable knowledge and skills. Colour-coding is used to indicate at which of three levels in the training continuum candidates are expected to achieve the objectives: basic training, advanced training or continuing professional development (CPD) programs.

The new Professional Qualities Curriculum provides plenty of information for prospective trainees and measurable outcomes in terms of knowledge and skills which can be assessed. However, as in the RACP’s earlier program for the 2003-2005 triennium, the professional qualities desirable in a physician are outlined but no advice given on how they may be gained beyond reference to the apprenticeship model of training. In the 2008 program there is heavy emphasis on assessment to ensure that trainees have successfully achieved the program goals. The adoption by the RACP of a competency-based model leaves little room for consideration of the attitudes, values and beliefs inherent in the behaviours designated in the curriculum matrix. This is despite a professionalism literature suggesting more complexity than simply acquisition of a set of competencies (Brian Castellani & Hafferty, 2006).

There are other issues that the new RACP program fails to address. For example, there is no mention of the informal or hidden curriculum which is recognised to be a powerful influence on the development of professional values, behaviour and identity (F W Hafferty, 1998). Neither is there any explicit reference to the possibility that a trainee may encounter lapses in professionalism amongst colleagues or mentors or advice on how to deal with this likely eventuality. There is provision of a twice-yearly Professional Development Session which trainees will attend to “discuss experiences encountered in the workplace... focusing on specific domains of the Professional Qualities Curriculum”. While this may give an
opportunity to raise such issues, it assumes that the supervisor running the session values this aspect of the training program as important and that he or she has the ability to deal with the range of situations that may arise. Furthermore, the necessity for trainees to obtain satisfactory reports in order to complete their specialist training is an inhibitory factor in trainees reporting lapses in professionalism by supervisors. This remains an issue for the RACP and other Australian Colleges which endorse professionalism curricula with similar lofty aims and ideals.

1.3.3 Continuing professional development

In most developed countries there is a requirement that doctors demonstrate a commitment to life-long learning. Once fully qualified as specialists they are expected to commit to lifelong learning through participation in a continuing professional development (CPD) program, usually run through the relevant professional College. In Australia this is a requirement for continued registration as a doctor and the programs are largely focused on educational and evidence-based medicine activities. This is laudable and a major improvement on days past when graduates in medicine could simply put up a nameplate and practise without ever opening another journal or a book. However, regulation of the CPD process is largely through points collected for sessions attended rather than evidence of engagement or participation in an educational activity. In relation to professionalism, there may be room for innovative ideas to engage practitioners who are often involved in clinical teaching and supervision of medical students and trainee doctors.
1.4 The hidden and informal curricula

Apart from the formal curriculum delivered by educational institutions, it is recognised that there are at least two further influences at work in universities and teaching health services which impact on medical students (F W Hafferty, 1998), and resident medical officers (Hundert, Hafferty, & Christakis, 1996); (F W Hafferty, 1998). Some authors conflate the two concepts (Gaufberg, Batalden, Sands, & Bell, 2010) but, in this thesis, I differentiate between hidden curriculum, which is described as:

*A set of influences that function at the level of organizational structure* (F W Hafferty, 1998)

and informal curriculum:

*An unscripted … highly interpersonal form of teaching and learning that takes place among and between faculty and students.* (F W Hafferty, 1998)

My justification for maintaining the difference is that in exploring these concepts and looking for ways to modify curricular influences on developing professionalism separation of organisational (hidden) from interpersonal (informal) factors makes sense. Both are known to be strong influences on development of students’ values and on their developing professional identities (F W Hafferty, 1998); (Suchman, et al., 2004), but medical education researchers are only just beginning to explore their effects on learning. Existing work suggests a strong link between both hidden and informal curricula and notions of professionalism but the process by which this operates is unclear. Even during undergraduate medical education students come in contact with many people both in university and health service settings. All are potential sources of learning about professionalism either directly or indirectly through interactions with others. It is possible, indeed likely, that the
hidden and informal curricula may continue to operate even as doctors mature and gain seniority. Role models in the profession are significant sources from which novices learn and it is known that doctors have a role-modelling effect, even as juniors (Stern, 1998). Recently, as professionalism is explicitly taught as part of the formal curriculum, medical students have increasingly reported lapses in professionalism among medical educators (Brainard & Brislen, 2007). The hidden and the informal curricula are often in direct conflict with what is taught in the formal curriculum (Coulehan, 2006,p108) and this is a challenge with which medical educators grapple. I am very interested in finding out whether the effects of the hidden and informal curricula are more than short-term and, if so, how they influence the way in which professionalism is taught to successive generations of doctors. The nub of this thesis is the nature of professionalism, the process by which doctors develop their own construct of professionalism as professional socialisation occurs and the complexity of influences that impact on that process. I will argue that a predominantly scientific approach to supporting this process encourages a reductionist ‘one size fits all’ view which cannot address the complex needs of learners. Furthermore, reliance on a formal curriculum fails to address the need to align content with the, often tacit, lessons learned in the clinical environment.

By reframing the notion of professionalism qualitatively to reflect this complexity, progress towards more appropriate and effective ways of facilitating and monitoring professionalism may be found.

1.5 The structure of the thesis

The research is qualitative and conducted from an interpretive, sociocultural perspective using narrative methods. The work is iterative and in presenting it I
have adapted the traditional framework of an academic thesis as the structure for the unfolding of the research story. Reflexivity is fundamental to the research and consequently links to the literature and discussion are interwoven throughout. At the same time it is important to maintain a grasp on how the work can be of practical use in medical education. I have chosen familiar chapter titles to signpost segments of the thesis which has nuances of both postmodernism and pragmatism.

In Chapter 2 I present a literature review outlining and critiquing the professionalism and medical education literature most relevant to this research. In Chapter 3 the research methodology is discussed in detail and the data collection methods are outlined. The three separate analyses are presented in Chapters 4, 5 and 6 where each study’s methods and findings are reported and discussed. The final chapter of the thesis comprises a synthesis of the results, recommendations and implications and a final discussion pointing out both limitations and innovations. The epilogue is a final reflexive account of my own research story.

The next chapter in this thesis takes a critical look at the existing literature on professionalism and on how it is learned and taught. The focus is on the interpersonal relationships experienced during medical education and training and on what is known about how these influence the development of professionalism and professional identity.
2 Literature review

2.1 Introduction

The professionalism literature is extensive and this review is focused on the areas which are most pertinent to my research questions. The review is organised into two sections. The first section deals with the question: What is professionalism? It sets a brief historical context and considers the various ways in which professionalism has been defined and conceptualised through the work of the major scholars in the field. The second part focuses on the process of learning and teaching professionalism, especially in relation to how the accepted values, norms and culture of the medical profession are passed on to successive generations of doctors. Because of their relevance to my research questions, the major elements discussed in the second part of the chapter are the influence of role models and the concepts of the hidden and informal curriculum. Relevant literature was identified mainly through Medline searching using ‘professionalism’ as a search term and sifting through results for papers pertinent to the research questions. Reference lists from selected articles were a useful source of further relevant papers and a large Endnote library was developed.

2.2 The meaning of professionalism

Over the last thirty years there has been a surge of interest in professionalism in medicine and a rapid increase in the related academic literature. An appropriate place to start is to ask: What is professionalism? This is not a simple task and
efforts to define the term are numerous and varied. Many authors have grappled with this question, producing an extensive literature on the topic mainly based in three academic disciplines of sociology, medicine (underpinned by psychological understanding) and education. The sociological and medical literature have both been concerned with the survival of professionalism in the rapidly changing environment of medicine (F. W. Hafferty, 2006). Few doctors would disagree that the concept of professionalism is inextricably linked with their identity as a professional and the medical literature reflects this in looking at professionalism in terms of attributes and behaviours. Sociologists on the other hand look at the interaction of the professions with the rest of the world. They are concerned with the “nature of social control in modern society” (F. W. Hafferty, 2006). Thus, again there are individual psychological and collective sociological connotations to the notion. There is still debate over whether a succinct, precise definition of professionalism is even possible.

The *Macquarie Dictionary* defines *professionalism* as “professional character, spirit or methods” (Delbridge et al., 1997). This is not particularly helpful as the nature of professional *character*, professional *spirit* and professional *methods* are not elucidated. However, this definition does allude to professionalism as a multidimensional and multilayered concept.

Herbert Swick, physician and Director of the Institute of Humanities and Medicine at the University of Montana, using a psychological model, proposed a set of nine behaviours through which doctors could demonstrate their professionalism. These were: subordination of their own interests to the interests of others; adherence to high ethical and moral standards; responsiveness to societal needs; demonstration of the core humanistic values including honesty and integrity, caring and compassion, altruism and empathy, respect for others and trustworthiness;
accountability for themselves and their colleagues; a continued commitment to excellence; a commitment to scholarship and advancement in their field; an ability to deal with high levels of complexity and uncertainty; and an ability to reflect upon their actions and decisions (H. M. Swick, 2000). As he had intended, Swick’s landmark paper was used as a basis for ongoing discussion and for the development of many other codes and policies relating to professionalism. He alluded to multiple interactional discourses of professionalism by connecting psychological and interactional perspectives:

*The values and behaviours that individual physicians demonstrate in their daily interactions with patients and their families [psychological perspective], and with physicians and other professional colleagues [interactional perspective], become the foundation on which medical professionalism rests.*

(H. M. Swick, 2000)

In other words, professionalism is embodied and lived by doctors. Swick also identified that although the behaviour of the doctor is key it is not the only element to professionalism. The way in which the physician's behaviour affects the interaction *between* people is also relevant. Furthermore he emphasised the fundamental place of compassion, altruism, integrity and trustworthiness in the work of doctors, stating that “no doctor can truly be effective without holding deeply such values” (H. M. Swick, 2000). Neither can adherence to high ethical and moral standards be switched on and off and Swick urged physicians to behave ethically and morally in their personal as well as their professional lives. This all-consuming notion of professionalism as a way of life has clear implications for all doctors and anyone considering joining the medical profession. Some felt that Swick was asking too much especially in relation to his call for doctors to subordinate their own interests to those of patients (F. W. Hafferty, 2006). In practice, it may be that many doctors agree with Swick’s idealism but human
nature makes it a challenge for them to live up to lofty aspirations. Working clinicians steeped in the day-to-day work of dealing with medical problems brought to them by real people are likely to have a different perspective on the meaning of professionalism in medicine than academic doctors with a more conceptual take on the idea.

Nevertheless, following Swick’s paper, august bodies across the world tried to clarify the principles, commitments and responsibilities comprising the notion of professionalism in doctors (ABIM Foundation, Medicine., Foundation., Medicine., & Medicine., 2002);(Royal College of Physicians, 2005);(General Medical Council, 2006). The current vogue for professionalism means that the word ‘professionalism’ is ubiquitous; as one elder statesman of medical education puts it: “[professionalism] springs like kudzu5 from every nook and cranny of medical education” (Coulehan, 2006). This can be problematic as over-familiarity with a term can lessen meaningful engagement. Indeed some people contend that the overuse of the word ‘professionalism’ in a variety of contexts and by different groups has rendered it almost meaningless (H. M. Swick, 2000). Before looking in detail at the various nuances in current definitions of professionalism, a more general historical overview will contextualise the notion.

2.3 Tension between the science and the art of medicine

The ancient notion of physician as healer encapsulates the humanistic side of medicine. It can be argued that this idea has been lost in the predominantly

5 Kudzu is a Japanese vine which grows rampantly in many areas of the United States
science-based medicine of current times. A desire to achieve more of a balance between compassionate humanism and rigorous science is one of the major drivers of the contemporary professionalism movement (Gordon, 2003b; Rabow, Wrubel, & Remen, 2007).

### 2.3.1 Historical perspective

Since ancient times doctors have promised to uphold the tenets of the ancient pledge penned by Hippocrates, dubbed the ‘father of medicine’ two and a half thousand years ago. The oath was solemnly sworn by graduating doctors virtually unmodified until the mid-twentieth century (Jotterand, 2005). Professing their commitment to serve the community was part of the doctors’ unwritten contract with society. In common with the two other ancient professions, the law and the church, medicine provided essential services, particularly to the sick and vulnerable. During delivery of these services the doctor, or lawyer, or clergyman was relied upon not to exploit the client’s trust and this is the basis of a professional relationship (Moline, 1986). The therapeutic relationship between doctor and patient involves close interpersonal interaction. The Hippocratic oath outlines a standard for doctors’ behaviour within that relationship, and generally, including maintaining patient confidentiality and abstaining from “whatever is mischievous and deleterious” (Hurwitz & Richardson, 1997). Until recently there has been a similar all-encompassing breadth to the expectations that society has of doctors. Indeed, until the last thirty or forty years the behaviour of doctors went virtually unquestioned. The medical profession projected an image of being beyond reproach and doctors were held in high esteem by those who did not share their expertise but who needed their help. Since it was deemed that expert knowledge was essential for the task, doctors held authority, respect and power in controlling the health system (Cruess, et al., 1999) and the profession was also held
responsible for monitoring and regulating the activities of its members. In return for these privileges the profession has maintained a sort of contract with society, a gentleman’s agreement to serve the public’s best interests. This autonomy is the hallmark of a profession and remains central to the concept of professionalism (Southon & Braithwaite, 1998). Doctors have traditionally guarded their specialist knowledge fiercely and hung on to the power and autonomy that came with it (D. Irvine, 1997). In terms of medical education the primary goal was to attain the necessary specialist knowledge. In the late twentieth century the public began to doubt that doctors were keeping their end of the bargain and in an effort to reassure a cynical society a renewed energy for professionalism developed. The Hippocratic Oath, now in updated form to reflect current society and culture, is still taken at doctors’ graduation ceremonies in many universities as a pledge to a moral code (Hurwitz & Richardson, 1997) and an important mark of an individual’s adoption of a new identity (as doctor) and a recognition of acceptance into the profession and of society’s recognition of her new status.

2.4 Recent history of professionalism

The evolution of professionalism over the past thirty years has been described as occurring in a series of overlapping waves (F. W. Hafferty & Levinson, 2008). Hafferty is an influential voice within the professionalism literature and his wave framework is a useful basis for discussion of the key elements within the literature.

2.4.1 The first wave – (Re)Discovering professionalism

In the latter part of the twentieth century many changes took place that undermined medicine’s dominant position. Criticism of the way in which doctors had apparently protected their own position in society grew. One reason for this
was the rapid rise of a for-profit health-care industry especially in the United States (B. Castellani & Wear, 2000; F. W. Hafferty, 1999; Relman, 1980; Sheldon, 1998). The threat of public distrust loomed as people became aware that there was a possibility of financial concerns affecting doctors’ clinical decision-making.

*Everywhere in the United States the professions have reached new heights of social power and prestige ... yet everywhere they are also in trouble, criticized for their selfishness, their public irresponsibility, their lack of effective self-control, and for their resistance to requests for more lay participation in the vital decisions professionals make affecting laymen.* (Barber, 1978)

Hafferty focuses entirely on the situation in the United States, but similar calls for doctors to attend to issues of professionalism were made in the United Kingdom. In the UK the context for the rise in interest in professionalism was different. In the US the focus was on fiduciary aspects of the relationship between doctor and patient, whereas in the UK the issues were more related to the threat to the autonomy of doctors brought about by the broadening of health care teams in order to cope with increasingly complex health care delivery and wider access to health information by the public (D. Irvine, 1997; Tudor Hart, 1981). In a desperate attempt to reduce the impact of these erosions on the profession’s hitherto powerful position in society there was a call to doctors to return to their core professionalism ideals and to commit to advocating on behalf of patients (F. Hafferty & Salloway, 1993).

While very persuasive in stating the profession’s obligation to protect both vulnerable individuals and vulnerable social values (M. K. Wynia, Latham, Kao, Berg, & Emanuel, 1999), the rallying calls were not clear about the precise goals of the action. Some exhortations were to proclaim the primacy of the individual doctor’s commitment to each patient (Cruess, et al., 1999). Others stressed the
importance of professionalism’s role in the maintenance of a civilised society (M. K. Wynia, et al., 1999). The overall effect was to propose a yet-undefined ‘professionalism’ as a solution to all of the problems besetting the medical profession. As a result there were new calls for clarification of what was meant by the term ‘professionalism’.

2.4.2 The second wave – formal definitions of professionalism

The second surge of activity was an attempt to give cohesive direction to the professionalism movement by agreeing upon a formal definition of the term. This proved easier said than done and although Hafferty’s framework suggests that the definition wave is over, the debate is still very much alive today. Indeed, along with others, I would argue that a static definition is impossible due to the integral role of context to the notion of professionalism.

In addition to the nine behaviours discussed in section 2.2, Swick highlighted the collective as well as the individual discourse of professionalism (H. M. Swick, 2000). The two discourses are not unrelated: the individual actions of doctors in any community contribute to the public perception of the medical profession as a whole within that society. The reverse is also true in that medical organisations convey a great deal about the attitudes of the profession through the way they interact with the public. This can be a help or a hindrance to individual doctors depending on the nature of the interaction.

Also inherent in Swick’s normative definition is the responsibility which doctors have to their patients as well as to the profession. Indeed he issues a warning that:

*Serious negative consequences will ensue if physicians cease to exemplify the behaviours that constitute medical professionalism and hence abrogate*
their responsibilities both to their patients and to their chosen calling. (H. M. Swick, 2000)

Swick does not elaborate on what the “negative consequences” might be but does suggest that the ramifications of not adopting professional behaviours will affect doctors as well as patients and this concern is recurrent in the literature. Neither does he consider the consequences of a mismatch between doctors’ exhibited behaviours and apparent underlying values, beliefs and attitudes.

A major initiative during the second wave was Project Professionalism undertaken by a consortium of the American Board of Internal Medicine, the European Federation of Internal Medicine, the American College of Physicians and the American Society of Internal Medicine. The project began in 1999 and culminated in publication of a Physician Charter (ABIM Foundation, et al., 2002). The Charter outlined a set of principles and commitments for doctors, summarised in Table 2.1

<table>
<thead>
<tr>
<th>Fundamental Principles</th>
<th>Professional Responsibilities</th>
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<tr>
<td>Primacy of patient welfare</td>
<td>Professional competence</td>
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<tr>
<td>Patient autonomy</td>
<td>Honesty with patients</td>
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<td>Social justice</td>
<td>Patient confidentiality</td>
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<td></td>
<td>Just distribution of finite resources</td>
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<td></td>
<td>Maintenance of appropriate relations with patients</td>
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<td></td>
<td>Improving access to care</td>
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<td></td>
<td>Commitment to scientific knowledge</td>
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<td></td>
<td>Maintenance of trust by managing conflict of interest</td>
</tr>
<tr>
<td></td>
<td>Commitment to professional responsibilities</td>
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</tbody>
</table>

Table 2.1: Principles and responsibilities of professionalism. Adapted from Physician Charter (ABIM Foundation, et al., 2002)

The solemn commitment by three influential organisations was very worthy and the intentions noble. There was however lack of specificity in the broad general
statements and there was no acknowledgement that several of the responsibilities included elements outside the control of doctors. For example, doctors alone cannot implement improving access to care, because they have little influence over transport, infrastructure, education and government policy which contribute to access to healthcare but are the responsibility of other groups. On careful reading of the summary, the Charter is more a statement of intention and encouragement than an action plan:

\[\text{we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the healthcare system for the welfare of society (ABIM Foundation, et al., 2002)}\]

Despite continuing debate the third wave rolled in.

**2.4.3 The third wave – measurement and assessment**

While energy was still going into documenting the components of professionalism attention turned to the practical issue of assessment. This imperative was linked to the need to instil an appreciation of the relevance of professionalism to medical practice. There was an underlying assumption that teaching professionalism as part of the formal undergraduate curriculum would suffice. It was further assumed that unless professionalism was formally assessed students would afford little energy to the topic and undervalue or simply ignore it (Stern, 2006, p7). Studies looked mainly at ways of testing medical students or doctors in their first and second postgraduate years (PGY) (Veloski, Fields, Boex, & Blank, 2005). Developing valid, reliable and fair assessment processes, however, for a relatively ill-defined concept such as professionalism presents a considerable challenge. Another imperative for fast-tracking assessment was the reporting of an
association between unprofessional attitudes while in medical school and disciplinary action later as a practising clinician (Papadakis et al., 2005). This raised the possibility that medical schools may be held accountable for the postgraduate misdemeanours of their alumni and galvanised action. Discussions abounded about what as well as how, when and how often to measure. Whether the assessment should be formative (conducted with built-in feedback as part of the learning process) or summative (a barrier to be passed successfully to allow progression in the course) was another concern. The view that numerical scores were more reliable, resulted in the more quantifiable elements, such as ethical behaviours, teamwork or empathy, being assessed as a multiscore proxy rather than measuring professionalism as a whole (Veloski & Hojat, 2006, p118). Objective structured clinical examinations (OSCEs) were devised to give students the opportunity to demonstrate ethical behaviours to an examiner. The scenarios were standardised and an actor or surrogate patient with a script interacted with the candidate. Empathy was measured using a questionnaire and validated scoring scale such as the Jefferson Scale of Physician Empathy (Veloski & Hojat, 2006, p120). Rees and Knight point out the potential ethical problem with a strategy of measuring professional behaviours rather than attitudes: that is, students with professional behaviour but unethical attitudes will pass examinations, while those who display unprofessional behaviour, which can occur for a variety of reasons, will fail even if they possess ethical attitudes (Charlotte E. Rees & Knight, 2007). An additional concern was that the behaviours could be faked for the observing examiners.

2.4.4 The fourth wave – institutionalisation and a social contract

Hafferty’s fourth wave in professionalism’s evolutionary journey is adoption of professionalism at institutional level. Professional organisations, specialist
Colleges, medical schools and hospitals articulated professionalism and taking professional responsibility as core to their curricula. As part of the drive to emphasise the importance of professionalism a new ritual, the White Coat Ceremony (WCC), was devised and quickly gained in popularity. The WCC involves students at the start of a medical program taking a pledge to mark their entry into medicine and their intention to embrace professionalism. Introduced in the early 1990s, the WCC has been taken up rapidly by many medical schools across the United States and Europe (Huber, 2003). The WCC is an interesting phenomenon. It was introduced as part of a drive to reassure the public of the medical profession’s commitment to serve them (Arnold P Gold Foundation). It also makes new medical students and their families aware of their change in identity and status from layperson to proto-professional. The ceremonial welcome into the profession centring on the powerful symbol of the white coat is also a reminder of the profession’s power. The white coat represents the special knowledge and skill of the profession as well as indicating an almost spiritual purity in the wearer. It would, therefore, be easy for a young person to interpret this as becoming one of a privileged elite and to confuse the donning of the white coat with the attainment of status and entitlement. In Australia the first White Coat Ceremony took place in 2008 with veterinary medicine graduands (Jones, 2008) but as yet there is little or no participation by medical students. Part of the reason for this may be that Australian doctors often do not wear white coats for a variety of reasons, including infection risk. In psychiatry and primary care settings white coats were dispensed

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6 The first full white coat ceremony took place in 1993 at the University of Columbia
7 Ceremonies may also take place mid-way through the course prior to starting clinical training
with several years ago, though in other specialties there is a more nostalgic view about white coats. Indeed, as recently as 2001, the editor of the *Medical Journal of Australia* questioned whether:

*In these troubled times of uncertainty and confusion in medicine, might not the time be right to rediscover the white coat as a symbol of our purpose and our pride as a profession?* (Van Der Weyden, 2001)

This question suggests a need for an affirmation of identity and a desire for a visible sign of solidarity and status. The General Medical Council of the United Kingdom produced *Good Medical Practice*, a professional code (D. Irvine, 2001), and the Physician Charter already discussed in section 2.4.2 was published in the United States by a Euro–American consortium (ABIM Foundation, et al., 2002). There were calls to doctors to profess their values and to negotiate with society about what those values might be (M. K. Wynia, et al., 1999). The notion of professionalism promoted by these revered institutions was in the main conventional, idealistic and nostalgic (Brian Castellani & Hafferty, 2006). Individual attributes of altruism, autonomy, interpersonal competence and personal morality were highlighted over the broader societal issues of commercialism, lifestyle considerations and social justice. While the responsibility was given to individual students to fulfil the aspirations of the charter it was unclear how they could achieve them, especially as their more senior colleagues were not being similarly assessed. As commentators at the time noted:

*Yet in our zeal to reward those progressive medical educators who are taking the humanistic side of medicine seriously, we surge ahead with a single-mindedness that fails to foster the kind of scrutiny of ourselves, the environment and the profession itself that we should be engaged in even as we expect it from our students as evidence of their professional development.* (Wear & Kuczewski, 2004)
Despite institutions beginning to look beyond professionalism as inherent only in the individual patient-doctor relationship and to discuss promotion of social justice within the healthcare system as a clear responsibility for doctors as a collective body (F. W. Hafferty & Levinson, 2008), the charters failed to call on the learned institutions of medicine to take any responsibility for social issues (Lewis, Rees, Hudson, & Bleakley, 2005). This is unsurprising since the people who were involved in writing the documents were leaders in the organisations and held high status. However, it did reflect a traditional nostalgic view of professionalism amongst the institutions whose members appeared to think that their responsibility was discharged by articulating and assessing expected professional norms in the classroom. There was further concern that as a consequence of the speed at which professionalism had been subsumed into medical curricula that educators would simply rename medical ethics as professionalism rather than spend the time to integrate the now more clarified principles of professionalism meaningfully throughout the whole undergraduate and postgraduate curriculum (Wear & Kuczewski, 2004). Similarly, little thought was given to how professionalism was actually taught and learned outside the formal curriculum in the day-to-day activity within healthcare organisations and educational institutions.

2.4.5 **The fifth wave – the bigger picture**

The fifth wave of professionalism directed energy towards the ways in which organisations themselves may “enable or constrain the motives and behaviours of trainees and practitioners” (F. W. Hafferty & Levinson, 2008). There was recognition that organisations themselves modelled the principles of professionalism in the way they acted towards their member departments, students, patients and employees. This included acknowledgement that the
functioning and policies of the institution may act as either barriers to or facilitators of professionalism among its constituent members (J. J. Cohen, et al., 2007). This influence has been labelled “the hidden curriculum” (F W Hafferty, 1998) and, along with ‘the informal curriculum’, comprising the informal interpersonal interactions between students and others in the clinical or university environment, is known to have powerful effects on the learning of professional behaviours and the understanding of the meaning of professionalism (R. M. Arnold, 2007; Glicken & Merenstein, 2007; F W Hafferty, 1998; Lempp & Seale, 2004).

In the fifth wave there was a shift towards recognising professionalism as a matter for everyone and indeed one that:

…resides within the relationships among system participants, including physicians and the public, medical and nonmedical organisations, industry and government. (F. W. Hafferty & Levinson, 2008)

In this fifth wave a discourse of connectivity is prominent. Health systems and organisations are recognised as networks of interpersonal relationships. With each successive wave of professionalism the issues became more complex and it became more evident that any problem to do with the nature of the concept of professionalism was a ‘wicked’ one.

**Wicked problems**

Wicked problems are the sort that most people who work in medical education or the healthcare system encounter every day (Donnelly, 2006). Wicked problems are not simple or linear. There is no clear and straightforward answer for the problem has many interlinked components and indeed the problem itself can be hard to define. Any solution applied to any part of a wicked problem is likely to have a knock-on effect on
another area of the problem. This means that in trying to solve a wicked problem there
must be constant re-evaluation and flexibility in approach. In the fifth wave Hafferty
alluded to such ‘wickedness’ in the challenges of professionalism (F. W. Hafferty &
Levinson, 2008). In the sixth wave he makes the complexity explicit.

2.4.6 The sixth wave – complexity and professionalism

The sixth wave, Hafferty asserts, has emerged as a result of the failure in achieving
a cohesive and consistent professionalism movement (F. W. Hafferty & Levinson,
2008). Despite the charters, the policies, large numbers of academic papers and
curricula on the subject medicine is still beset with conflicts and inconsistencies in
professional behaviour and notions of professionalism. There remains
disconnection between what happens in the classroom and what happens in the
reality of medical practice (Coulehan, 2006). For example, a student taught to take
time to listen attentively and respectfully to all of a patient’s concerns feels
uncomfortable and confused when (s)he observes a busy doctor take a cursory
history ignoring additional information offered by the patient. It appears that
exhortations to adhere to a set of rules do not guarantee that the rules will be
followed even when leaders of the profession have endorsed the principles. The
other problem with a rule-based approach is that rules are not context-specific. An
action considered to be appropriate in one situation may be quite inappropriate in
another context.

2.4.7 Professionalism in different countries

While Hafferty’s wave framework is useful in delineating some of the issues, it
reflects mainly the situation in the United States. There the aim is to maintain
autonomy and power for doctors through persuading the public that the profession
is worthy of such privilege. In contrast to doctor-centred and paternalistic
professionalism, a new professionalism emerged in the United Kingdom (UK) early in the twenty-first century. As in the United States of America, but for different reasons, a professional body conducted a major review of professionalism (Royal College of Physicians, 2005). Britain did not have the level of commercialism and managed care seen in the USA. However, there was a very low morale among doctors subsequent to ever-increasing public expectations of a National Health Service struggling to keep up with demand, frequent re-organisation of the Service, health care rationing (D. Irvine, 1997) and media vilification of the profession after some serious malpractice and criminal cases (Kennedy, 2001; D. J. Smith, 2002).

In the United Kingdom the professionalism discourse is more about the profession working with the public to ensure a high quality service focused on meeting societal needs and standards (D. Irvine, 2001). Australia remains a follower of both the UK and the US and moves cautiously. It was not until 2009 that the Australian Medical Council published its own code of conduct for doctors (Australian Medical Council Working Party, 2009). In the US, altruism appears as one of the cardinal qualities expected in the Physician Charter (ABIM Foundation, et al., 2002). However, a totally altruistic attitude is incompatible with a balance between work and home life increasingly sought by contemporary doctors. Indeed, as part of professionalism, quality in healthcare initiatives encourage doctors to ensure their own health is maintained by avoiding excessive work hours (Reis, 2008; West & Shanafelt, 2007). The apparent incompatibility of the two notions is confusing for everyone.

Hafferty maintains that a reframing of professionalism to that of a “complex adaptive system where social actors, organisational settings and environmental factors interact” (F. W. Hafferty & Levinson, 2008) is needed. He advocates the conceptualisation of professionalism as a dynamic process occurring within many
environments and influenced by many relationships occurring almost simultaneously. Furthermore, the relationships do not exist in isolation. Rather they all interact with each other in a web of connections. While this postmodern perspective is intellectually fascinating it is not particularly useful in practical terms to the development of an effective professionalism education strategy.

2.5 Current views on the nature of professionalism

The nature of professionalism remains the topic of ongoing debate (J. J. Cohen, 2006; F. W. Hafferty, 2006; Martimianakis, Maniate, & Hodges, 2009), making it a vibrant and exciting field for research. Very broadly, there are three main approaches: firstly a ‘tick box’ approach, where professionalism is regarded as a list of competencies to be mastered (ABIM Foundation, et al., 2002); secondly the sociological perspective in which the concept of professionalism is regarded as much more multifaceted, complex and dynamic (Erde, 2008; F. W. Hafferty & Levinson, 2008); thirdly there is a ‘new professionalism’ movement which focuses on the social justice responsibilities of the medical profession and the reintroduction of humanism to medical practice (D. Irvine, 2001; Mechanic, 2000). Of course, these three strands intertwine and reach out to the profession, the institutions and to the public in an ongoing relationship.

2.5.1 Tick-box professionalism

What I call the ‘tick-box approach’ to professionalism is the somewhat reductionist perspective influenced by the dominance of a biomedical model of medicine. In the overlapping of waves two, three and four of Hafferty’s sequence, notions of professionalism were kept simple to facilitate assessment. The approach encouraged by the production of charters and codes (ABIM Foundation, et al.,
2002; K. L. Smith, Saavedra, Raeke, & O'Donell, 2007) is to list the qualities which are agreed by various stakeholders as necessary attributes of medical professionals. Words like ‘altruism’, ‘honesty’, ‘integrity’, and ‘leadership’ appear but there is no acknowledgement that the appropriate display of such attributes may change with context. In Australia all of the professional Colleges include professionalism in their training program. Curricula range from the comprehensive program of the College of Physicians (Royal Australian College of Physicians, 2008) to a brief account of what is expected of a surgeon with regard to professional behaviour in a few bullet-pointed statements (Royal Australian College of Surgeons, 2009). The tick-box approach is linked closely with the need to set and maintain standards of behaviour and much work has been put into trying to define exactly what is required of candidates to be deemed sufficiently ‘professional’ to gain standing as a doctor. The inclusion of professionalism in this format in any training program necessitates meaningful assessment before the candidate is deemed to have successfully passed the course. This in turn means that learning objectives must be clear and specific in order that assessment can be objective and fair. However it is extremely challenging to a supervisor or teacher to observe every attribute and behaviour on a long list of requirements in all of their trainees. In practice the assessment ends up as an end-of-term conversation where the supervisor asks the trainee if (s)he has demonstrated the attribute and the boxes are ticked if (s)he says “Yes”. This practice in itself has hidden curriculum ramifications in that it suggests that certification of unsubstantiated events is acceptable.

The tick-box approach is also born from the imperative to assess ability and document progress discussed earlier. Easy to define and grasp, the more concrete elements of professionalism such as medical ethics and patient safety come to the fore. Both topic areas have a cognitive component that can be taught in lecture format and easily tested
using multiple-choice questions. Individual attitudinal elements, such as altruism or integrity or compassion, are much harder to test, tend to be forgotten by faculty and are consequently less valued by students (Ozolins, Hall, & Peterson, 2008).

2.5.2 Professionalism and complexity

From this point of view the tick-box approach to professionalism is too simplistic. Professionalism is inextricably bound with context (L. Arnold, 2002; F. W. Hafferty, 1988) and context in clinical medicine is invariably complex. Taking a pluralistic perspective of professionalism especially as it operates at the individual level and the relationship level offers a way forward in unravelling the processes involved in the hidden and informal curriculum. A recent paper in the sociological literature looking at the different interpretations of professionalism over the last century concludes that: “professionalism is too complex and nuanced a construct to be reduced to a simple checklist of individual characteristics and behaviours” (Martimianakis, et al., 2009)

The notion that professionalism is a process dependent on context and ever changing in the light of a multitude of different circumstances and interactions is reminiscent of the view expressed by Hafferty in his description of the sixth wave of professionalism. Seven different and competing types of professionalism have been identified among doctors (Brian Castellani & Hafferty, 2006; Frederic W. Hafferty & Castellani, 2010). These have been named nostalgic, academic, entrepreneurial, lifestyle, empirical, unreflective and activist. The authors assert that doctors displaying each of these types of professionalism assign different levels of importance to ten key aspects of medical work namely: autonomy, altruism, commercialism, interpersonal competence, lifestyle, personal morality, professional dominance, social contract, social justice and technical competence.
The analysis is predicated on the view of the authors that professionalism is a way of “organising work such that an occupation can claim the status of a profession” (Brian Castellani & Hafferty, 2006).

<table>
<thead>
<tr>
<th>Type</th>
<th>Most important aspects</th>
<th>Least important aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nostalgic</td>
<td>Autonomy, Altruism, Interpersonal competence, Personal morality</td>
<td>Lifestyle, Commercialism</td>
</tr>
<tr>
<td>Entrepreneurial</td>
<td>Commercialism, Autonomy, Technical competence, Professional dominance</td>
<td>Interpersonal competence, Altruism, Social justice, Social contract</td>
</tr>
<tr>
<td>Academic</td>
<td>Altruism, Interpersonal competence, Technical competence, Lifestyle</td>
<td>Social justice, Commercialism</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>Autonomy, Lifestyle, Personal Morality</td>
<td>Altruism, Social contract, Social justice, Professional dominance</td>
</tr>
<tr>
<td>Empirical</td>
<td>Autonomy, Technical competence, Commercialism</td>
<td>Social justice, Interpersonal competence, Lifestyle</td>
</tr>
<tr>
<td>Unreflective</td>
<td>Autonomy, Interpersonal competence, Personal morality, Altruism</td>
<td>Commercialism, Social justice, Social contract</td>
</tr>
<tr>
<td>Activist</td>
<td>Social justice, Social contract, Altruism, Personal morality</td>
<td>Lifestyle, Commercialism, Professional dominance</td>
</tr>
</tbody>
</table>

Table 2.2: Types of professionalism with most and least important features. Adapted from (Brian Castellani & Hafferty, 2006)

This classification appears, at first, to be at odds with the protestations of virtue, excellence and selflessness proclaimed by doctors and professional organisations desperate to hang on to their power and status. However, on reflection, the classification is an attempt to give a realistic and honest assessment of the different ways in which the notion of professionalism is embodied, contested and negotiated by health systems and the ordinary doctors within them. The authors’ intention is to explore and add depth to the various nuances in the concept of professionalism.
in a widely varying profession. But the model still tends to compartmentalise people into neat(ish) boxes and is based on stereotypic assumptions. For example, ‘Nostalgic professionalism’ is put forward as dominant especially among the leaders of the professional holding powerful positions. To them, autonomy, altruism, interpersonal competence, personal morality and technical competence are most important; social contract and social justice of moderate importance; and lifestyle and commercialism of least importance. This reflects that the environment in which they work at a senior level is somewhat removed from the raw reality of the needy. By contrast, the group dubbed ‘activist professionals’ rate social justice, social contract, altruism and personal morality as most important, and lifestyle, commercialism and professional dominance as least important. These physicians, who often are those who advocate for national health systems, represent the more selfless of the profession. They have often worked with underserved populations or in public health, which has given them direct exposure and shaped their values and attitudes. Interestingly, rather than being praised for their altruism, the ‘activists’ are seen to have a level of commitment to patients outside the professional norm and therefore are regarded by their peers as “professionally deviant” (Brian Castellani & Hafferty, 2006, p17). At a pragmatic level the splintering of the notion of professionalism into seven sub-types is hardly surprising in view of the diversity of entrants to the medical profession and the myriad of experiences they have during training. On balance this framework is a useful one and, in my view, merits further investigation.

2.5.3 The new professionalism in medicine

Supporters of what is termed new professionalism on both sides of the Atlantic take a firm view that explicit collaboration between the public and the profession is essential in setting reasonable standards to be met by doctors in the service of the
public. Stern and colleagues see professionalism as a “way of acting”, and humanism as a “way of being”. There is a strong connection between deeply held values and beliefs (being) and behaviour and they argue the bond between humanism and professionalism persuasively:

*Humanism is the passion that animates authentic professionalism.* (Stern, Cohen, Bruder, Packer, & Sole, 2008)

In the UK, the College of Physicians report on professionalism stresses the partnership between doctors and patients and acknowledges the dynamic nature of the concept. The very brief definition introduced the concept of trust as fundamental to professionalism: “Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors” (Royal College of Physicians, 2005).

The UK professionalism focus is on service and emphasises medicine’s vocational aspects:

*Professionalism codifies the idea that a doctor’s responsibilities go beyond a mere contract of employment* (Royal College of Physicians, 2005)

In a positive move, certainly as far as forging partnerships in health with the public, the report authors have identified the aspects of traditional or nostalgic (Brian Castellani & Hafferty, 2006; Frederic W. Hafferty & Castellani, 2010) professionalism which should be jettisoned, namely autonomy, privilege, self-regulation and mastery. These have connotations of superiority, authority and power which, the authors say, have no place in today's society where equality is a goal and high quality healthcare is increasingly a team activity.

The challenge lies in implementing the ‘new professionalism’ with its patient-centred ethos. Elder statesmen of the profession welcome the move and support it
unequivocally (D. H. Irvine, 2004, 2007). However, although recommendations abound that undergraduate medical education provides experiences that are ‘critically formative’ in developing a professional ethos in students, no advice or example is given as to how this might be achieved. At postgraduate level the use of mentors is strongly recommended so that professional values may be further established. This is a bold statement without either supporting evidence for its efficacy or a credible and sustainable implementation plan. My research explores the possible long-term effects of both educational experiences and relationships with medical teachers on the development of professionalism.

2.5.4 Interplay between professionalism and the culture of medicine

Not only is a sense of the complex construct of what is referred to as ‘professionalism’ inextricably linked to doctors’ individual identity, it cannot be separated from the culture of medicine. Culture refers to the customs, behaviours, and attitudes of a social group and it usually refers to different racial, ethnic or religious groups. It is also applicable to groups that are distinguished by shared knowledge and symbols (Jenkins, 2008, p69).

*Culture: the sum total of ways of living built up by a group of human beings, which is transmitted from one generation to another.* (Delbridge, et al., 1997)

The culture of the medical profession depends on the behaviour and interactions of doctors within the community or society it serves. It makes sense, therefore, that neophyte doctors will glean something of the culture of their chosen profession from the interactions and behaviours of doctors they encounter. As they progress through their career they themselves become the doctors who create the culture of medicine and those who influence the next generation of doctors. As explained
earlier, this occurs over many different clinical placements during a doctor’s student and postgraduate education and indeed it continues throughout the lifetime of the doctor. The notion of lifelong learning is well recognised as necessary to keep up to date with advances in medical care (Mann, Dornan, & Teunissen, 2011). There is also the likelihood that lifelong learning is involved in professionalism. The literature on teaching and learning professionalism will be explored in the next section.

2.6 Teaching and learning in medicine

*Tell me and I will forget,*
*Show me and I may remember,*
*Involve me and I will understand*  
(Chinese proverb)

The idea of constructing knowledge and understanding is very different from the dominant view in universities and vocational training models that knowledge is a commodity to be passed on by experts (who know a lot) to novices (who know nothing) in much the way that an empty fuel tank is filled. Not only does this concept of education limit the depth of understanding achieved by students, it perpetuates a power differential between teacher and learner which can have far reaching social effects (Friere, 1996). The teacher has power over the learner because the teacher controls the knowledge which the learner can access. The knowledge-as-commodity concept is insufficient to achieve the deeper levels of understanding and more complex learning required by medical professionals (Mann, et al., 2011, p23).

Furthermore, a duality of roles where a teacher is the assessor as well as the facilitator of learning can inhibit the process of education. For example, students may not ask questions of their teacher for fear of revealing a deficit in knowledge or
understanding which could adversely affect grades, future employment or promotion. In terms of learning about professionalism, students or trainees may be influenced to behave in a particular way simply because of the seniority of the teacher (legitimate power) or by apparent expertise (expert power) (Wilkes & Raven, 2002). This is illustrated in a study where medical students felt compelled by supervising doctors to conduct intimate examinations of patients under general anaesthesia even although the students were concerned about lack of informed consent by the patient (Coldicott, Pope, & Roberts, 2003).

The discussion thus far has looked at learning as an individual pursuit. Humans are sentient beings who interact with each other (and with the world) in groups, communities and societies. Learning involves other people. Medicine cannot be practised as a solitary pursuit. At the very least there are two people, doctor and patient, involved. Sociocultural theories of learning are, therefore, appropriate in considering questions about learning in medicine. We learn from experience meaning that human interaction is an integral part of learning (Wenger, 2006).

2.6.1 Learning from interaction in the workplace

The prominence of clinical settings as learning environments for doctors makes the workplace education literature highly pertinent to this discussion. Billett argues that as well as propositional knowledge (facts, concepts and in-depth knowledge necessary for a profession or vocation) and procedural knowledge (skills necessary to do the job) a third knowledge domain, dispositional knowledge, is needed. By ‘disposition’ Billet means attitudes, values and beliefs held by individuals and mediated by personal social or cultural factors which, in turn, affect how they behave. According to Billet, these three types of knowledge – propositional,
procedural and dispositional – are interdependent and influence each other (Billett, 2001, p55).

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**Figure 2.1: Interdependence of propositional, procedural and dispositional knowledge. Adapted from (Billett, 2001, p55)**

Billet’s model emphasises the interdependence of each of these three types of knowledge and the fact that, from the learner’s point of view, each aspect is moderated by the other two. It follows, therefore, that when individuals apply their learning in the real world of practice all three parameters are in play. This is at odds with the priority usually given to biomedical knowledge (propositional) in most medical courses. From a constructionist perspective all three types of knowledge will be affected by different aspects of the various experiences which clinical placements afford and by interactions with many people (clinical teachers, health professionals and patients) the trainees meet along the way.
The picture is further complicated by suggestions from medical students that they may have a clearer grasp of what is required to meet standards of professionalism than their seniors and feel that exposure to the professional values of some clinicians can be detrimental (Brainard & Brislen, 2007).

**2.6.2 Teaching and learning of professionalism**

The notion of professionalism as a dynamic process within a complex adaptive system (Frederic W. Hafferty & Castellani, 2010) has ramifications for consideration of how it is learned and assimilated into a professional identity – or a way of being. Increasingly it seems that educational initiatives to date have been overly simplistic.

> Medical student learning is multi-dimensional, multi-situational, multi-contextual and interdependent and to treat it otherwise is to create a false and misleading picture of the overall educational environment. (F. W. Hafferty & Levinson, 2008)

This, one imagines, is especially so when the topic is professionalism and it may be that this is exactly the reason that medical educators still debate the best way forward. Following the “Professionalism must be taught” (S. R. Cruess & R. L. Cruess, 1997) call to action which resonated through medical schools worldwide, a plethora of teaching sessions on the topic resulted in the early years of this century. In the enthusiastic rush to do something quickly there was initially little time taken to plan or attention paid to the complexity of factors involved in learning. As a result a large number of papers report on discrete programs and strategies delivered to emphasise professionalism and encourage its development. My contention is that taking time to explore the process of learning about the complex
and hard-to-define concept of professionalism may offer more illumination as to how it can be nurtured.

2.6.3 Learning professionalism: A journey towards phronesis

As outlined in chapter 1, medicine is learned through a mixture of campus-based study and clinical apprenticeship, where, as students and then young doctors, trainees are immersed in clinical settings in which they gain experience and expertise. The journey from novice student to expert doctor spans several years. On completion the doctor must have gained not only the necessary basic science knowledge and clinical expertise but also professionalism, the behaviours and values which society demands of its medical professionals. The physician should also practise with wisdom, something the ancient Greeks called phronesis. More recently phronesis has been described as developing through a process of ongoing and sophisticated reflection on the experience of clinical practice in the context of core professional values, such as ethical practice and respect for patients (S. R. Hilton & Slotnick, 2005). Medical knowledge and proficiency in clinical skills are essential elements of phronesis. However, the existence of these alone, while essential to certify proficiency to be an autonomous practitioner, does not guarantee that a state of phronesis has been reached. A more meaningful description of what is meant by phronesis in practical terms may be:

*Phronesis is the quality that the good professional needs when the algorithm runs out, or when there is a conflict between the guidelines and the reality of the situation, or conflicts of interest between different patients or team members. It justifies the trust in the doctor to make the best decision in the interests of the patient.* (S. Hilton, 2008)
Hilton and Slotnick describe a student or doctor on this path of reflection on their developing skills as a proto-professional. My thesis is very concerned with the journey towards phronesis.

This is a useful model as it highlights the loss of idealism and the gaining of cynicism which occur on the journey from being a naïve new medical student to reaching towards phronesis as a mature professional. It shows the opposing effects of what I refer to as influences supportive and detrimental to the process. There is no time scale for reaching phronesis implying a lengthy process. However, there are assumptions implicit in the model. The first issue is that it starts at the beginning of the medical program making the assumption that all students are equally naïve and equally idealistic about medicine at that time. This is unlikely to be the case, especially with the increasing number of graduate medical courses.
where students have often had considerable life experience prior to medical school entry. Similarly medical students from medical families or those who have worked in other health-related professions may already have had experiences which have affected the journey towards phronesis. The latter point raises the question of how phronesis applies to healthcare professionals other than doctors. The complexity of contemporary professionalism discussed earlier in this chapter suggests that a collective approach to phronesis of the interprofessional health care team may be appropriate to consider. The model also suggests a steady path throughout medical training towards phronesis. Does this imply that everyone reaches phronesis and that they do so along an even continuum? The fact that Hilton and Slotnick refer to phronesis as a ‘state’ rather than as a ‘trait’ indicates their assumption that nurture contributes to professionalism more than does nature (C. Rees, 2005). This is a key factor for medical educators especially in thinking about the learning environment and learner–teacher interactions.

2.6.4 Clinical setting as a workplace learning environment

Newcomers to the medical profession gain crucial experience on their path towards phronesis in clinical settings. Over time, students build up a bank of experience and ability and gradually move from legitimate peripheral participation towards expertise (Lave & Wenger, 1991). In clinical settings there is the concept of a “community of practice” (Wenger, 2006) in which learners first observe experts in action and then increase their learning by involvement in the process or procedure in a graduated fashion. Looking through a socio-cultural lens it is known that the relationships students have with others are important (Mann, et al., 2011, p32). During this process, sometimes called professional socialisation or enculturation into the profession, novices are influenced by a multitude of experiences both inside and outside the medical education environment. They must merge and meld
these into a coherent concept of professionalism. The traditional focus on cognitive learning of facts within medical education makes this difficult. While values can be listed and learned like facts, they cannot be enacted without an understanding of how they relate to practice and this may not be immediately apparent to the medical student. Furthermore, unless there is genuine belief in the values they will not be assimilated into their own professional persona and identity. In the field of clinical education these matters have been recognised as part of the informal and the hidden curricula (F. W. Hafferty & Franks, 1994).

### 2.6.5 The hidden and informal curricula

The hidden and informal curricula have been written about extensively in recent medical education literature and are known to provide a highly influential learning environment (D’Eon, Lear, Turner, & Jones, 2007; Fitz et al., 2007; Gaufberg, et al., 2010; Lempp & Seale, 2004). Furthermore, they can undermine or enhance material being taught in the formal or stated curriculum. While some authors use the terms interchangeably and loosely they are distinct, though interrelated, just as they are to the formal curriculum.

...the notion of a multidimensional learning environment embraces at least three interrelated spheres of influence: (1) the stated, intended, and formally offered and endorsed curriculum (formal curriculum) (2) an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students (informal curriculum); and (3) a set of influences that function at the level of organisational structure and culture (the hidden curriculum). (F W Hafferty, 1998)

Although the hidden and the informal curricula have distinct definitions, the terms are often used interchangeably in the literature to mean anything that is learned outside a formal teaching program. Another name for this is tacit learning. This
term implies that the learning occurs imperceptibly, which is a crucial element for medical educators to consider.

**Tacit learning**

Tacit learning (Coulehan, 2006, p107) about professionalism arises from both the hidden and the informal curriculum (Brainard & Brislen, 2007; Hundert, et al., 1996), as opposed to explicit learning which (hopefully) occurs as a result of activities designed to achieve learning about professionalism. Tacit learning results from experiences which instil a sense of 'professionalism in action' without an explicit discussion of professional issues. Being more action-oriented than talk-based, tacit learning is very powerful (Coulehan & Williams, 2000) but rather unreliable in ensuring desirable learning takes place because of its ad hoc nature.

**Medical culture**

Newcomers learn most about the culture of medicine from the hidden and informal curriculum. The passing on of the cultural mores and values of medicine involves successive generations of doctors and this is highly relevant to this thesis.

Medical students and doctors do not work in isolation, especially when involved in a busy clinical setting. There is constant activity on the ward and talk between staff and patients. In the course of a day there are many interactions in which the student or doctor is involved directly or as a witness. Moreover, in medicine the interactions are not just verbal. There is often touch involved as, for example, during physical examination. During procedures or surgery there may also be physical interaction with colleagues. Sometimes, especially in doctor–patient
interactions, there is pain or discomfort involved. What happens during all these interactions is the stuff of the hidden and the informal curriculum

**Informal curriculum**

“Actions speak louder than words” is a well-known aphorism and applicable to the powerful way in which the informal curriculum influences learners. Immersed in the clinical setting and involved in the everyday work that goes on there gives neophyte doctors many opportunities to observe and to absorb the rules, regulations and routines that are part of medical practice (Stern, 1998). In their quest to be accepted into the profession, early adoption of the behaviours they see around them is likely. In comparison with what they have learned in the classroom, or bring with them from their time as a layperson, it is natural for newcomers to assume that their direct experience in the real world of medical practice is the more reliable.

Much is written about the internal conflicts which can arise when students and junior doctors discover that the reality of medical practice does not match their preconceptions (Brainard & Brislen, 2007; Coulehan & Williams, 2003; Draper & Louw, 2007; Glicken & Merenstein, 2007; Rosenbaum, Bradley, Holmboe, Farrell, & Krumholz, 2004; Wear & Castellani, 1999; White, Kumagai, Ross, & Fantone, 2009). All too often clinical placements reveal a reality far removed from the ordered world of the medical school classroom. People bring complex problems to the doctor. Rarely is the issue one single patho-physiological process which can be modified or reversed by pharmaceutical treatment or by surgery. Health and illness do not exist in a vacuum. The person who presents to the doctor has a life outside the illness, responsibilities which must be met and a value system based on the culture of their own community. Just like the doctor, they have multiple identities only one of which is as patient and while that identity may, at the time of
consultation, be the most prominent it is rarely the one they wish to develop and maintain. In other words medical practice is complex and doctors need to have a variety of skills and attributes to deal with this. Patients want a competent, respectful doctor whom they can trust and with whom they can form a good relationship (D. H. Irvine, 2007).

Early in their careers doctors often feel overwhelmed by the demands on them (Prins et al., 2007; Thomas, 2004). Surrounded by sick and dying patients, distressed families and demanding seniors, they feel that they have too much, too stressful work to do and too little time to do it. The new doctors quickly realise that those around them know what to do and how to behave. So they watch and learn from their colleagues, not in formal lessons but through everyday interactions. This is the informal curriculum. Inevitably conflict arises when they find the mismatch between reality and what was taught in medical school. Coulehan, an American primary care physician and academic, has postulated that a common result of this is to practise unreflective professionalism (Coulehan & Williams, 2001). That is when the doctor professes traditional medical values but is unaware that (s)he behaves in ways which contradict those values. An example of this is for the doctor to be convinced that they are showing compassion for a patient while being detached and focusing on the cognitive rather than the affective aspects of practice. Another protective mechanism is to adopt an objective professional identity and concentrate only on the technical aspects of practice. These doctors consider the attributes of sensitivity and good communication skills as irrelevant to the notion of a good doctor. Of course, there are many doctors who maintain their values of patient-centred practice throughout. It has been postulated that they have an immunity to the negative effects of the informal curriculum (Coulehan & Williams,
but perhaps their medical education experiences have been more nurturing. Alternatively, perhaps they are more critically reflexive.

**Hidden curriculum**

The hidden curriculum is mediated through structural components of the organisation. For example, a medical course where all written assessment is by single best answer multiple-choice questions conveys the tacit message that there is one correct answer to a problem and, by inference, that there is no uncertainty in medicine. Medical schools where prizes are awarded only to students who excel in written examinations devalue the importance of attributes other than academic prowess. Thus the hidden curriculum undermines formal curricular efforts to encourage development of qualities such as leadership, caring and compassion which are not similarly rewarded. Initiatives to foster effective teamwork through educational modalities employing collaborative group work are similarly undermined by the competitive environment in which many medical students and postgraduate trainees find themselves. Lempp and Seale report that 50% of the medical students in their study of the hidden curriculum stated that competition rather than cooperation was the impression of medicine they had gained from their course. Among clinical students this rose to 65% (Lempp & Seale, 2004).

In clinical settings the informal and hidden curriculum are dominant and there has been enormous interest in the potential to transfer appropriate notions of professionalism via this route (Cottingham et al., 2008; Suchman, et al., 2004). The opposite is also true and there has been much work on the effect of the informal and hidden curriculum transmitting adverse messages about the culture of medicine (Coulehan, 2005; D’Eon, et al., 2007; White, et al., 2009). To the chagrin of medical educators there is considerable data to show that there is an erosion of professionalism during medical education (C. H. Griffith & Wilson,
Several studies explore students’ experiences on the wards and in the corridors and expose a great deal of less-than-professional behaviour (Brainard & Brislen, 2007). Much of this is mediated through another influential force in professional identity formation: the role model.

**2.6.6 Clinical teachers and professionalism**

In a profession where apprenticeship has been prevalent over centuries role models are a familiar concept in medical education. They are people with whom trainees can identify and who demonstrate sought-after attributes and positions (Paice, Heard, & Moss, 2002). Role models provide inspiration and motivation to succeed as they teach lessons about the practice and culture of medicine through the behaviour, attitudes, values and identity they exhibit in their day-to-day work (Kenny, Mann, & MacLeod, 2003; White, et al., 2009). The influence of doctors as role models to juniors in the way they behave towards patients is well recognised. In addition Glicken and Merenstein highlight the responsibility that medical teachers have in perhaps unwittingly conveying values of the medical profession to students during classroom or lecture hall sessions (Glicken & Merenstein, 2007). The inference from their paper is that teachers may be able to identify the beginning and the end of a lesson on anatomy or therapeutics but easily forget that students and trainees are learning something about the values of medical professionalism at all times in their interaction with anyone connected to the profession of medicine.

Several authors have taken this concept further in recommending that only doctors whose professionalism is exemplary should be involved in the teaching of students and trainees (Reuler & Nardone, 1994). This presents a number of challenges. Firstly, it assumes that there are sufficient numbers of doctors who are always good
role models and who can be distinguished easily from those who are always bad role models. It is much more likely that doctors may be ‘good’ some of the time and ‘bad’ some of the time, depending on circumstances. Secondly, it assumes that students and trainees will uncritically emulate the behaviour they see around them so that it is imperative to expose them only to an ‘ideal’ world. Thirdly, it gives no credit to the ability of trainees to be able to distinguish acceptable from unacceptable behaviour and to be able to learn from experiencing both. This is contrary to the evidence that shows that young people entering medicine are able to identify professional attributes, such as good relationships with patients, enthusiasm and integrity, in medical teachers (Paice, et al., 2002). Paice and colleagues also showed that the qualities most emulated in role models differed and were more likely to be those of doctors with responsibility and status. There is a further argument that if learners do not experience lapses in professional behaviour they will not have an opportunity to develop the necessary skills to recognise such lapses in themselves and others and to deal with them when they occur (Ginsburg, Regehr, & Lingard, 2003). In any case, further investigation of the process by which role models mediate learning is warranted.

### 2.7 Role models in medical education

Much of the role model literature is descriptive (Kenny, et al., 2003) but there is recognition that the relationships mentors have with learners form a powerful element of the informal curriculum. A review of 275 papers showed that role models were influential in the choice of specialty by students and junior doctors (Campos-Outcalt, Senf, Watkins, & Bastacky, 1995), but there is also evidence that the type of role model behaviour that students choose to emulate differs from that which they identify as signifying a good role model (Paice, et al., 2002). It is
recognised that as their enculturation into the profession progresses, medical students tend become more cynical (Inui, 2003). It may well be that, on entry to the medical profession, young doctors find it easy to distinguish professional from non-professional behaviour. However, as they strive to absorb the culture of medicine they become numbed to the effect of professional lapses, especially if people they admire and look up to ignore or appear not to notice the lapses. The influence exerted by a role model can either be supportive or detrimental to the development of professionalism. The processes by which this occurs are less clear and merit further investigation.

2.8 Further questions raised by the literature review

This review of the literature on professionalism and how it is learned has answered some of my original questions but raises a number of others.

2.8.1 What is professionalism?

It appears that this is not an easy question to answer. Attempts by many learned people have failed because of the complex and multilayered nature of the concept. The answer depends to some extent on the person and the situation she or he is in. In other words, professionalism is both context- and perspective-dependent. If you are a sick patient, you expect to be able to trust that your doctor has the knowledge and skills to diagnose and manage your problem, the motivation to make the effort to do so and the humanity to treat you with care and compassion. Implicit in all of these elements is trust that the doctor will not take advantage of the relative vulnerability of the patient. If, on the other hand, you are an experienced nurse, you expect the doctor to demonstrate professionalism by doing the ward round on time, making well-informed decisions about patient management after consulting
with the patient, relevant nursing and allied health care staff, all of whom s/he treats with respect. A senior medical colleague, in comparison, may regard efficient, well-organised work based on logical clinical reasoning delivered with a minimum of fuss but with attention paid to the tenets of ethical practice, as the gold standard for professionalism. So, professionalism means many things to many people but at its core it is about each person and society as a whole being able to trust in doctors, both individually and collectively to provide good medical and health care to anyone who needs it.

2.8.2 Gaps in the literature

The vast majority of the studies involve medical students or doctors in the very early years of postgraduate training. This is understandable since the majority of explicit teaching takes place in undergraduate curricula and medical students and junior doctors are easier to access for research purposes than their more senior colleagues. However, it raises the question of how long the effect of each of the influences (role models, formal, hidden and informal curriculum experiences) last and indeed whether they exert effects later in careers.

A second striking aspect of the literature is the dominance of a medical rather than an educational approach to the topic of professionalism. The talk is much more commonly about the ways in which professionalism can be taught rather than the more educationally meaningful issue of how professionalism is learned. The suggestion of the dominance and superiority of the expert teacher reflects the

8 Because of the hierarchical nature of medicine where junior doctors can easily be nominated by seniors to take part in research studies
hierarchical medical system in which students are low and professors are high – in itself a hidden curriculum message. Such a view is unhelpful in creating a supportive learning environment conducive to the development of a well-rounded professional.

The hidden and informal curriculum and relationships with role models and clinical teachers are highlighted as crucial elements of medical education. However, the variety of personnel involved and the number of clinical settings experienced during education produce unpredictable effects. More understanding of the process of learning in these ways would be helpful for future improvement.

### 2.8.3 Individual or collective professionalism?

A further issue is the tension between thinking about professionalism as an individual (doctor) responsibility rather than a collective group (medical profession) or organisational (university or health system or government) activity. The latter makes the further exploration of the workings of the hidden curriculum highly relevant.

On the 100th anniversary of Abraham Flexner’s famous review of United States’ medical schools, the Carnegie Foundation published a new call for an update in the light of advances in scientific and medical education literature. Included in the recommendations is an apparent recognition of the complexity and scope of contemporary professionalism:

> …explicit instruction in professionalism, combined with effective role modelling and attention to the hidden curriculum of the practice environment, can support the development of a comprehensive and sophisticated understanding of professional education. (M. Cooke, Irby, Sullivan, & Ludmerer, 2006)
2.8.4 Need for research

The authors of the report *Doctors in Society, Medical Professionalism in a Changing World* (Royal College of Physicians, 2005) acknowledge that the research base for professionalism is not convincing. There is, they say, no real evidence to prove that professionalism improves patient outcomes. This reflects the evidence-based, biomedical model of medicine where measurable outcomes, such as death and severe morbidity, are considered concrete and, therefore, real outcomes. The sort of trial that convinces evidence-based medicine (EBM) followers is one where an intervention applied in a standard way to a large number of people with a particular condition is tested to see whether it makes a difference to mortality or to the incidence or duration of the known morbidities of the condition. EBM looks at firm outcomes that are easily measurable across a large number of patients. More individual outcomes (for example, the perceived quality of the doctor-patient interaction) are much less valued in the EBM paradigm. This is regardless of whether a genuinely compassionate professional relationship may have facilitated the eliciting of a superior history, a more effective and acceptable management plan or better patient understanding of the condition leading to improved compliance. Although these may be of high importance to the patient the heterogeneity and subjective nature of outcomes makes it hard to draw a robust conclusion. Nevertheless, perhaps in deference to common sense, there is agreement from many sectors that medical professionalism is essential and must be nurtured.

2.9 Discussion

So where does all this leave us in terms of enabling new doctors to progress towards a state of phronesis? We know that, at least in developed countries,
societal trends such as increasing commercialism and the primacy of the individual have impinged on medical professionalism. A profession which has considered itself elite and invincible has been caught out by a public who have been encouraged by a paternalistic profession to believe that doctors can fix any ill and that the patient need take no responsibility for his or her own health. A new generation of doctors is less willing than their predecessors to sacrifice themselves to an all-consuming vocation and instead demands a balanced lifestyle. These doctors they consider that their families are just as important as their patients, after all, their families are somebody else’s patients. The notion of professionals as those with specialist knowledge and skills who are granted autonomy in return for serving the public's health interests is regarded as static and old-fashioned. The notion of a complex dynamic professionalism within the context of a rapidly changing society is currently to the fore (Wass, 2006). Some authors question the capability, or indeed the motivation, of the medical profession to keep up with the speed of change in society. There does, nonetheless, appear to be growing support for more balance between the art and the science of medicine in producing a fair medical system which maintains high standards and genuinely cares for all involved.

Many of the challenges outlined here are vast, complex and beyond the scope of this research. However, it is evident from the literature that the learning environment and the people within it are an important influence in the formation of professional identity and medical culture. Despite an extensive literature describing the often negative and sometimes traumatic experiences of medical students and junior doctors in the clinical setting (Rosenberg & Silver, 1984; Seabrook, 2004; Sheehan, Sheehan, White, Leibowitz, & Baldwin, 1990) there is little attention paid to the possible ongoing effects of such experiences, especially
early in a medical career. It does not seem unreasonable to assume that the experiences of students and junior doctors persist in memory and have a continuing influence on their own professional and personal identities and indeed on how they relate to their own patients, colleagues and trainees.

A key issue is the evolution and development of a professionalism movement where doctors and patients work in partnership to improve health and manage illness. Role models, the hidden and the informal curriculum are important facilitators in the shift towards the new professionalism and to a deeper understanding of the process involved and an enhanced theoretical understanding of their place in medical education is essential.

2.10 Research questions

The importance of the hidden and the informal curriculum within medical education is clear from the literature. What is not made as clear is that they simply reflect the prevailing culture of medicine. No fundamental change, therefore, is going to be possible without a shift within the culture of the medical profession as a whole. The current charters on professionalism are not enough to make this change because they focus on the goal but fail to provide a guide to reaching the goal. More understanding of the nature of the culture of medicine as it operates at the grassroots level of clinical learning and teaching is needed. Furthermore, bearing in mind the continuous nature of learning through experience and reflection on experience, there is a need to explore the long-term effect of interactions with doctors during acculturation to the medical profession. Through my own experience, thinking back to events in my medical student and junior doctor days, I know that I have a richer insight now into how those events were assimilated into my own impression of the medical profession’s values and
behaviours. It seems to me that older doctors are an untapped source of valuable insights into how learning happens and how culture is created, maintained and modified. The primary research questions in this study are:

- What can be learned about the meaning of professionalism through the stories told by senior doctors about their navigation into the medical profession?

and

- What insights can be gained from the stories of senior doctors about the process of learning about professionalism from role models, the hidden and the informal curriculum?

These were further developed into the three sets of research questions answered in Chapters 4, 5 and 6.

The questions answered in Chapter 4 are:

- What does the term professionalism mean to senior doctors?
- What are the factors which senior doctors perceive as formative to their understanding of the meaning of professionalism?

Those explored in Chapter 5 are:

- How are role models characterised in stories told by doctors about their navigation into the medical profession?
- What does the way in which role models are characterised in stories told by senior doctors tell us about the culture of medicine?

And the research question in Chapter 6 is:
• What is learned about the culture of medicine from the metaphorical language used by senior doctors in narratives about professionalism?

2.11 Conclusion

In this chapter I have described the limitations to teacher-centred methods in the education of health care professionals. In particular wholly didactic methods do not take into consideration the need for interaction as an aid to effective reflection and transformative learning. *Tell me and I will forget.*

The role of the learner as observer – *Show me and I may remember* – has been considered and we have seen that the learner may observe more than the teacher intends, by way of the hidden or informal curriculum.

Together we have looked at theoretical reasons for the saying *Involve me and I will understand* to be true and have noted that this does not simply refer to hands-on practical education but also to a supportive, collaborative and mutually respectful relationship between learner and tutor. We have also noted that the roots of this are ancient and that looking back in time can be illuminating.

In the next chapter the epistemological and ontological underpinnings of the research are discussed and the methodology and methods employed in the research are outlined.
3 Methodology

3.1 Introduction

In the last chapter the importance of the hidden and informal curricula, role models in learning about professionalism and the culture of medicine were highlighted and the research questions for this study were identified. In this chapter I will outline the epistemology underpinning the research, the theoretical perspective and the methodology and methods, using Crotty’s four-element approach as a template (Crotty, 1998). Epistemology is the philosophical foundation of the research and concerned with the nature of knowing. The theoretical perspective is rooted in the particular epistemology and contextualises the methodology chosen. Thus each element is founded on the previous one and together they lead to the choice of methods used in collecting and analysing data. Each of the four elements will be discussed in detail and its use in this project justified. The ethical principles pertinent to the project and the strategies used to mitigate initial concerns raised by the research ethics committee are discussed. The research methods, including recruitment of participants, data collection and the analysis are given. The analytical process outlined in this chapter is the initial analysis which underpinned the three different studies which developed iteratively from the first stage and became the major part of this research. The analytical methods for these individual studies are outlined separately in the relevant chapter. This chapter concludes with a reflexive section on potential methodological and theoretical innovations arising from my work.
3.2 Research questions

In order to contribute usefully to furthering knowledge or developing theory it is best to investigate a specific question thoroughly, rather than a broad question superficially (Silverman, 1998 p86.). It is important to clarify the research question in order to identify the most appropriate methodology and methods to use to answer it. In qualitative research it is not uncommon to have an exploratory initial research question which, nevertheless, is specific in stating the aim of the study. As the researcher learns more about the topic under study the question is refined and shaped. Qualitative research is often iterative in nature and evolution of the research question is integral to the process.

As discussed in Chapter 2, the questions at the start of my research were:

- What can be learned about the meaning of professionalism through the stories told by senior doctors about their navigation into the medical profession?

and

- What insights can be gained from the stories of senior doctors about the process of learning about professionalism from role models, the hidden and the informal curricula?

3.3 The research paradigm

The nature of my research questions meant that qualitative research methodologies were most appropriate. Working in a highly academic unit of a teaching hospital for several years had made me very aware of the strengths of quantitative research methods but also of their limitations. A double-blind
randomised control trial is very useful when testing a single intervention, for example a therapeutic drug (Seale, 2002), in large populations to test whether there are benefits or harms associated with its use. However, the individuality of people is lost in quantitative research with the controlling of variables, relative risk, number needed to treat and statistical significance. Differences between people are dealt with by evening them out in the experimental design to allow generalisation of the results to other populations. Quantitative studies do not account for individual variation in reaction or behaviour. These methods are less appropriate, therefore, when looking at complex processes where the difference between individuals and the way they act, react and interact is relevant.

Qualitative research methodologies, on the other hand, acknowledge that many aspects of life are not logical or linear. Qualitative work strives to deepen our understanding of the world and give a richer perspective on human experience. As an exploration of the processes by which medical education experiences had influenced doctors as they developed their own professional identity, behaviour and notion of the meaning of professionalism, my study was well suited to qualitative research methods being used to unravel the inherent complexities. The topic was more akin to social science methodologies than the basic science milieu in which I was schooled. This in itself presented a welcome challenge as I had long felt that the dominance of science in medicine limited the range of more humanistic research undertaken in the discipline.
3.4 **Epistemology and ontology**

3.4.1 **Background**

Before going further it is important to clarify the epistemological foundation of this research. Epistemology is concerned with *ways of knowing* and the philosophical background to the nature of knowledge (Crotty, 1998 p8). It is closely related to ontology, the study of *ways of being*. Together, epistemology and ontology underpin and orient the research study and ground the theoretical perspective and the methodology in which they are embedded (Lincoln & Guba, 1985).

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![Figure 3.1: Schema showing relationship between elements of research](image)

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Figure 3.1: Schema showing relationship between elements of research
Ontology and epistemology represent a particular way of understanding ‘being’ and ‘knowing’ respectively. For example, objectivism is an epistemological position in which meaning is deemed to exist in the world independent of any conscious thought and waiting to be discovered (Crotty, 1998, p8). To the objectivist ‘true’ meaning can be discovered by dispassionate investigation. By contrast, the epistemological perspective of constructionism is based on the tenet that meaning arises out of, or is constructed from, human interaction with the world and the things and people in it (Crotty, 1998, p8). Ontologically, constructionists believe that there are many ways of being, and that those multiple ‘realities’ depend on the interaction between people and things and upon social context (Crotty, 1998, p42). The view that phenomena only have meaning because humans have constructed that meaning makes more sense to me. It explains why different people have a different understanding of the world, despite apparently having the same experience. For a constructionist, the construed meaning of any given phenomenon may be quite different depending on the context and other factors, such as environment, culture and other people involved. For example, the meaning of ‘tree’ may be very different when talked about in a logging town, an art class or in a treeless urban environment (Crotty, 1998, p43). From a constructionist perspective there is no ‘true’ or ‘valid’ interpretation of the world as would be sought from an objectivist viewpoint but, rather, there are multiple credible interpretations (Crotty, 1998, p48).

3.4.2 Theoretical perspective

The epistemological and ontological paradigm forms the foundation for the theoretical perspective which in turn shapes the research by providing a particular philosophical stance and context for the methodology and methods (Crotty, 1998, p66). The broad theoretical perspective for this study is interpretivism which fits
well with a constructionist epistemology. Interpretivism is commonly linked to the work of Max Weber, who distinguished social science from natural science in terms of their aims. The social sciences, Weber suggested, were concerned with Verstehen or understanding, while the natural sciences focused on explanations and causality referred to in his native German as Erklären necessitating different research approaches (Crotty, 1998, p67). Another reason for the different approaches is the differing purpose of research in the natural and the social science arenas. Natural science is looking for consistency and the unchanging laws of science and nature, whereas in the social world the individuality of humans is the main concern. The interpretive premise is that individuals construct meaning differently, depending on context, place and other circumstances. This means that, in my study, this theoretical perspective permitted consideration of the different layers and nuances of meaning in different people’s accounts of the concept of professionalism.

*The interpretivist approach … looks for culturally derived and historically situated interpretations of the social life-world.* (Crotty, 1998, p67)

### 3.4.3 Symbolic interactionism

The specific theoretical perspective for this research is symbolic interactionism (SI), one of the three major strands\(^9\) which has developed from interpretivism and is:

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\(^9\) The other two strands are phenomenology and hermeneutics.
a theoretical perspective that emphasises how people interpret, act toward and thereby give meaning to objects, events and situations around them … through the social processes of interpretation, communication and role taking. (Sandstrom, Martin, & Fine, 2006, p17)

A key element of SI is putting oneself in the place of the person being studied (Crotty, 1998, p75). Symbolic interactionists observe cultures closely and endeavour to gain an understanding of the perspective and practice of the people who belong to that culture. SI is rooted in pragmatism, a generally optimistic and progressive philosophy. A symbolic interactionist perspective looks at the way in which the actions and behaviours within a society are influenced by the shared meanings attributed to the words, gestures and other symbols that members of the society have grown up with and take for granted. For example, consider the story told in the prologue to this thesis through an SI lens. The patient, Mrs Campbell, although very breathless and sick was asked to spell her name and address to facilitate a demonstration of history-taking by an eminent physician. One area of that narrative we might focus on is the co-construction of deferential behaviour from lay people and medical students towards doctors with the title ‘Professor’. Reflecting on my own experience as a medical student, I took for granted that the Professor was highly skilled and very clever and would act in the patient’s best interests. The title of Professor symbolised to me both high intelligence and an inherent recognition from the university and the hospital of his medical prowess. I was a student with little medical knowledge and he was an erudite and experienced clinician. Furthermore, as a professor in the medical school where I was studying and a consultant in its major teaching hospital there was the possibility that he would be an assessor in examinations or a potential employer. The interaction, therefore, was one where the power inherent in the relationship was enacted, recognised and, to some extent, resisted. From an SI perspective, the way this
interaction unfolded was almost predetermined by the culturally accepted norms of behaviour of patients, doctors and medical students. The three main characters, the Professor, Mrs Campbell and I were aware of these expectations from previous experience. We knew that the Professor held the dominant role in the interaction and the culture of medicine at the time meant that Mrs Campbell and I remained passive despite our discomfort. However, symbolic interactionists recognise that this encounter would change the understanding each of us had, up to that point, of patient and professional roles, the nature of illness, of care and compassion and of a variety of other aspects of health care. Furthermore, the three of us, although involved in the same experience, were unlikely to have interpreted what happened in the same way due to our different prior experience, different values, different personalities and social status and different levels of awareness at the time. Despite being outwardly passive, the inner turmoil of emotions of distress, anger and powerlessness I felt then have stayed with me for a long time. My resistance to the enactment of power I saw that day was in refusing to ever work in that large hospital and, indeed, my ultimate choice of a career outside hospital medicine was almost certainly a direct result of the experience. Several times since that day I have shown resistance more overtly by telling the story to others. I have often wondered if my interpretation at the time – that the professor was being uncaring and pernickety – was correct. Unbeknown to me, he may have spoken with Mrs Campbell prior to the encounter and explained what he intended to do. Perhaps I was particularly upset because I had never seen such an ill young woman before. Had I been less timid and felt less subordinate, the professor and I could have talked about my fears and feelings. I could have asked Mrs Campbell what she thought. An SI approach is useful in exploring the way in which meaning is constructed and co-constructed through the interpersonal relationships occurring in our everyday life.
3.4.4 Justification

My constructionist epistemology and symbolic interactionist theoretical perspective thus stand in sharp contrast to the current dominance of a highly scientific approach in medicine where a positivist perspective underpinned by objectivism assumes scientific supremacy. Positivists view the world as ordered, factual, systematic and organised; a place where objects in the world have meaning independently of any consciousness of them (Crotty, 1998, p27). Medical education organised from a positivist perspective gives preference to protocols, procedures, facts and competencies. The personal interactions, emotions and feelings ubiquitous in clinical settings are traditionally considered less important, despite growing evidence of their educative value. My chosen theoretical framework is very appropriate for exploration of these latter factors.

3.5 Methodology

Different sorts of research questions are answered using different research methodologies (Silverman, 2005, p5). The first step in answering my research question is, therefore, to choose an appropriate methodology and method.

My narrative inquiry methodology is appropriate to the form and nature of my research questions and for my theoretical framework. Narrative inquiry keeps people and their activities central to the research. In talking about themselves they are the “embodiments of lived stories” (Clandinin & Connelly, 2000 p43). It provides the opportunity to explore my topic in sufficient depth and a framework for dealing with the complexity of the topic. As explained in Chapter 1, I believe both experience and interpersonal interaction to be key to learning. Furthermore, I believe that, although all experience has the potential to be educational, not all of it contributes to meaningful learning. Learning can be promoted or inhibited by
circumstances and, I suspect, by the nature of interpersonal interaction and relationships. It is likely that several factors in the socio-cultural environment determine the extent and direction of learning possible for any individual. As I researched the various methodologies open to me, I realised that I naturally look at the ‘wholeness’ of people, linking what they are saying with what I know or deduce about their personality and their situation. This is probably a result of the many years spent as a primary care physician in family practice where these skills are key to the holistic approach. This is a feature of narrative inquiry where the researcher builds up a picture of the narrator as an integral part of the process of inquiry.

As described in the prologue to this thesis, I have long been interested in the way in which the interpersonal interactions and relationships occurring in the everyday practice of medicine shape the attitudes and beliefs of medical students and junior doctors about the meaning of medical professionalism. My own experience as a medical student and doctor had afforded me many opportunities to reflect on and develop my view of how I should behave as a professional. I was aware that my own core values of honesty, humanity and compassion came from my early life and had been severely shaken by much of what I had experienced as a young medical professional. If this is a common experience during medical education it certainly has significance for wider society, in this case patients and those using medical services. I wanted to elicit stories from established doctors about experiences and memories from their own medical training which they felt had shaped their subsequent notion of professionalism and their identity as a doctor. Using narrative inquiry methodology meant that as a researcher I could move backwards and forwards along a temporal axis in my exploration of participant experiences (Clandinin & Connelly, 2000). Thus a past experience is brought into the present context and environment of the narrator. In these different circumstances and
after the passage of time the interpretation may be different so that the story of the experience is modified in the telling. At the same time the telling of the story may spark memories in the listener which, with the passage of time and gaining of experience, take on new meaning. The more I learned about narrative as a methodology the more appropriately it seemed to align with my research question. In the next part of the chapter I will present a more detailed exploration of narrative inquiry.

3.6 Narrative inquiry

*Narrative inquiry is stories lived and told.* (Clandinin & Connelly, 2000, p20)

3.6.1 Background

As a species, humans have long made sense of their experiences by telling stories. Storytelling was, and still is, common to all ages, races and levels of society. Folk tales, or oral narratives, where the values and social norms of a tribe or community are reinforced through storytelling have been traced back to megalithic times (Zipes, 2002, p7). Group discussion contributed to the storytelling and, over the years, modifications to these stories in response to questions asked or suggestions made, have gradually modified societal norms and culture passed down through the generations via a collective oral tradition. In contemporary western cultures, fairy tales are read to children from an early age. These stories are based on folk tales which reflected the social situation and aspirations of those who recounted them. Stories told by the poor and illiterate were often about escape from poverty and exploitation (Zipes, 2002, p9). Often the stories contained moral messages, such as the good will be rewarded and the bad will be punished. The popular story of Cinderella, for example, involves the beautiful and kind but downtrodden and abused Cinderella finding riches and a royal husband despite the selfishness of her
step-sisters. In the story the step-sisters are ugly, which symbolises their inner ‘badness’ in contrast to the ‘goodness’ of Cinderella who initially looks dirty and unkempt but turns out to be beautiful outside as well as inside. The close relationship between the narrative form and morality makes narrative inquiry particularly suitable as a methodology to research complex phenomena such as professionalism. Symbolism too, is integral to narratives and narratives represent an area of commonality and a mechanism by which people can share experiences and understanding of life. Narratives are a way in which groups and communities evolve and pass on their culture. As Polkinghorne asserts: “At the cultural level narratives serve to give cohesion to shared beliefs and to transmit values” (Polkinghorne, 1988, p14).

In the same way, narratives from doctors can reasonably be expected to give insight into the culture and customs of medicine.

### 3.6.2 Advantages of narrative inquiry as a methodology

A basic tenet of narrative inquiry methodology is that stories or narratives are considered in their entirety as well as in the context of the narrator and the audience. Narrative offers more than simply a factual account of an event. Additional meaning is implicit in the way the story is told; in the words chosen; in the elements of the story included or left out. This gives rich material for the narrative analyst to study.

The challenge is to glean meaningful interpretation from the complexity of interrelating and interwoven data. In the health field, narrative inquiry has been used to deepen understanding about complex areas, such as living with chronic illness (Williams, 1984) or terminal cancer (Bell, 2006). In the field of sociology the methodology has been used to study the different ways in which people respond to
non-health-related life experiences, such as divorce (Riessman, 2008, p86). In these studies the researcher is able to analyse the interplay between the events happening to the narrator, his or her identity and the way it is changed through experience. Gathering narratives or stories gives a rich data set in which the narrator-participant has invested in a very personal way. Much more is revealed than simply what happened; a story contextualises actions and interactions. Furthermore, the way in which the story is told gives much information to a researcher about the narrator’s perceptions of the world and its meaning. As Riessman says:

*Narrativisation tells us not only about past actions but how individuals understand these actions, that is, meaning.* (Riessman, 1993, p19)

Narrative scholars assert that narratives must be preserved as whole units in order to analyse the way in which the narrator is making sense or meaning of his or her experience (Riessman, p4). For me, it was important to avoid too much fragmentation of the data as I felt that to best understand the participants as individuals it was vital to keep their stories intact and to analyse them in the appropriate context. I felt that narrative methodology was a suitable way to take into account the multidimensional nature of influences involved in learning about the concept of professionalism while, at the same time, acknowledging the individuality of the participants.

### 3.6.3 Diversity in narrative approaches to research

Narrative inquiry as a research methodology seeks to understand rather than to control over or predict the human world (Pinnegar & Daynes, 2007 p30). For narrative researchers the data are words rather than numbers and the search for
meaning is in careful, systematic and rigorous interrogation. Within the framework of narrative research there are several different approaches. Some researchers analyse data collected in interviews or from field-notes on a certain topic to give an overview of a ‘typical’ experience (Pinnegar & Daynes, 2007, p4). For example Williams’ study on the impact of a chronic illness in which he conducted interviews with thirty people who suffered from rheumatoid arthritis (Williams, 1984). From analysis of his data he constructed three case studies to illustrate the processes of making sense of developing a disability. Other narrative researchers have added images giving a visual component to the narrative and thereby enriching the study of human experience, for example of illness (Radley & Bell, 2007) or of the impact of war (Riessman, 2008, p145). Some researchers analyse particular components of narrative, for example plotline, characterisation or theme to make sense of experience (Pinnegar & Daynes, 2007, p5). Researchers exploring unfamiliar communities or societies construct a cross-cultural narrative of lived experience to assist in understanding. Clifford Geertz, a leader in cultural anthropology, recognised the importance of detail in cross cultural research:

_We must, in short, descend into detail, past the misleading tags, past the metaphysical types, past the empty similarities to grasp firmly the essential character of not only the various cultures but the various sorts of individuals within each culture, if we wish to encounter humanity face to face_ (Geertz, 1973, p53).

Narrative methodology offered the combination of a systematic and rigorous research approach highly suitable to answer my research questions along with opportunity to learn analytical methods which permitted sensitivity to the complexity of the human condition.
3.7 Ethics approval

As my interviews were to be with practising clinicians, ethics approval for my study was obtained from the Area Health Service Human Research Ethics Committee (AHSHREC). I had to address several ethical principles in the application: consent; confidentiality; and devising an adequate strategy to avoid harm to participants and to deal appropriately with any sequelae arising from distressing events being recalled during the interview process. Gaining informed consent from the participants was straightforward since all were practising doctors and, therefore, assumed to be able to understand the participant information (Appendix 1) and competent to make the decision to take part in the study. Confidentiality is crucial for research and was a particular concern in my study because of the professional standing of the participants and potentially sensitive nature of the material discussed. Ensuring anonymity of participants was especially important because of the potential for them to be in senior positions that might identify them easily. Using pseudonyms and removing any reference to the location of their work was done throughout to maintain privacy. The AHSHREC questioned the proposal to videotape the interviews, and considered imposing a condition of pixilation of the faces to de-identify the participants. The committee was however receptive to the argument that the reason to record visual images was to link non-verbal, visual information to the verbal and paralinguistic data in the exploration of meaning intended by participants. There is evidence that facial expressions, gestures and posture and position can indicate emphasis or emotion and thus enhance verbal communication (Mehrabian, 2007, p8-10). I was able to assure the committee that the visual data was only to be viewed by me (as chief investigator) and my research supervisors where appropriate. Another ethical issue to be considered was the possibility that revisiting potentially painful or traumatic events in their past could be injurious to participants. As all participants were to be doctors in the
workforce with at least ten years since graduation in medicine it was considered that they would be reasonably resilient to this very small risk. In addition, my level of experience as a general practitioner and well able to identify signs of undue distress and to arrange suitable follow-up should it be necessary, was regarded as a secondary safeguard. All of the committee’s concerns were thus resolved and approval was granted.

3.8 Methods of data collection

3.8.1 Personal reflections as narratives

As I read and learned more about narrative inquiry I realised that including episodes from my own life was an important part of the narrative process. Other researchers had started out in narrative inquiry because of questions arising out of their own reflections on their own experience: “One of the starting points for narrative inquiry is the researchers’ own narrative of experience, the researchers’ autobiography” (Clandinin & Connelly, 2000, p 70).

Clandinin and Connelly discuss the importance of their own background and experience in teaching, firstly to their motivation to conduct research in the educational field and, subsequently, to the way in which they framed and presented their research. They made use of their own experience in schools and knowledge about teaching in their interpretation of the narrative data they analysed. Through this process they were able to enhance the interpretation, meaning and understanding of the factors involved. Rather than being over-reflective and ruminative, reflecting on their own experience helps researchers to position themselves clearly within the research. For narrative inquirers the ability to make
the link between their own interests and the broader societal issues raised through
the stories of others is crucial (Clandinin & Connelly, 2000, p 122).

I began my research journey by documenting my own stories remembered from
medical student and junior doctor days as a way of examining the influences on my
own professional identity development. Originally I did this as a way of making
explicit the experiences and preconceptions which were likely to influence my
research and research processes. Still shaking off the remnants of research practice
based in positivism, I was concerned at that time about my own experience and
perspectives biasing the research (Strauss, 1998, p 7).

Building on the two stories told in the prologue, I wrote about other experiences
from my life which I felt had shaped my views on the nature of medical
professionalism. Coming from a non-medical family my assumption was that the
main influences would be from my medical school training and primarily involve
doctors I had encountered as teachers. I was, however, surprised that, when
thinking about experiences which had shaped my views of professionalism, it was
impossible to separate my educational experiences at medical school from the
impressions I had formed as a child about doctors and the way I expected them to
behave. There was a clear influence from the virtues and values instilled in me by
my family and the small Scottish town community in which I was raised.

The process of writing about my own past experiences convinced me that this was
likely to be a fruitful method to gather data from other doctors. As I focused on
memories relevant to my own concept of professionalism and my professional
identity, I was surprised how many experiences came into my mind. This resonated
with the concept of a three-dimensional narrative inquiry space (Clandinin &
Connelly, 2000, p50). Clandinin and Connelly describe temporality, personal and
social factors, and place as the three dimensions of any narrative. Thinking of narrative in this three-dimensional way is helpful in considering that these factors apply simultaneously as a story unfolds. Each story element may spark a memory or feeling in the narrator and helps to build up a three-dimensional picture. When another person listens to the story or reads it and they attend to it, more memories can be sparked for them. With a large audience the effect is multiplied, since each individual brings their own temporal, personal and social dimensions and the possible interpretations are thus increased. Narratives, therefore, can raise questions, deepen understanding or alter perspective and this is what my research is about

In the next section of this chapter, the way the study was conducted is outlined. Where needed, the justification for the methods used is given, based on the methodological and theoretical issues already discussed. My research plan was to conduct in-depth interviews with senior doctors and to apply different qualitative analytical methods to the resulting data. Data also included my autonarratives, field notes and a video record of the interviews.

3.8.2 Sampling and recruitment

My research questions specifically indicated senior doctors as participants and this was implemented in the sampling by including only doctors who had been medically qualified for at least ten years. Participants who were still working clinically in hospital or in general practice and currently involved in clinical teaching or supervision of medical students or junior doctors were needed. Logistically the doctors were all based within one Area Health Service in a large Australian city where it was possible to access both urban and rurally based practitioners. A hybrid of convenience and purposive sampling was used.
Convenience sampling is common in qualitative research and I was keen to include doctors with training experience in a range of clinical areas. The study was qualitative and the target group (experienced doctors) well defined. Along with anecdotal evidence from many of my medical friends and colleagues about their own memories, it seemed that any group of doctors would have several relevant stories to tell. My literature review had shown that there are plenty of studies involving medical students and junior doctors but very little research conducted from the perspective of the older doctor, especially those teaching in a clinical rather than an academic setting. The rationale for involving established doctors in the study was the assumption that, as established members of the medical profession, they would have insight into the ways in which the learning experiences they could recall had actually influenced their practice. Looking at the narratives both as individual case studies and thematically across individuals it would be possible to glean new ideas about the long-lasting effects of role models and the hidden curriculum on professional behaviour and notions of professionalism.

Recruitment to the study was through an advertisement placed on the intranet site of a large tertiary teaching hospital in Sydney, New South Wales, Australia, and in the general practitioner newsletter of one Sydney Area Health Service. The advertisement is shown in Appendix 2. The two advertisements resulted in a number of replies from doctors in a range of hospital specialities and in general practice. Two volunteers were obtained during the data collection phase through word of mouth from previous participants. This is referred to as snowball sampling (L. A. Goodman, 1961). I made one direct approach to a particular hospital department to ensure that a participant from a very busy, acute service was included. Attention was paid to gender balance, as well as seniority and location of
practice in either urban or rural setting, thus achieving a maximum variation sample.

3.8.3 **Preparation and pilot interview**

At the start of the project, despite many years speaking with patients and medical colleagues in day-to-day clinical practice, I was apprehensive in my new role as researcher. This feeling was lessened by careful preparation and conducting a pilot interview. While the opportunity to rehearse with the recording equipment was most welcome the main benefit of the practice interview was to familiarise me with the role of researcher. The pilot interview also showed me that taking notes during the interview was not feasible. I had imagined that making notes during the course of the data collection, as done in ethnographic research, would add richness. In narrative inquiry, however, it is more important to engage fully in talk and I found there was a risk of inhibiting the flow by breaking eye contact, as happens when notes are made. In addition, as the topic of study was ‘professionalism’, it seemed to me that it was especially important to conduct the interviews in a highly professional manner which meant showing respect and giving undivided attention in order to elicit detailed information. Research notes were therefore written up as soon as possible after each interview and added to as tapes and videos were reviewed.

3.8.4 **Data collection**

Narrative interviewing was used to encourage participants to talk about their experiences during medical training either at undergraduate or post-graduate level. In order to focus on the areas of particular interest a short prompt sheet was developed and taken to each interview in case trigger questions were needed. The aim of the interview was to explore memories of experiences which participants felt
had influenced their own understanding of the meaning of medical professionalism and their own professional behaviour. The assumption was made that experiences remembered for at least ten years must have been significant to the narrator in some way. By exploring such moments I anticipated gaining a deeper understanding of the nature of professionalism from the perspective of senior members of the profession. Through careful attention to the way in which I conducted the interview, I hoped to reach “greater communicative equality” (Riessman, 2008, p26). That is, by creating an atmosphere where participants felt comfortable enough in conversing with me, they would feel able to tell me their personal stories. In narrative inquiry it is well recognised that the story narrated is not necessarily an accurate record of the actual events discussed (Polkinghorne, 1988, p63). This is of little consequence when thinking narratively. The inquirer is not looking for an absolute ‘truth’ – indeed, from the epistemological position of constructionism, there is no such thing. There is no single way to tell a story about a particular sequence of events. The narrator adapts the narrative depending on a multitude of factors including the effect (s)he wants to achieve, the nature of the audience, the speaker’s location, the context in which the story is being told and many others.

Dramatic devices such as pauses, gestures, colourful characterisations and metaphors are used to engage the listening audience whose responses as the story unfolds become an integral part of the process. In an interview situation, the interviewer is the audience and, therefore, central to the production or co-creation of the story (Elliot G Mishler, 1991). Narrated accounts of the same experience may differ when told by different people to different audiences but all are ‘true’ (Greenhalgh & Hurwitz, 1999). An aim of my research is to explore these
differences to illuminate how to enable improved learning and teaching of professionalism and professional behaviour in doctors.

In narrative interviewing, the researcher has to relinquish control of the interview so that the participant is free to raise issues not previously considered by the interviewer. The collaborative, dialogic nature of narrative interviewing is, therefore, very different from the fixed question-and-answer format often employed in research (Elliot G Mishler, 1991 p29). Eliciting the sorts of inner thoughts, insights and reflections characteristic of rich qualitative research data requires skill, sensitivity and the ability to make an interview more like a conversation. There is much more to meaningful communication than simply asking questions, and narrative inquiry acknowledges the crucial role of the interviewer in the collection of data. I gained confidence with the realisation that eliciting stories was what I had done in the consulting room for a major part of my working life. I had learned through many years of gathering sensitive information in my GP consulting room that listening to people and letting them talk was successful and often yielded unexpected information which would have been missed had a series of rapid-fire questions been used. For me narrative interviewing was almost intuitive.

I knew that adopting a listening rather than an interrogative style allowed people to feel more in control in a stressful situation. I anticipated that, although the participants in my study were experienced doctors, they could feel anxious in the unfamiliar role of study participant and need to be put at ease. I was also mindful that their awareness about my position as an experienced doctor may have also engendered some apprehension among participants. To make participation as easy as possible, interviews were held at a location of the participant’s choice. Most usually they were conducted in their own home or office in order to maximum
convenience and comfort. Participants who opted to be interviewed at work were asked to arrange not to be interrupted during the interview and, because of their senior status, this was usually possible.

In-depth, narrative interviews were conducted. A prompt guide (Appendix 3) was used to encourage participants to speak about anything they considered relevant to professionalism. Interviews were recorded using an Olympus 4000 digital recorder and a Sony Handycam set up on a tripod. After the interview I wrote my reflections on the interviewee, my impressions of the interview, the surroundings and the interaction between the two of us.

### 3.8.5 My status as an insider

It is important to acknowledge my own position as researcher, doctor and as internationally experienced academic clinical educator in this study. As already discussed, a key element of narrative inquiry methodology is thinking far beyond simply what is said in any story. The time and the place of the story as well as the personal context of the narrator are crucial elements to consider in the search for meaning. All of these may spark thoughts or memories in the listener which can enhance understanding and add to the depth of meaning. As someone who had also been through the process of becoming a doctor, I already had an understanding of the culture of medicine and experienced firsthand the process of socialisation into medicine. Thus I was an insider to the context in which this research study was situated. Academic debate has questioned the ‘objectivity’ of an insider researcher in studies undertaken within a positivist paradigm (Brannick & Coghlan, 2007). However, an interpretive insider status can be advantageous in giving insight and understanding of the topic not possible for outsiders. The disadvantage is that because of familiarity with the study area there is a risk that assumptions may be made by an insider. This may result in a less rigorous investigation than might be carried out by
someone with no previous knowledge who questions everything. In relation to some aspects of my participants, I was also an outsider. For example, I was not raised in a medical family, I had not pursued a career in hospital medicine and I am female. My own medical education and socialisation into the profession and my working life as a clinician had occurred in the United Kingdom, meaning my existing knowledge was general rather than specific to the Australian context. On the other hand, I had worked in an Australian teaching hospital as an educator and had familiarity with many aspects of postgraduate medical education. No researcher is a total insider or a total outsider to the lives of others (Rabe, 2004) and, having reflected on the issue, I felt well placed to collect and analyse my data in a systematic way.

3.9 Methods of analysis

3.9.1 Introduction

Having collected my data I now undertook both analysis of the narratives and narrative analysis in three separate studies or analyses conducted on the data. Each of these studies sets out to answer a different set of research questions and contributes in a different way to the knowledge and understanding of professionalism and the process by which it is learned and taught. The first study was a thematic analysis of the narratives and the second and third studies were two different sorts of narrative analyses. There is an important distinction between the two: In the former, narratives are examined to identify common themes emerging across them with the aim of adding to the understanding of the research topic. Narrative analysis, by contrast, explores the uniqueness of stories and incorporates the process of narration as well the content of the narrative in the interpretation. Thus narrative analysis makes meaning retrospectively from the lived experience of others (Chase, 2008, p65). What I wanted to do in my research was to make
sense of the narratives through three different analytical methods and then synthesise the resulting data into a new and meaningful perspective on learning and teaching professionalism in medicine.

Later in this chapter I will outline the three separate analyses as an introduction to the fuller description of each given in the following three chapters. Before doing that I will detail the methods of analysis common to all three studies.

3.9.2 Transcription as part of analysis

Riessman recommends that the investigator conducts the interviews because the interpretive process starts at that stage (Riessman, 2008, p26). Indeed, I agree that analysis begins during the interviews as I found that driving back to the office or home immediately after the interviews I was already going over in my mind what had happened. Even at that early stage there was an overall impression of the participant and how the range of stories they had chosen to tell gave insight into the meaning of professionalism for them.

Formal transcription of the audiotapes and viewing of the video recording was done within one week of each interview. Transcripts were annotated to record non-verbal features of the conversation. Video-tapes were viewed and gestures, movements and facial expressions were also noted.

The first task was to transcribe the interviews and, as discussed above, I decided to do this myself despite the many hours of additional work involved. The transcription process is highly interpretive (Riessman, 2008, p29) and I considered it an important early part of the data analysis. I was also aware that delegating the task might result in inaccuracies in the data. Other researchers have reported errors made even by experienced transcribers (Elliot G Mishler, 1991,
and I did not want to take that risk. I transcribed each audiotape and cross-checked with the video tape to ensure accuracy of content. I quickly realised that there were considerable limitations with transcripts as representations of the interviews. It is impossible to include adequately in a transcript all of the linguistic and paralinguistic features which occur in speech (Elliot G Mishler, 1991) and the written record, therefore, does not capture the dynamism of the spoken voice. In narrative inquiry the process of storytelling is key to the interpretive process and therefore repeated listening to and viewing of interview tapes is necessary. However, even the tapes do not capture the completeness of what actually occurred in an interview (Elliot G Mishler, 1991, p49; Riessman, 2008, p29). In my experience there is an intangible ‘something’ within face-to-face interactions which does not easily translate onto camera or tape but which is sensed in the moment it occurs. Depending on the degree to which it is present, there may be said to be a real connection between the people involved.

3.10 Identification of narratives

The next step was to search the transcripts for narratives relevant to the research questions. There are many definitions of what constitutes a narrative (Riessman & Speedy, 2007 p428), ranging from stories of reportable events constructed for a particular audience (Labov, 2006) to narratives of personal experience (Labov, 2002). The most often cited definition of narrative is that of Labov and Waletsky in which they outline six distinct parts (Labov & Waletzky, 1967).
<table>
<thead>
<tr>
<th>Component</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract:</td>
<td>Summary of the substance of the narrative</td>
</tr>
<tr>
<td>Orientation:</td>
<td>Time, place and other orienting information</td>
</tr>
<tr>
<td>Complicating action:</td>
<td>Sequence of events – temporality</td>
</tr>
<tr>
<td>Evaluation:</td>
<td>Significance and meaning, attitude of narrator</td>
</tr>
<tr>
<td>Resolution:</td>
<td>What finally happened</td>
</tr>
<tr>
<td>Coda:</td>
<td>Perspective returns to present</td>
</tr>
</tbody>
</table>

**Figure 3.2: Components of narrative adapted from the work of Labov and Waletzky**

Riessman adopts a more flexible approach to what constitutes a narrative. She defines it as “a bounded segment of talk that is temporally ordered and recapitulates a sequence of events” (Riessman, 2008, p116). Another alternative is to consider narrative as a collection of interviews, documents and observations brought together into a loosely woven whole life story (Riessman, 2008, p4). The definition I adopted was that of narrative as an account of events perceived by the speaker as important and which are selected, organised, connected and evaluated as meaningful for a particular audience (Riessman, 2008, p3). I chose a broad definition of narrative because of the exploratory nature of this study. I was interested to identify general narratives which participants presented as specifically about professionalism and narratives of personal events which arose during the course of the interview which helped me to understand the way each doctor had constructed his or her own meaning of professionalism.

I read and reread transcripts of the interviews and identified two types of narrative: Firstly, particular lived experiences of the narrator recounted in personal incident narratives (PINs). Typically these contain contextual information about the time and place of the event as well as an ordered and chronological account of what happened. Secondly, I included narratives of a more generalised nature in which the narrator offered a perspective relevant to
professionalism. My justification for doing so is that, having worked as doctors for at least ten years, I expected, and indeed found, that some of their accounts included stories drawing on experiences and observations over several years and their reflections on them. Bleakley describes narrative inquiry as a process of synthesising experience and ideas through storytelling (Bleakley, 2005). In keeping with this notion, some of the stories told by participants to illustrate professionalism in my study were composite memories and reflections woven together to give a narrative impression of professionalism.

All narratives were named, numbered and entered into an Excel spreadsheet along with the name of the participant, pending further analysis. I found that this was a more suitable way for me to manage the narratives and form an overview of the data than the software packages designed for qualitative work which I investigated and trialled but decided against.

The bulk of this thesis is about the three separate analyses and I will now briefly explain the methodology and methods employed for each study:

### 3.10.1 Study one

Study one was a thematic analysis looking at the content of the narratives. This explored the nature of professionalism from the perspective of each of the participants and answered my broad exploratory research question regarding the nature of professionalism and the factors influencing how it is learned. In other words, the thematic analysis looked at what was happening in the narrative. Each narrative was read and reread and themes noted using Braun and Clarke’s six-phase method of familiarisation with the data, immersion in the data, preliminary coding, searching, review of themes and synthesis (Braun & Clarke, 2006). This method is explained more fully and the results are given in Chapter 4.
My second and third studies look at two different aspects of the way the narratives are told. They acknowledge the importance of process as well as content to storytelling and integrate the two.

3.10.2 Study two

The dialogic-performative analysis, a term coined by Riessman (Riessman, 2008, p105), requires the researcher to consider the various factors involved in the production of the narrative and to interrogate the underlying meaning in producing a reasonable interpretation. One element of the dialogue is the conversation between the narrator and the listener (in this case the researcher) that produces the narrative. A further element is the internal dialogue that takes place as the researcher reflects upon and processes the narrative in the light of her own experience and knowledge. This in turn leads to new understanding of the topic under study. I utilised dialogic-performance analysis as a method of interpretation because it draws on symbolic interactionism (Riessman, 2008, p106). In addition to looking at the content of a narrative and how it is said, dialogic-performance analysis asks who (is the story for), when is it told and for what purpose? This type of analysis acknowledges that narratives are produced within a specific context, between people and are informed by the environment from which they arise (Riessman, 2008, p105). In my second study the answers to these questions were that the narrative was for me, as informed researcher; it was being told in contemporary times for the purpose of explaining the narrator's understanding of professionalism and perceptions of how he or she learned about it. Reflecting on my own narrative it seemed to me that 'professionalism' was a somewhat ephemeral concept, existing only in talk and interaction between, for example, doctor and patient; doctor and colleague; or health professional and family member. It was obvious from the first analyses that the majority of stories
were about interactions with doctors especially role model doctors. For this reason, in my second study I focused on exploration of the various ways in which narrators characterised the different protagonists or antagonists in the stories. This will be explained more fully and the findings discussed in Chapter 5.

### 3.10.3 Study three

My first study showed that role models and the clinical learning environment were strong influences on developing professionalism. Having analysed role model characterisation in the second study, I was ready to delve further into the meaning of professionalism and the culture of medicine. This required a sophisticated analysis endeavouring to gain insight into the atmosphere of the environment. My third study is a metaphorical analysis which delves further into the meaning of professionalism for the participants through examining the symbolic use of language in the process of narrative construction. Metaphors are fundamental to cognitive thought (Lakoff & Johnson, 2003) and aid our understanding by giving novel insights to phenomena (Hager, 2008). Analysing the way metaphors are used in the narratives, therefore, gives insight into the narrator’s thoughts about professionalism which underpin the storytelling.

### 3.11 Reflexivity

In narrative inquiry, reflexivity is considered an integral and contributory factor in the analysis. “We work within the [inquiry] space not only with our participants but with ourselves” (Clandinin & Connelly, 2000, p61).

A key component of my analysis is the reflexive process constantly linking my own experience of life and of medicine with the stories of the study participants. This cycle of self-reflexivity was integral to the interpretation of the data, as was
reflexivity achieved through long immersion in the data over the period of the research and through writing. My aim was to achieve new and deeper understanding of the notions of professionalism within the medical profession and culture. My findings are relevant to medical educators, anyone involved in clinical teaching and supervision, the public who want and need good doctors and to institutions with responsibility for overseeing medical education.

3.12 Quality criteria in qualitative research

It is important for research to be of high quality and trustworthy so that it may be useful to others. In quantitative studies criteria such as generalisability, validity and reliability are those by which the quality of a study is judged. In qualitative research there is disagreement among researchers as whether or not these concepts apply (Mays & Pope, 2000). There are many qualitative research methods and their philosophical underpinnings are varied. This diversity makes finding criteria applicable to all qualitative studies a significant challenge. This is particularly problematic in relation to health service research where a ‘one size fits all’ approach of checking a list of quality criteria is simplistic and unhelpful when research methods are increasingly sophisticated. A suitable compromise is to acknowledge that quality criteria for all studies depend on the topic and the purpose of the research and also that qualitative research can be based in one of several theoretical frameworks and employ a range of methodologies requiring flexibility in assessment criteria (D. J. Cohen & Crabtree, 2008). The four main criteria agreed as necessary to ensure quality in qualitative research are credibility, transferability, internal coherence and researcher reflexivity. I will explain briefly how each is addressed in my work.
3.12.1 Credibility

Credibility is the equivalent of reliability and validity in quantitative studies and can be addressed in qualitative research in several ways. Member-checking is a commonly advocated method in which participants or similar groups verify the data and findings, for example by letting them read interview transcripts or check analytical findings (Lincoln & Guba, 1985, p314). I began member-checking formally, asking participants to review their transcripts and to edit as necessary. I abandoned this step after four interviews as no changes were made and participants reported that they felt it unnecessary. Triangulation is another method of verification, in which data is collected from several sources (D. J. Cohen & Crabtree, 2008). In my study triangulation is achieved through the three different analytical methods I used, each of which added another few pieces to the jigsaw of professionalism. This will be further discussed in Chapter 7 where the findings of all three analyses are synthesised and discussed.

3.12.2 Transferability

This criterion concerns the relevance of the research. It requires sufficient detail about the research process to enable others to ascertain whether the findings are relevant and applicable to their particular setting or circumstance. The relevance of my research is enhanced by the inclusion of male and female doctors from several different medical and surgical specialties and general practice as well as both urban and rural practitioners. The sample also included doctors who trained over three decades. Had all of my participants been female paediatricians who graduated as doctors fifteen years ago, now working in a tertiary teaching hospital the transferability of my findings would have been less.
3.12.3 *Internal coherence*

Internal coherence refers to the alignment of the research findings, the theoretical framework, methodology and research methods. A clear outline of the philosophical stance of the researcher and the lenses used in each element of the research is needed and I have given this in sections 3.4, 3.5, 3.6 and 3.8.

3.12.4 *Researcher reflexivity*

The fundamental nature of reflexivity in narrative inquiry was discussed in section 3.10, but it is pertinent to mention here that in the debate about appropriate indicators of quality in qualitative research researcher reflexivity and evidence of immersion in the data have been agreed as essential to studies worthy of note (D. J. Cohen & Crabtree, 2008).

3.13 *Summary*

In this chapter I have outlined the philosophical underpinnings of my research, the methodology, the sampling and data collection methods used and the reasons for choosing them. I have described in detail the analytical methods used in identifying narratives and outlined the different analyses carried out on my data. I have discussed the attributes associated with high quality qualitative research and indicated how they have been addressed in my research. In the next three chapters the three separate studies that comprise this research are presented. Each chapter contains an in-depth account of the analytical methods used, the findings and discussion of results.
4 Study 1: A thematic analysis of senior doctors’ narratives about professionalism

4.1 Introduction and research questions

In the last chapter the methodology underpinning the research and the methods employed in gathering the data were presented. In the following chapters the three different studies conducted on the data in order to explore the nature of professionalism and how it is learned, are reported and discussed. Each study addresses different, but related, research questions and each uses a different analytical method. This chapter focuses on the first of my main research questions given in Chapter 2.10 (What can be learned about the meaning of professionalism through the stories told by senior doctors about their navigation into the medical profession?) which I have broken down into two parts:

- What does the term professionalism mean to senior doctors?
- What are the factors which senior doctors perceive as formative to their understanding of the meaning of professionalism?

The background, context and rationale for this study, including a review of relevant literature, are explained and the application of thematic analysis is described in detail. The results are presented in two parts in relation to each of the research questions. Thus, the first looks at the elements of the participants’ understanding of professionalism. The second draws out the factors perceived by them as influencing their learning about professionalism. The discussion explains how
these findings progress existing knowledge in the field and provides implications for medical educators. Finally, the limitations of this aspect of the study and further research questions are identified.

4.2 Background

The premise of this thesis is innovative in that it seeks to explore the perceptions of senior clinicians about professionalism. As pointed out in Chapter 3, the majority of the studies in the literature about how professionalism is learned involve medical students or junior doctors surveyed early in their careers (Arora et al., 2010; Brownell & Cote, 2001; Gaiser, 2009; Reddy et al., 2007; Wiggleton et al., 2010). Flowing from this work, role models and the hidden curriculum are identified as important influences on learning, including the development of professionalism, professional identity and professional behaviour. What is less clear is the process by which the learning takes places and whether, as they gain experience and seniority in the profession, doctors still regard these factors as important. Since medical students and doctors in training learn from a large number of doctors both in the clinical years of their undergraduate degree and during their postgraduate training, further in-depth exploration of how this occurs in relation to professionalism is important.

4.3 Theoretical framework

Learning about oneself and about the world takes place through lived experience (Boud & Walker, 1990) and is facilitated by reflection occurring during or after any experience. Such ‘reflection in experience’ and ‘reflection on experience’ are necessary for learning to take place (Andresen, Boud, & Cohen, 2000, p233). Narratives serve to disseminate not simply an account of the actual events experienced but also an evaluative perception of
the narrator’s interpretation of the experience. From a symbolic interactionist perspective meaning is negotiated between individuals through interaction and through the symbols which are used during that interaction. In this first study of the three within the thesis, I focus on the content of the interviews. That is, I focus on what is said by examining the most commonly used symbols in storytelling – the words.

A diagrammatic representation of my perspective on the relationship between the formal, the informal and the hidden curricula is shown in Figure 4.1. As a new doctor progresses through undergraduate and postgraduate medical studies all of these curricular elements contribute to his or her understanding of professionalism. It is known that this is mediated strongly through the informal and hidden curriculum (Inui, 2003) as discussed in Chapter 2.6.5. Investigation of the particular factors influencing this process and of the process itself is needed to ensure that as many doctors as possible are supported in their journey towards phronesis. As discussed more fully in Chapter 2.6.3, phronesis is defined as practical wisdom leading to action and always moving towards excellence (Kinghorn, 2009).

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Figure 4.1: Relationship between formal, informal and hidden curricula
Time spent in gaining experience in the practice of medicine is an essential component of striving for phronesis and the necessary period may be lengthy. Furthermore, there is no guarantee that all doctors will reach a state of phronesis. Curricula contributing to increasing understanding of professionalism continue to operate although they are themselves subject to changes in response to academic, political, social and environmental factors impinging on medical practice. Listening to the perceptions of senior doctors about factors influential to them can shed light on when and how the various elements operate.

4.4 Methodology

From a constructionist epistemological perspective, the process of learning from different experiences is influenced not only by the experience itself but by factors such as the learner's existing knowledge and understanding (Andresen, et al., 2000, p226) and the context in which the experience occurs. Using a thematic analysis founded in interpretive methodology within a socio-cultural framework allowed me to identify these factors from my data.

4.5 Method

The recruitment and data collection processes are described fully in Chapter 3 and I will describe here the analytical methods used. The dataset for the thematic analysis comprises the transcripts of the interviews, with particular attention paid to the personal incident narratives or small stories identified within the transcripts. Thematic analysis is a method commonly used in qualitative research and favoured because of its flexibility. It is appropriate to a number of different epistemological and ontological positions and offers a way of identifying and reporting patterns, or themes, within data (Braun & Clarke, 2006).
The thematic analysis was conducted in six phases following Braun and Clarke’s guide to thematic analysis (Braun & Clarke, 2006). As a method, thematic analysis of narratives is concerned solely with the what rather than the how of stories (Riessman, 2008, p53). In conducting such an analysis the researcher looks at the content of the story rather that the way in which the story is told.

Phase one is familiarisation with the data and this began during the interviews themselves and continued through the process of transcription. Reading and re-reading transcripts is a common way for researchers to immerse themselves in the data. I was able to enhance this immersion by viewing the video-recordings of the interviews. Traditionally research has concentrated on talk rather than the visual aspects of interpersonal interactions (Charlotte E. Rees, 2010), despite it being well known that visual cues are important in communication (Mehrabian, 2007 p17). Every interview was watched and listened to several times as well as the transcripts being read and re-read so that I was thoroughly acquainted with the content. The next four phases are preliminary coding, searching, reviewing themes and naming themes and this was done by annotating transcripts, recording themes in the narratives and grouping similar ones together. Synthesis, explanation and reporting of themes is the final phase of Braun and Clarke’s process of thematic analysis and this took up a great deal of time through writing and discussion. Writing this Chapter of the thesis is the culmination of this final phase. With the two research questions given in section 4.1, my thematic analysis addressed two topics, namely the meaning of professionalism for the participants and then the factors they perceived as having influenced their understanding of that notion.
4.5.1 Exploring the meaning of professionalism

The broad themes in each interview were ascertained by careful review of the transcript and of the videotape. In eleven of the twelve interviews the relevant data comprised mainly responses to a direct prompt asking about the meaning of professionalism. In the twelfth interview there was no need for a prompt as the doctor spontaneously talked sufficiently about professionalism to facilitate interpretation of meaning.

The talk generated by the prompt was analysed and the constituent elements of the meaning teased out and coded. A framework was developed highlighting the key concepts of professionalism for the group.

4.5.2 Exploring factors perceived as influential in learning about professionalism

The strategy I employed in the interview process was to encourage participants to talk about anything related to learning and understanding the meaning of professionalism. What they told me in response were stories based on their lived experience, or narratives (Clandinin & Connelly, 2000, pxxxv). Here, the evaluation section of the structure of classical personal incident narratives was useful (Riessman, 2008, p18). The theoretical assumption underpinning this analysis is that learning is very much experiential and that the nature of the experience may be multidimensional. Furthermore, the influence of reflection on experience is likely to be stronger if the experience is repeated. Inviting senior clinicians to discuss their recollections and perceptions of the learning process was expected to facilitate exploration of the cumulative and complex nature of learning often overlooked in papers describing single interventions.
4.5.3 Context

In examining their current perceptions of the meaning of professionalism, matters of context, including the temporal dimension, were relevant considerations. It was anticipated that the time at which participants had undergone their primary medical education and the prevailing attitudes and circumstances of the medical profession during the formative years in medicine for successive generations of doctors may be relevant. It was also possible that the upsurge in the global academic interest in professionalism may have influenced the participants more or less, depending on when they joined the profession. There was, too, an assumption that the rapid changes in medicine over the last forty years would be reflected in fundamental concepts of professionalism depending on the attitudes prevailing during training.

During immersion in the transcripts and in order to gain some insight into the contextual features as background to the main narrative thematic analysis, data on location of medical school and year of graduation were recorded for each participant. In addition, the stage in the narrator’s life from which the narrative arose and any comment they made about the significance and meaning of the event was noted. Details of postgraduate training location were also recorded.

4.5.4 Participants

The participants were twelve doctors, six men and six women, from a variety of medical and surgical specialities. Nine participants were hospital-based, representing seven specialties (respiratory medicine, neonatal intensive care, accident and emergency medicine, obstetrics, gynaecology, paediatrics and psychiatry) and three were general practitioners. Two doctors were rurally based – one general practitioner and one hospital specialist. Between them the participants
in my study had trained in medicine between ten and forty years prior to the study being undertaken. They had attended six different medical schools and been trained in a wide variety of clinical settings in Australia, New Zealand and Europe.

The range of time since qualification in medicine was ten years to forty years with roughly one-third of the cohort in each decade group. Table 4.1 shows the participants arranged into three groups by the decades since qualification. All participants were Caucasian, with nine graduates of three different Australian medical schools. The remaining three doctors had immigrated to Australia having trained overseas in Europe or New Zealand. These three doctors were all in hospital specialist positions. All participants were actively involved in teaching at undergraduate and postgraduate level and all had an affiliation with either a university, as a clinical teacher or supervisor, or with a professional College. As senior doctors, they are expected to have considerable knowledge and understanding of the culture of medicine through their own experiences as learners, as doctors and as medical educators.
<table>
<thead>
<tr>
<th>Group</th>
<th>Assigned Name (years since graduation)</th>
<th>Medical School location</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified 10 – 19 years ago</td>
<td>Karen (10)</td>
<td>Australia 3(^{10})</td>
<td>Paediatrics</td>
</tr>
<tr>
<td></td>
<td>Kevin (11)</td>
<td>Europe 2</td>
<td>Neonatology</td>
</tr>
<tr>
<td></td>
<td>Helena (14)</td>
<td>Australia 1</td>
<td>General Practice</td>
</tr>
<tr>
<td></td>
<td>Lorna (15)</td>
<td>Australia 3</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td></td>
<td>Roy (16)</td>
<td>Australia 1</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Qualified 20 – 29 years ago</td>
<td>Molly (20)</td>
<td>Australia 1</td>
<td>General Practice</td>
</tr>
<tr>
<td></td>
<td>Gemma (20)</td>
<td>New Zealand</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td></td>
<td>Julie (21)</td>
<td>Europe 1</td>
<td>Obstetrics &amp; Gynaecology</td>
</tr>
<tr>
<td></td>
<td>Harry (26)</td>
<td>Australia 1</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>Qualified 30 – 40 years ago</td>
<td>Derek (30)</td>
<td>Australia 2</td>
<td>General Practice</td>
</tr>
<tr>
<td></td>
<td>Ricky (33)</td>
<td>Australia 1</td>
<td>Gynaecological surgery</td>
</tr>
<tr>
<td></td>
<td>Alan (40)</td>
<td>Australia 1</td>
<td>Obstetrics</td>
</tr>
</tbody>
</table>

Table 4.1: Participants, showing time since qualification, location of medical school and specialty

The thematic analysis was done in two parts, as discussed in section 4.5.

4.6 Thematic Analysis Results Part 1: Constructs of professionalism

Sixty-eight separate words or phrases were given across the twelve interviews, either in response to a prompt asking the participant to describe their

\(^{10}\) Participants included graduates of one New Zealand, three Australian and two European Universities
understanding of the term professionalism or in spontaneous talk on the topic. The coding process described in Section 4.5 distilled down to three main ways in which participants constructed the notion of professionalism: as related to their own sense of self or identity; as related to behaviours expected of and exhibited by doctors as a group and, thus, accepted as the norm; and as a notion which seemed impossible to reify and was described in a somewhat nebulous way as a kind of atmosphere existing between and around doctors. A diagram of the themes and subthemes is shown in Figure 4.2

![Diagram of themes and subthemes](image)

**Figure 4.2: Taxonomy of understanding of the meaning of professionalism for senior clinicians**

Three main themes were identified relating to different aspects of professionalism: self and identity; behaviour expected of doctors; and the atmosphere existing between doctors and others. These themes and the sub-themes within them are discussed more fully below.
4.6.1 Professionalism as relating to self and identity

All participants talked about professionalism from a personal perspective with a prominent subtheme being the specialised knowledge that is part of being a medical professional. For example, Derek emphasised the exclusivity of medical knowledge:  

...the notion of profession, as I understand it, is having a discrete body of knowledge which is specialised and you profess and it’s a body of knowledge which no-one else shares in the community. (Derek: lines 27-29)

Derek goes on to nuance a feeling of superiority in the notion of medical professionalism when he says:

There is something noble about medicine that sets it apart from selling tickets on a bus. (Derek: lines 18-19)

Harry and Lorna echo the sentiment when they say of professionalism:

I think it’s pretty important in medicine. It distinguishes medicine from a lot of other careers. (Harry: lines 36-37)

I think it [professionalism] should be the slightly intangible things that set us apart as a craft group, as a professional group. (Lorna: lines 12-13)

11 Transcription notes: Dash – following a word indicates running-on speech; Ellipsis … indicates an edited section; [square brackets] indicate general information where proper names have been removed; (1) indicates a pause to nearest second; (,) indicates a micropause.

12 Line numbers refer to the location of the quote in the transcript
Being special as a profession is not just about knowledge. Helena alludes to the status of medicine and understands professionalism as a way in which doctors can “generate respect from other groups and from the community” as a whole. Derek suggests that the meaning of professionalism has changed over the years and in doing so appears to be talking about the process of professionalisation, where any group with specialist knowledge of a topic becomes a profession:

...clearly professionalism has become much broader in definition so the local seller of shoes or nurseryman is now a professional, which means that he has special knowledge in his little area of interest. (Derek: lines 8-10)

Here Derek conflates the concept of professionalism with that of professionalisation. It is not uncommon in the literature to find the two words used almost interchangeably (S. R. Hilton & Slotnick, 2005) but this leads to confusion and lack of clarity. In his ironic juxtaposing of what he refers to as the “little” crafts of shoemaking and market gardening to the complexity of modern medicine, Derek mocks the phenomenon of professionalisation.

A third subtheme relating professionalism to self and to identity was about being valued as an individual and the connection to building confidence and self-esteem. In the data there are several references to the difficulty of achieving admission to medical school and to feeling inferior to other students or doctors. For example, Molly says:

I’d wanted to be a doctor my whole life but everyone told me there’s no way I was going to get the marks. (Molly: lines 100 &101)

For Molly there is a link between self-esteem, professionalism and money:
There’s an importance in being professional and feeling that you’re actually (2.0)\textsuperscript{13} that people appreciate your professionalism and are willing to pay for it. So I think I would have a lot of difficulty working in a bulk billing practice\textsuperscript{14} in keeping my sense of self-esteem. (Molly: lines 682-685).

This example is specific to the Australian healthcare system in which Molly works, where patients are aware of a monetary value on each consultation and there is flexibility for doctors in setting charges. In such an environment it is possible to see how one’s identity as a professional could become associated with how much a patient is prepared to pay for services. For Molly supports the notion by saying:

I like the fact that people actually have to take some money out of their pocket to see me because it actually makes me feel that they value what I do and value the service that I give. ... I feel that if a patient values me I’ll go 200%. (Molly: lines 685-694)

When Molly said this during the interview I was very aware of having to hide my feelings. I was angry because she seemed to be suggesting that it is acceptable for a doctor to give a better service to patients who pay directly. Her inference was that the patients in a bulk-billing practice appreciate her professionalism less because they cannot afford to pay more than the Medicare fee and, therefore, deserve only a basic service. I felt disappointment because Molly had already explained that she

\textsuperscript{13} Designates a pause in speech of 2 seconds in length

\textsuperscript{14} A bulk-billing practice is one where the doctor’s fee is paid directly from Medicare to the doctor requiring no payment by the patient. Medicare sets the schedule of fees. Non-bulk-billing practices can charge more than the Medicare approved fee for the service provided, the patient pays up front and then reclaims the Medicare schedule fee.
was from a less well-off part of town and I felt that she should have been aware of
the hardships endured by many people, especially those who are sick. Molly's sense
of self-worth was directly associated with how much her patients were prepared to
pay to see her. For her, professionalism meant “going 200%” for those who valued
her in this way. This was similar to the doctor-centred and financially driven
attitude which caused concern to many doctors in the United States during the
1980s and 1990s, giving rise to the professionalism movement as a counter to
commercialism in medicine (F. Hafferty, 2006).

The fourth subtheme in the *Professionalism related to self and identity* section
was an attention to medico-legal issues, to protecting one's professional identity
and, in some cases, to enhance it by becoming a recognised medico-legal expert.
Alan raised the issue when talking about the professional College in which he had
served as a senior member.

The things [related to professionalism] we’ve spent a lot of time on from a
college point of view are medico-legal, both for your own self-protection like
how you do things to protect yourself but then also how do you contribute to
giving opinions both written and verbal and getting credentialing on that.
(Alan: lines 42-45)

Molly also linked professionalism with taking a leadership role in medico-legal
issues:

I think professionalism is a very important component in the medico-legal
expert opinions that I write in that I am purporting to be representative of
the profession in giving an opinion about what I think peer professional
practice is in a particular area. (2.0) So for me it [professionalism] is not just
a patient-to-patient thing it’s also in what I write. (Molly: lines 33-38)
It is not surprising that medico-legal issues are raised in relation to professionalism. Work published in 2005 showed a relationship between concern about students’ professionalism at medical school and later disciplinary action against them at medical board level (Papadakis, et al., 2005). Both Alan and Molly add an additional dimension with the idea that doctors as individuals can contribute to the process of establishing expert opinion. In this there is overlap with the concept of professional autonomy or independence which has long been considered a pillar of professionalism (Brian Castellani & Hafferty, 2006, p10; D. Irvine, 1997).

4.6.2 **Professionalism as related to behaviours exhibited by and expected of doctors**

The most common way in which participants explained professionalism was by giving behavioural examples. Gemma states simply that it means that “you do your utmost to do your best”. She goes on to elaborate:

> The practical things are: you’re on time, that you come to work when, you know, unless you’re sick, you’re always there so that you’re reliable. (Gemma: lines 7&8)

Other behaviours put forward as indicating professionalism included “behaving in a respectable manner” (Helena) or “being reliable” (Derek). Exactly what constitutes respectable or reliable again depends on context and circumstance. Professionalism, therefore, comprises personal factors as well as contextual factors necessitating flexibility within a sociocultural framework. Further complexity in the notion is signalled by Roy who includes higher order behaviours such as synthesising information and clinical reasoning skills in his perspective of professionalism:
...using one’s expertise but where you’re unlikely to have the exact answer to the problem. And so you’re trying to utilise the existing information you have and gain an understanding of what’s going on and come up with a solution.

(Roy: lines 38-40)

Subthemes highlighting particular types of behaviour were identified. The first of these was behaviour related to interpersonal relationships. Lorna refers to professionalism as inherent in the way working relationships are conducted, but she is not explicit about the parameters:

It [professionalism] describes the way in which we interact with our peers and with all our colleagues at all sorts of levels. (Lorna: lines 10 & 11)

By mentioning “colleagues at all sorts of levels” she does imply that, for her, a key measure of professionalism is how doctors relate to others in the broader healthcare team. Gemma gives an example of what she means by professionalism within the relationship between doctor and patient and in doing so she introduces the concept of emotions and feelings:

...then from the patient point of view professionalism is that you actually discuss with the patient in a non-emotional way, but obviously with feeling, but you discuss with them the options in a way that they can understand. So that you don’t direct them or make them feel as though this is pushed upon them. (Gemma: lines 11-15)

In this excerpt, which occurred early in the interview, the close juxtaposition of the phrases “a non-emotional way” and “but obviously with feeling” signals a tension for Gemma. It is as if what she has been taught as a doctor (to be non-emotional) is at odds with what she knows patients need from her own personal experience
(obviously with feeling). It emerged later in the interview that Gemma’s mother has a chronic medical condition meaning that Gemma has witnessed many consultations as a family member rather than as a doctor. These experiences over the years have heightened Gemma’s awareness of the patient perspective on professionalism and her awareness that, for patients, emotion is important to the doctor–patient relationship (Malterud & Hollnagel, 2005).

This leads to the second subtheme in the professionalism-related behaviours theme. Still about relationships, it is specifically concerned with professionalism as the ethical framework in which practitioners work:

[Professionalism is] that sense of how one relates to other people, looks after other people in an ethical boundaried way. (Roy: lines 45-47)

A further element of this subtheme is the notion of codes of conduct in relation to ethical practice. Three participants in the most recently qualified group (Kevin, Helena and Lorna) referred to a “general code of conduct” in their descriptions of professionalism. Furthermore, as Lorna points out, this applies to more than doctor–patient relationships:

It [professionalism] describes the way in which we interact with our peers and with all our colleagues at all sorts of levels and it describes the sort of code of conduct of that interaction I think. (Lorna: lines 10-12)

None of the doctors who qualified more than twenty years ago specifically mentioned codes of conduct despite the longstanding existence of the Hippocratic Oath. Possibly this is because formal codes of conduct are more recent phenomena within medicine. Indeed, it was not till 2009 that the Australian Medical Council (AMC) published a nationally agreed code of conduct for doctors, entitled Good
Medical Practice (Australian Medical Council Working Party, 2009), based on codes produced earlier by the General Medical Council of the United Kingdom (General Medical Council, 1998, 2006) and the Accreditation Council for Graduate Medical Education (United States), the American Board of Internal Medicine (ABIM Foundation, et al., 2002). Although such codes of conduct do provide useful guidance for maintaining professional standards, they still rely on the individual judgment in the interpretation of advice. For instance, as part of the Working with patients section of the AMC code there are nine criteria in section 3.3 directly related to effective communication. Each one is commendable but written in such a way that there is latitude for variation in interpretation. One of the criteria, section 3.3.3 states that effective communication involves:

*Informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment.*

(Australian Medical Council Working Party, 2009, p 9)

The interpretation of how much information to give and what constitutes an “adequate opportunity” is left to the doctor, to allow for variation depending on the individual circumstances, the nature of the problem and the wishes of the patient. This means that there is still scope for considerable variation in actual practice. This leeway may account for the lack of precision in the examples given by participants to illustrate what they meant by professional behaviours.

The third subtheme of the professional behaviours theme is clinical excellence and taking responsibility. Harry described professionalism simply as “doing the job well’ and, to a large extent, clinical excellence was taken as a given. Helena expands this by alluding to the personal satisfaction resulting from a job well done when she says:
Really being able to be proud of what you do I think is professionalism.

(Helena: lines 40-41)

Other doctors gave a broader view of clinical care, as exemplified in the following two quotations:

Part of being a professional is that you are able to give them [patients] a sort of rounded treatment plan. (Gemma: lines 15-16)

Also how to behave and how to communicate is actually a bigger part of professionalism than just the knowledge. (Kevin: lines 31-32)

Ricky also refers to professionalism as being “concerned about the whole welfare of the patient” and goes on to voice a more general view of professionalism as not only clinical actions but including responsibility to society:

[Professionalism is] being responsible for all of your actions, clinical or social, that may impact on other human beings be it in a patient care setting or be it any setting where you’re exposed to the public. (Ricky: lines 63-65)

Karen was clear about the degree to which she felt her professional responsibility extended:

I feel responsible for my patients even when I’m away on holiday they’re still my patients and I should be the first contact for those groups of people. (Karen: lines 51-53)

It is interesting that Karen is possessive in talking about ‘my’ patients, almost as if she owns them, which is reminiscent of a paternalistic view of medicine. The concept of professionalism as the doctor being constantly available to patients alludes to the selflessness and altruism typical of nostalgic professionalism.
(Frederic W. Hafferty & Castellani, 2010), although there is also a hint of martyrdom in the notion of extending the availability into holidays.

A commitment to lifelong learning and research was a further element related to the clinical excellence subtheme. Derek expresses this eloquently:

> I see professionalism as being very much involved in constant reflection and enquiry and discovery in the field of learning in which one practises. (Derek: lines 22-24)

The emphasis in my data on behaviours as indicative of professionalism mirrors the way in which the term ‘professional behaviour’ is often used interchangeably with ‘professionalism’ in the literature, especially in relation to assessment (Elcin et al., 2006; Stern, Frohna, & Gruppen, 2005; Van De Camp, Vernooij-Dassen, Grol, & Bottema, 2006).

### 4.6.3 Professionalism as an atmosphere existing between and around doctors

All participants found the concept of professionalism hard to define, as indicated by thoughtful pauses prior to giving an answer, or by comments such as, “That’s right, jump in on the easy question!” (Lorna). The video of those who responded to the prompt “tell me what professionalism means to you” shows participants significantly engaged with the question. Molly, for example, stops folding her washing,\(^\text{15}\) thinks before responding and then goes on to describe professionalism

\[^{\text{15}}\text{Molly was interviewed at home and was multi-tasking.}\]

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as “An all-pervading theme that goes through your work”. Lorna closes her eyes and scratches her head pensively before offering a description of professionalism as “The slightly intangible things that make, that set us apart as a craft group, as a professional group”. The challenge participants show in explaining professionalism is striking. Lorna acknowledges this as she talks about professionalism as “a sort of unwritten, difficult to describe collection of interactional skills, morals, ethics and behaviours”. Although it is hard for participants to articulate the exact nature of what I have called the atmosphere of professionalism, they do identify some of the associated characteristics. Resonant with the successive waves of professionalism described by Hafferty and discussed in Chapter 2, Alan says:

It [professionalism] means a lot more than it did when I first graduated forty years ago, as there's been an enormous clarification. (Alan: lines 14 & 15)

He goes on to say

I’ve been able to give quite a lot of thought to it and I think of it under the three sorts of headings of educational expertise if you like, risk management and sort of professionalism in a broader sense... And just sort of thinking of it under those headings has helped me a lot to be a bit clearer about which bits are where. (Alan: lines 15-24)

Here Alan demonstrates that, for him, the clarification was not necessarily through the professionalism literature but through reflection and clarification as an ongoing process within his own mind. He conjures up a picture of professionalism as a jigsaw in which the parts of the picture have to be found and put together by each individual according to their own context. This is a good analogy for my research.
Another subtheme is the ubiquity of professionalism in place, as suggested by Molly’s description of professionalism as “An all-pervading theme that goes through your work”. Harry extends this to the dimension of time when he refers to professionalism as being “more of a twenty-four seven occupation”. These characteristics represent an acknowledgement that professionalism is a constant and fundamental principle for doctors. Academically speaking, this aligns with Castellani and Hafferty’s seven competing clusters of professionalism and the notion of ‘Activist professionalism’ in which physicians “live their commitment to patients” (Frederic W. Hafferty & Castellani, 2010). However, my sense is that Harry and Molly more closely represent the cluster that Castellani and Hafferty call ‘Unreflective professionalism’, those physicians who are so busy providing medical care that they have no input to the academic medicine literature (Frederic W. Hafferty & Castellani, 2010). Since all of the participants in the study are primarily clinicians, they are highly aware of the place of professionalism in their day-to-day work. As discussed at the start of this section, some comments conjure up an ethereal and intangible quality existing between doctors and others, and one which changes with the context and the people involved. It is not only interactions with patients in which professionalism is involved

It [professionalism] describes the way we interact with our peers and with all our colleagues at all sorts of levels. (Lorna: lines 10 & 11)

The emotional aspects of interaction are raised by Gemma, Molly, Derek and Harry all of whom refer to the primacy of “putting personal preferences aside” when “doing the right thing for the patient”. Julie adds care and compassion to the mix by suggesting a gold standard level of care for everyone:
although this may be somebody you don’t know, you’d like to think that “this is how I’d like my Mum to be treated if she was in here”. (Julie: lines 512-513)

Compassion is increasingly recognised as a quality explicitly encouraged in modern medical curricula but sometimes discouraged by real life experience and the hidden curriculum (Coulehan, 2005). Studies have shown that there is loss of empathy and caring during the years spent in medical school (Inui, 2003; Newton, et al., 2008). A factor in this may be that supervising doctors are often reluctant to give explicit feedback on disrespectful or uncaring behaviour towards patients by juniors (Burack, Irby, Carline, Root, & Larson, 1999). It is interesting that, in this study, all of the doctors explicitly discussing caring in relationships as relevant to professionalism, have been qualified for more than twenty years.

4.6.4 Discussion: Nature of professionalism

The participants in my study are working clinicians, all of whom are involved in the education of medical students and junior doctors at grassroots level. They are aware of the myriad of different people involved in the hidden curriculum of professionalism in everyday actual practice and offer an alternative view to the academic one. It is striking that these experienced clinicians all had difficulty in articulating the meaning of professionalism at a personal level. In this there is resonance with the academic literature, where finding a satisfactory definition of professionalism remains a challenge (Erde, 2008).

My analysis has produced three distinct constructs of professionalism: an inward-looking, reflective construct related to self, personal and professional identity development; an action-oriented construct related to the behaviours expected of doctors; and a creative construct of professionalism as related to a somewhat nebulous atmosphere existing between and around doctors. As the professional
identity of a doctor develops it is overlayed onto and engages with pre-existing personal identities. Furthermore, the internal perception of what other people expect of us is as integral to our identity as the external perceptions of others manifested in the way people relate to us (Jenkins, 2008, p47). There are, therefore, close links between the first two constructs. The third construct of atmosphere is reminiscent of the ‘I know it when I see it’ notion of professionalism (Rizzardi, 2005). The three constructs are, in some ways, similar to the three levels in the professionalism as a complex system model (Frederic W. Hafferty & Castellani, 2010). The micro level is personal, the meso level is interactional and macro is the organisational level. The constructs emerging from my analysis of the way in which fulltime clinicians – as opposed to academic clinicians – conceptualise professionalism offer three different dimensions. The construct related to self and identity is reflective and inward-looking; the construct related to behaviours is action orientated and sometimes spontaneous and the construct related to atmosphere is creative and dynamic. I suggest that these different dimensions represent the different ways in which the jigsaw of professionalism is learned and goes on being learned throughout a doctor’s working life. There is creativity, there is action and there is reflection on action. This supposition forms the background for the next part of my thematic analysis.

4.7 Thematic Analysis Results Part 2: Factors influencing professionalism

Having teased out the various ways in which the study participants understood professionalism, the next stage was to answer the research question:

- What are the factors which senior doctors perceive as formative to their understanding of the meaning of professionalism?
The data I analysed to answer this question comprised transcripts and video recordings of the interviews and field notes written afterwards. During the interview, participants told stories in response to a prompt about issues they felt had influenced their learning about professionalism. In looking at what the influential factors were rather than how they influenced perceptions, an analysis of the content of the narratives was appropriate. The way in which the narratives were identified is explained in Chapter 3.10.

One hundred and thirty-three personal incident narratives related to professionalism were identified from the twelve transcripts. The average number of stories per person was eleven, with a range of seven to sixteen. Stories chosen to demonstrate professionalism (or its lack) were commonly about everyday encounters and interactions, which, although run of the mill, had made enough of an impression on narrators to be remembered for many years – sometimes decades (Foster, 2009). The experiences and observations identified by participants as relevant to professionalism were embedded in stories of interpersonal interactions with doctors they had encountered at some time in their lives. The reason why the encounters were quite so impactful is key to gaining understanding about the process of learning from role models and from the hidden and informal curriculum. Although interviewees were encouraged to focus on their medical training experiences, the stories they told were not limited to that period and spanned participants’ whole lives. They included encounters in childhood or in the workplace as a senior doctor. The perspective from which the story was told, the ‘voice’ used in telling it was noted to ascertain whether there were any stages particularly relevant to the development of professionalism. A summary of the stage in life at which the narratives originated is given in Table 4.2.
Table 4.2: Range and frequency of perspectives from which senior doctors’ narratives are told

<table>
<thead>
<tr>
<th>Perspective from which narrative is told</th>
<th>Number of narratives (N = 133)</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Medical student</td>
<td>33</td>
<td>25</td>
</tr>
<tr>
<td>Intern or JMO</td>
<td>42</td>
<td>31.5</td>
</tr>
<tr>
<td>Registrar</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>Consultant / Senior doctor</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Nurse prior to medical training</td>
<td>3</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Almost half the stories were told from memories as an intern, junior medical officer or registrar, compared with only a quarter from medical student recollections. Despite the focus of the study interview on clinical training, more than ten percent of the narratives dated from childhood. Postgraduate stories comprise more than sixty percent of the total narratives in the study.

Three main themes emerged from the data:

- Personal factors form a foundation for the doctors’ subsequent understanding of professionalism and also continue to operate as experienced is gained.
- People factors related to observation of the relationships and interpersonal interactions between doctors and others.
- Environmental factors related to the learning environment as well as the culture of medicine.

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16 These are position titles of doctors in postgraduate years 1, 2 and 3-6 respectively and all are training grades
In terms of sociocultural theoretical concepts these themes correspond with individual, interpersonal and contextual perspectives. The interrelation of the themes and subthemes as they influence understanding of professionalism is shown in Figure 4.3 and the data underpinning this model will be explained and discussed in the remainder of the chapter.

Figure 4.3: Interrelationship of factors influencing understanding of professionalism

### 4.8 Personal factors influencing understanding of professionalism

From my data it is clear that participants had preconceptions of professionalism when starting medical training. Norms of attitudes and behaviour developed during childhood are hard to shake off and these early stories demonstrate that preconceptions could be different depending on the participant’s upbringing.
4.8.1 Preconceptions

Being raised in a medical family offers a plethora of experiences and an intimate understanding of both the advantages and the demands of medicine as a career. Two participants had doctor parents and their stories give an idea of the different kinds of impressions that can be gained: Roy's father was a GP who, perhaps inadvertently, inspired his son to study medicine through his dinner-time conversation.

And my memory of growing up is of Dad coming home having spoken to really interesting people. He never told us anything about the medicine but he’d come home and say “I spoke to a guy who was in Changi” or “I spoke to a guy who's just sailed round the world” or “I was talking to a guy, or a woman who ...”

So he always had these interesting stories about people and I think that was the sort of attraction. (Roy: lines 27-31, more than 25 years previously)

Roy’s father is presented as someone who conveyed a more humanistic than clinical view of medicine to his son. Roy’s preconception was that medicine was a “really interesting” with the opportunity to meet fascinating people. It is striking that Roy does not use the word ‘patient’ as he tells the story. In terms of what this narrative reveals about Roy’s developing understanding of the meaning of professionalism it suggests that, for the young Roy, medicine was about people.

17 Changi is the name of a Japanese prisoner of war camp in Singapore where many Australian and British soldiers were held during World War Two
The habit of his father sharing the stories with the family at home may also have demonstrated to Roy the vocational aspect of medicine as an integral part of a doctor’s life. At the same time, discussing patients’ stories over the family dinner table became normalised for Roy and although it is not clear whether any sensitive patient information was revealed it may well have led to a misunderstanding of the boundaries of patient confidentiality. The attraction of interesting stories about people may even have influenced Roy’s career choice, as he is now a psychiatrist. Alan, also from a medical family, explained the he had never considered a career other than medicine:

I guess my process [choosing a career] was fairly simple, because my mother and father were both doctors. I lived in that sort of household and grew up in that household and I never thought of doing anything else. Simple as that. Born and bred.18 (Alan: lines 7-9, 50–60 years previously)

Although both his parents were doctors, only his father was an obstetrician. It appears Alan identified with the same-sex parent, as is usual with children (Zehnder & Calvert, 2004) from an early age, and in doing so his career was set. Alan followed in his father’s footsteps:

Well you see I used to answer the phone for my father. Because he didn’t have a phone, he didn’t have a mobile phone. So I used to have to take the messages if he was out on a call in the middle of the night. Or [if] my mother was doing a surgery and he was out I would take a call and you know if it was

18 As is customary in thematic narrative analysis, interview text is presented without notation of non-linguistic elements for ease of reading.
labour ward and [I would] work out the degree of urgency, and (laughs) at the age of ten, and write a message for him and say “labour ward called they want you urgently” or “they want you to ring back at your convenience”. (Alan: lines 173-182, more than 50 years previously)

The interview video shows Alan telling this story in a very animated way as if he remembers the excitement he felt as a young boy undertaking what he perceived as an important job in the running of his father’s practice. His laughter indicates that he realises that he is probably overstating the scope of his message-taker role but he was certainly learning about the twenty-four-seven nature of medicine. Later Alan, telling a story about his own surgical training, says:

I’d watched my father do a lot of things. He’d taken me to theatres from the age of fifteen. I’d been regularly in theatre with surgical people so I was pretty comfortable. (Alan: lines 539 & 540, around 50 years previously)

Here the notion of privilege is raised. Being allowed to accompany a surgeon into the operating theatre was outside the usual experience for a teenager and probably inappropriate even fifty years ago. By today’s standards it would be unacceptable to take a teenager into an operating theatre without a series of checks and safeguards to protect both the child and the patient from mishap. For Alan, this experience prior to his medical training tacitly influenced his understanding of professionalism. He learned that being a doctor’s son could bring special favours, such as gaining entry to places not accessible to ordinary schoolboys. Alan was able to gain confidence to the extent that he “felt pretty comfortable” with “surgical people” even before he gained entry to medical school. This reality set him aside from his peers at an early stage in his medical education and lays a possible foundation for the feeling of elitism experienced by others, like Gemma, Derek and
Harry (see section 4.9.2), who did not share the privilege of being raised in a medical family.

Participants from non-medical families remembered attributes and behaviours of other doctors encountered when they were children. In a few descriptive lines about his childhood general practitioner (GP), Derek reveals how he felt about the doctor:

I had a great affection for our family doctor, Doctor [name], who was one of those old-fashioned doctors who always wore a suit and a waistcoat, who was a bit gruff but very kind. And he'd been our family doctor for at least twenty years and I liked him as a person. (Derek: lines 15-18, from around 45 years previously)

For Derek, as a small child, the preconception of what being a doctor entailed was the totality of the person and of his interaction with others. It was not just how he dressed, how he spoke or how he behaved, but the combination of kindness, constancy and the affection in which he was held. In terms of my research question (What are the factors influencing the understanding of the meaning of professionalism?), the factor for Derek as a small child, was the overall experience of the family doctor appreciated through all his senses. So his appearance, actions, attributes, voice and long-standing connection with the family all contributed to creating the essence of ‘doctor’ for Derek.
Preconceptions were formed too from the perspective of being a member of another health profession. Karen’s experience as a registered nurse prior to becoming a medical student sensitised her to apparently different attitudes towards professionalism. She recounts an experience she had while a nurse in a rural base hospital in Australia:

You know, I remember one night we had a bus crash where about twenty-five young footballers fell off a mountain in a bus, and we had to completely turn over our intensive care unit and turn patients off that didn’t need a ventilator anymore and put the new kids on. And we all worked really hard for about forty-eight hours and the nurses all got to go home and have a break but the doctors didn’t. So I think I was really impressed by that, and their teamwork and the way they were able to keep their cool. (Karen: lines 90-96, around 16 years previously)

In Karen’s story the nurses went home for a rest while the doctors worked on. She reflects her understanding of professionalism in medicine as a vocation rather than simply shift-work, like nursing. At the time Karen was considering a move from nursing to medicine and may have been especially sensitive to such differences. Of course, by the time she tells the story in my study Karen is a senior doctor socialised into the medical profession. This may account for her view that working non-stop for forty-eight hours is laudable rather than foolhardy.

\[19\] A base hospital is in a regional centre to which smaller hospitals in the region refer patients who need specialist care.
Karen presents the nursing staff as exemplifying professionalism by selflessly helping the junior doctors.

I think they [some nurses] are really intelligent and they could easily have done medicine but they function so well supporting junior medical officers ...and they do it so humbly that it’s really inspiring. (Karen: lines 243-245)

In this passage Karen appears to suggest that doctors are cleverer than nurses by saying that some really intelligent nurses could “easily have done medicine”, but then talks about these nurses being humble and inspirational in a support role to junior doctors. She may be alluding to a cultural difference between doctors and nurses since, having been a nurse herself, Karen has insight into both professions. Humility is a trait noted as lacking in many doctors who are more often accused of being arrogant rather than self-deprecating (Coulehan, 2010). For Derek, who was thinking back three decades, the memories of nurse and doctors were of a more collaborative relationship:

And they [nursing staff] would often make suggestions that proved to be important in clinical management and for the most part it was one of cooperation even in those days. There was a collegial sense.

I can well remember as an intern at [name] Hospital doing the morning round with Sister.20 Full veil, this is in 1976, and we were at a lady’s bedside and she [the nursing sister] said “Doctor the pulse this morning is less than

20 Sister is the senior nurse in charge of a ward.
fifty, we’ll not give her digitalis” and I said “Very well sister”. (Derek: lines 189-194, 30 years previously)

Derek’s story suggests that junior doctors in the 1970s showed respect for senior nurses whereas Karen’s more recent story indicates a relationship in which direct communication between senior nurse and registrar is less likely.

4.8.2 Identity-related factors: Self-esteem, gender and social status

Participants’ narratives covered a range of personal factors linking professional identity formation with the process of understanding the meaning of professionalism.

Self-esteem

Self-esteem refers to one’s appreciation and opinion of oneself and is closely connected to the concept of identity (Fryers, Olthuis, Leget, & Dekkers, 2006; Olthuis, Leget, & Dekkers, 2007). There was a range of levels of self-esteem among the study participants. Alan exudes self-confidence in recounting his story about attending the operating theatre with his father so that “I’d been regularly in theatre with surgical people so I was pretty comfortable” (Section 4.8.1). By contrast, Molly alludes to feelings of inferiority compared with her peers. Her stories are infused with references to her working-class background and to her female gender. The following excerpt illustrates how Molly thought of herself as in the ‘wrong’ group

21 Shorthand for ‘fifty beats per minute’, which is an abnormally slow heart beat and a sign of digitalis toxicity.
rather than the ‘right’ group, made up of elite peers she calls the “golden children”.

In her story Molly explains why she felt different from the elite group:

There was very much a sense at [name of hospital] of who the golden children were and who the golden children weren’t. And for all sorts of different reasons I attribute these things as to do with the fact that I wasn’t a girlie girl, that I wasn’t blonde, that I wasn’t well-married. There was this very strong sense of the right girls and the wrong girls at [name of hospital], and most of them were girls. And if you were really, really cute you could get away with it, and being single. But if you weren’t [cute and/or single] that was a problem. It was obvious in my [mind] and, you know, a couple of my other friends felt that as well. Particularly people who come from the [area] suburbs, cos I’d grown up near [area suburb] there’s a sort of a sense of bigotry almost I felt. (Molly: lines 377-404, 17 years previously)

Gold is a precious metal and associated with wealth and riches. The best in any field is often called the “gold” standard. As has previously been discussed in section 4.6.1 Molly talks later about the importance to her of being valued by patients “putting their hand in their pocket” to pay for her professional service. It appears from this additional data that Molly’s need for affirmation of her monetary worth is connected to lingering low self-esteem related to her feelings about how others perceived her early in her career.

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23 Suburbs of the city involved that are designated as working-class parts of town.
Gender

Factors related to Molly’s identity as a woman are prominent in the expressions of marginalisation from “the golden children”. For Molly a double discrimination of sexism and elitism imbue her professionalism-related narrative dating from when she was a registrar. She associates femininity with being a golden child and rules herself out of the category because she is not “girlie” and she is not blonde (golden haired). She even involves her identity as a wife, by referring to herself as not “well-married”, again bringing in wealth and meaning that her husband was not rich or upper-class. The implication from Molly’s perceptions is that, in this hospital, female trainees were judged according to their social standing, wealth, their looks or their availability for sexual relationships rather than any medical ability. In terms of learning about professionalism, the focus on female doctors as cute or blonde suggests a culture where they are regarded as women first and doctors second. Intertwining of identity as a doctor with identity as a woman was also raised by Lorna, who tells how she consciously sought out female role models who successfully maintained wife and mother as well as doctor identities:

...once I got married and I was trying to work out about children and things was to look at other women who’d done it before me. So that was, they’re the people I’m thinking about as role models because they modelled the roles that I, the whole thing that I have grown into (Lorna: lines 405-408, approximately 10 years previously)

I had hoped that the stories of sexism and elitism were out of date but Gemma’s story of a recent incident shows that gender issues are still prevalent and relevant to professionalism:
There was a cardiologist not long ago was yelling at me about something and telling me that I didn’t know what [common intermittent cardiac condition] was. And if I didn’t know what [the condition] is, was she [the patient] or was she not [displaying the condition] before? And, I mean, that is totally unprofessional. That was here, this was on the ward on the floor unprofessional behaviour yes definitely. (Gemma: lines 516-519, few weeks previously)

This incident took place in a busy public space within a tertiary teaching hospital, witnessed by many people including, medical students. It is very insulting for a doctor to question a senior colleague’s basic knowledge or patient assessment abilities. To do so by shouting about the alleged shortcoming so that both patients and staff in the vicinity cannot help but hear is highly unprofessional. This behaviour was accepted as another day on the ward and the male consultant’s loud and disrespectful behaviour towards a female consultant went without comment let alone reprimand. Gemma’s point in telling this story seemed to be to illustrate the somewhat unprofessional environment in which medical students and other healthcare staff learn and work. In doing so Gemma also highlights the male-dominated culture of medicine in her current workplace. When asked directly if she felt this would have happened to any of her male colleagues, Gemma was emphatic that she did not think so. As long as sexism and bullying are tolerated, unprofessional behaviour of this nature is perpetuated (Hicks, 2000) and this is a concern for students and junior staff who witness such behaviour.

**Social status**

At the same time Molly alludes to feeling discriminated against and “a sense of bigotry” because of her social status and being raised in the working-class suburbs
of the city. Harry echoed this sense as he recalled becoming aware of the social hierarchy as a new medical student:

And I found it hard coming from a public\textsuperscript{24} high school to understand and comprehend the elitism of the private schools. In a sense it was where they came from and who they knew, and rugby, rugger, and all that nonsense.

(Harry, lines 364-366, 34 years previously)

Like Molly, Harry (and some other students from less privileged backgrounds) felt alienated by the difference in social status indicated by having been at a less prestigious school.

We were in a sense different or loners. (Harry, 34 years previously)

Elitism is also an element of the next theme emerging from my data and discussed in Section 4.9

4.9 Environmental factors influencing notions of professionalism

Participants had strong recollections of what was happening around them as they trained in medicine. It was evident that the milieu in which learning and teaching took place was highly influential on the development of their understanding of the meaning of professionalism.

\textsuperscript{24} State schools in Australia are known as ‘public’ schools.
4.9.1 **Medical culture**

Even at an early stage of answering my research questions, it was clear to me that the meaning of professionalism for the participants was inextricably entwined within the culture of medicine into which they had been socialised.

Culture is defined in the *Oxford English Dictionary* as:

> The distinctive ideas, customs, social behaviour, products, or way of life of a particular society, people, or period. Hence: a society or group characterised by such customs etc. (Oxford Dictionaries Online, 2012)

Or with a modifying adjective such as ‘medical’, as:

> a way of life or social environment characterised by or associated with the specified quality or thing; a group of people subscribing or belonging to this (Oxford Dictionaries Online, 2012)

Medical culture, therefore, is the way of life of doctors at work and, as such, a powerful medium through which the hidden curriculum in relation to the understanding of the meaning of professionalism operates. In my data two apparently opposing cultural environments within medicine are apparent. One environment is hierarchical, elitist and competitive while the other is collegial and supportive.

4.9.2 **Hierarchy and elitism in medicine**

Nine of the twelve participants talked about the hierarchical nature of the medical profession and the elitism they encountered. Of the three who did not discuss this as a discrete topic, two were those from medical families (Alan and Roy) and one declared herself distanced from other doctors;
I don’t actually have a lot of doctor friends: in fact I don’t really talk to doctors very much. (Gemma: line 145, current)

Two-thirds of participants had felt unimportant, ignored or substandard within the hierarchy as medical students or as junior doctors. In answer to a direct question about hospital culture, Derek describes vividly just how insignificant he and his peers felt as medical students entering the world of clinical medicine. For them professionalism seemed to be about knowing your place in the hierarchy:

KF: What can you remember about the hospital culture when you got into fourth year?25

Derek: Well it was very hierarchical and as a student I felt, I think we used to say that we were less than the dust on the floor. (Laughs) That was in a university teaching hospital. It was very hierarchical and egos were large, so again with the professor and then the senior lecturer and his senior registrar, registrar, resident or senior resident ... You knew your place. (Derek: lines 167-173, 32 years previously)

The picture Derek paints is of the medical students feeling infinitesimally small and insignificant in comparison with the “large egos”. Derek comments that the behaviour resulting from being immersed in the hierarchy had to be confined to the hospital, as it would be regarded as unacceptable elsewhere:

25 The first year of clinical studies in the medical course which Derek undertook.
Yes and then when I graduated and went off to the [large teaching] Hospital where the hierarchy was certainly very much in evidence. I remember my wife said “Don’t bring that rubbish home please” (laughs), “you leave that at the hospital”. And that was a very salutary reminder that the culture at the hospital, unless you’re very careful can impinge upon your life and make you an unpleasant person in environments other than the hospital. So I’ve never forgotten that and that was said to me more than thirty years ago. (Derek: lines 177-183, 30 years previously)

Derek’s story is a reminder that junior doctors can become acclimatised to the hierarchical environment, so that they forget that the cultural customs are not the norm outside the institution. Thus another dimension in learning about professionalism is the separation of professional and personal life. Harry, too, talked about the hierarchy when asked about his first impressions of the medical profession as a student and a young doctor. He describes his first impressions of the medical profession as:

somewhat rigid, somewhat elitist, somewhat lacking communication, sometimes, being stratified into different pecking orders, being somewhat, eh, I guess dismissive depending on who it was at their level in terms of communication. (Harry: lines 202-205, 25 years previously)

This impression of the medical profession as hierarchical and elitist was a very strong one for Harry and one that he referred to several times during the interview. The analogy between a social class system and the profession are clear. As already mentioned in Section 4.8.2, Harry felt like an outsider coming to medical school and he illustrated this in a generalised narrative about his first year at medical school:
Cos your first day at medical school, I've gone from [name] High School with one girl who came from my year that I’d had very little to do with and knowing no-one. And then there’d be [name of private school], a whole bunch that went there and [name of private school] and all the private schools and some of the bigger public schools, but they were in a clique already and those cliques continued almost through the five years. (Harry: lines 343-348)

And I found it hard coming from a public high school to understand and comprehend the elitism of the private schools... So I think yes that’s an issue. (Harry: Lines 364-368, 31 years previously)

What Harry describes is the beginnings of a hierarchical elitism produced by large numbers of students entering medical school from private schools and retaining their readymade groups. This not only gives those students confidence but may increase feelings of isolation in those who are not part of such a group. Social identity theory (SIT) is pertinent to the scene Harry describes. SIT proposes two elements to identity: the personal self and the self as seen by others in the group to which one belongs (Stets & Carter, 2011). For Harry the majority of medical students in his year saw him as different because of his school and social status. He avoided being associated with the cliques and in opting out of them demonstrates resistance (Elliot G. Mishler, 2005) to joining what he perceived as an elitist culture. Feelings of difference between social groups persisted into postgraduate training when, rather than one's school, the alma mater university is the criterion judged. Lorna clearly remembers the sense of inferiority engendered by senior doctors when she was an intern:
Senior clinicians at the time when I was a junior doctor gave me the strong
impression that my qualifications, that [name of university] graduates
weren’t up to being specialists. (Lorna: lines 149-151, 14 years previously)

For Lorna, this attitude articulated by her seniors acted as a driver for her to go
onto specialist training.

And there was a very big part of me that was saying [flamboyantly makes V-
sign gesture with both hands] “get stuffed” and if I ever did need any
incentive to push on... it was that incentive – “you just watch us . . . ”. (Lorna:
lines 152-155, 13 years previously)

In this scenario, Lorna and her peers from the same medical school are
marginalised within the medical hierarchy. There is snobbishness (and a naivety)
inherent in the assumption that just by attending a particular university one can be
more or less academically able. Being determined to prove wrong the assumption
that she was not “good enough” to be a specialist, Lorna worked hard and became a
respiratory physician in what is a kind of narrative of resistance (Ewick & Silbey,
2003; Elliot G. Mishler, 2005; C. Rees & Monrouxe, 2010) to the attitudes of the
consultants. In doing so, she showed that it was possible for interns to empower
themselves from within.

Julie told a story in which the resistance was more immediate. In this narrative
from very early in her clinical career Julie stands up to being ridiculed by a male
tutor in a very direct way:

(Laughs) I remember the first week, or the first month I was doing clinical
medicine [as a medical student] and I was doing a surgery term in at [name]
Hospital in [city]. And I remember we all piled into the lift and I could feel
one of the surgeons, he was obviously doing this [moving flat hand over head] on top of my head to see where I came up to on him. And I don’t know where this came from. All I remember is just swinging my arm round and belting him in the abdomen. And everybody in the lift just laughed, and he laughed. And after that he thought I was fantastic because I hadn’t just stood there. And it was quite a kind of, I can’t find the word but that wasn’t intimidating. I guess you could say it’s insulting but that’s not the right word either. Whether he was reminding me ‘you’re below me’ sort of thing and when I turned round and belted him he thought – I actually got on very well with him after that. It was like he sort of respected me because I turned round and belted him. (Julie: lines 114-126, 24 years previously)

In terms of professionalism, Julie’s perception is that she gained the respect of the teacher following her physical assault on him, despite the general disapproval of resorting to physical violence in civilised society. My own reading is that the gender difference between the protagonists is significant. As a woman, and shorter in stature than the male consultant, Julie did not present a serious physical threat. The incident was regarded as amusing by the consultant. Indeed laughter broke out in the lift in response to what Julie presents as a somewhat comic incident. Julie’s comment (from her contemporary perspective) that the surgeon was comparing their heights in order to make the point that she was ‘below’ him, reflects the knowledge she now has about the medical hierarchy and about attitudes towards women. Taken in the context of a quarter of a century earlier in which it occurred, at a time when there were far fewer women in medicine, the scenario has definite gender overtones. At the time, male was the dominant gender in medicine. Julie’s reflex reaction to being ridiculed during her first month in a clinical setting, when she was still unaware of the power of the hierarchy is another
narrative of resistance against authority. If the incident occurred later in her course, when Julie had undergone more of her professional socialisation into medicine, she would have been more used to women being seen as less important than men. Had that been the case her reaction would have been duly modified. Had the retaliating student been male, the incident may also have turned out very differently. Had all of the students in the group been male it may not have happened at all. Men are typically seen as aggressive, competitive and strong meaning that the same action by the consultant towards a male student would have been interpreted very differently, perhaps even as a hostile act and would have been dealt with as such. Julie’s story contains no mention that she was sanctioned in any way for this physical assault, suggesting that from a woman the behaviour was regarded as insignificant rather than unacceptable. The term ‘andronormative’ describes the way in which male values are considered normal to the extent that female values disappear (Holge-Hazelton & Malterud, 2009) or have to be deliberately and obviously stressed to be noticed. For Julie, adopting traditionally male-type behaviour was one way to gain respect among colleagues. Other narratives suggested that this is still a contemporary issue in medicine.

4.9.3 Societal Expectations

The last of the environmental subthemes concerns the effect on professionalism of awareness of the expectations the community has of doctors. A sense of duty emanates from references to responsibility to the public. Helena feels that excessive public expectations of the profession are to blame for patients’ disappointment in some doctors:

I think the majority of people realise that doctors work quite hard and their heart’s in it and it’s for the good of the community. But then you do get
individual, you know “I had this problem” and “This doctor’s no good” or whatever but I think that’s merely because they [patients] expect them [doctors] to be terrific and when they’re not, they’re let down by it. (Helena: lines 593-597, contemporary)

Helena’s belief that all doctors are working for the good of the community is somewhat naïve in view of widely publicised cases (Elks, 2010; D. J. Smith, 2002) that demonstrate the opposite. Julie admits to feeling “quite nervous about the trust that the public has in the medical profession. I think that’s quite a big weight to carry”. Here she alludes to a personal duty to live up to the trust placed in her, as well as a collective professional responsibility for all doctors to be worthy of such trust.

4.10 People factors – relationships

This theme is about the experience of interacting with and observing other people and is a major factor in negotiating the meaning of professionalism. Different people and different relationship dynamics experienced over the years led to a multifaceted notion of professionalism. The largest and most influential group, as derived from the data, are doctors, who featured in almost half of all the narratives. But other people, notably patients, other health professionals, peers and family members were also perceived as influential.

4.10.1 Collegiality and support in medicine

A common feature throughout the narratives was reference by doctors from all three decades to the collegiality and support experienced during medical training. Often the stories were of banding together to be supportive of each other. This was
often at the stage when they first faced the challenges of being a doctor, as in Lorna’s comment from her internship year:

...there was a big group of us so there was a great sense of collegiate support.

(Lorna: lines 72-73, from internship 14 years previously)

The closeness between colleagues was due, at least in part to the long hours and night-work, which necessitated students and junior doctors “living in” on hospital premises. This situation led to a mateship or bonding between colleagues:

...you had to be back at ten o’clock every night because you were on call for your patients from ten p.m. till the next morning and so there was marvellous camaraderie amongst the people you were working with, there’s no doubt about that. (Alan: lines 356-359, from residency 39 years previously)

Camaraderie was an influence on notions of professionalism through formation of strong relationships and there was a view expressed that this may be lost with the move to reduce trainee doctor working hours:

But the hospitals seem to be far less sociable [nowadays] than they were at the time when, as house officers, interns and SHOs, Senior House Officers are doctors in their second or third postgraduate year of training, you’re actually spending more time in the hospital because of the hours you worked and there was a lot more camaraderie I think. (Julie: lines 325-327, from junior doctors’ training circa 20 years previously)

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26 Senior House Officers are doctors in their second or third postgraduate year of training
Julie's inference is that the lack of camaraderie experienced during medical training nowadays adversely influences the developing understanding of professionalism. Molly talks with fondness about the relationships with other juniors:

Some of the nicest experiences I remember as a junior doctor were the relationships that you built up with the registrar that you were working with.

(Molly: lines 195-196, 15 years previously)

The strength of support received through close relationships with colleagues only one or two years more senior was a factor commonly mentioned in relation to professionalism.

4.10.2 Doctor role models

Some role models influence proto-professionals through demonstrating qualities which are impressive to newcomers. Alan recalled a professor of whom he was very much in awe as an intern because of his highly organised and meticulous approach:

The professor of [specialty] had his own very characteristic way of doing things. I remember the first time he took me on a ward round with him. He was there at one minute to two for a two o'clock ward round. Very meticulous about absolute detail and he said “When we go to the bedside, I stand on this side of the bed, you stand next to me here with the notes, Sister[^27] stands on that side and anybody else can go anywhere else”, and every patient was like

[^27]: Sister in this context refers to the head nurse on the ward
that and it was very, he was just very attentive to detail, and everything had to be exactly according to a plan eh,

KF: Right, and where did the patient fit in there?

Alan: Not much, no it was his plan and the doctor and the nurse decided everything and they [the patient] would have no input whatsoever to the decision-making (Alan: lines 245-257, 40 years previously)

The attention even to the smallest detail in this narrative is extreme, with the professor being obsessively ordered and controlling. The way in which the professor wields his authority through micromanagement of those around him is reminiscent of the rigidity mentioned by Harry in section 4.9.2. Alan still holds the professor in high regard, perhaps because of his elevated position in the hierarchy. Power is seductive. When probed, Alan admits that patients were not consulted about their preferences, confirming that this was a largely doctor-centred and paternalistic approach. Asked how he felt about the situation at the time, he adds honestly:

I thought it was normal I think. That’s the way it was. (Alan: line 266, 40 years previously)

And this is exactly the point. Newcomers to the profession assume that the way they see doctors behaving is normal and assimilate it as acceptable and even desirable especially if they wish to follow in that doctor’s footsteps in terms of career speciality (Reuler & Nardone, 1994). This is especially true if they do not reflect on their experiences. Such unreflective doctors commonly purport to be highly professional when in fact they do not demonstrate the appropriate behaviour to substantiate that claim. (Brian Castellani & Hafferty, 2006, p 16)
Another type of role model is influential through sheer charisma. Many of the stories from medical student days were often told as entertaining, funny stories and featured teachers who were larger than life. Derek recalls a memorable professor from his preclinical studies whom he still regards as a role model:

And I still remember this to this day. Professor [name] who was one of those thespian professors of pathology, wore a bow tie, played a violin, acted Shakespeare with great proficiency (laughs) … pathology was my strongest preclinical subject and probably greatly influenced by very good teachers who had a great sense of humour. (Derek, lines 337-346, 34 years previously)

Even from this one sentence we can deduce that the Professor shared his interest in music and the theatre with his students through his teaching. In doing so students may have picked up tacit and unintentional messages. For example: that bow ties are standard attire for pathologists; or that there is time for cultivating an outside interest when you work in medicine; or that it is acceptable to use humour in medical settings. There is a fondness in the way Derek talks about the professor and an admiration for his unorthodox ways, but, as it goes on, the narrative serves to emphasise an underlying sexism subtly influencing those who witnessed the event:

another case I recall, in those days we had to attend a post mortem every week and we were out at [name] hospital where they had an amphitheatre in the mortuary and the girls would always stand up the back because they didn't like looking at the bodies on the slab. So [professor] and his mortuary assistant were there one Friday afternoon demonstrating the mortal remains and the diseases which had brought the patient to that place and all the girls were up the back and he said to Barry, “Barry, please pass the girls some
opera glasses” (laughs). So Barry goes to the drawer and gets out three or four sets of opera glasses and they're passed to the girls at the back (laughs). So humour in medicine and teaching, I think it's very important. And as you're aware something I enjoy doing myself in teaching. (Derek: lines 347-356, 34 years previously)

The incongruity of having opera glasses in the mortuary made this situation amusing and memorable. On the surface Derek presents the professor as having an understanding of the confronting nature of the setting, especially to people for whom it was unfamiliar. Rather than spending time on coaxing them nearer the mortuary slab and drawing attention to their discomfort, he provided a way in which students could see the effects of the disease on the body more clearly. In doing so, he showed the whole group that he was sensitive to their feelings, organised for teaching and that he was keen to help them learn. However, thinking back to the sexism in Molly’s and Julie’s narratives there is another more plausible interpretation. Derek makes a sexist statement when he specifically refers to the “girls standing up the back because they didn’t like looking at the bodies,” Thus the implication is made that only females will feel squeamish and stand at the back of the room avoiding the unpleasantness on the mortuary slab. There is no consideration that the male students may feel similarly distressed. The professor made a big show of handing out the opera glasses, further drawing attention to the girls’ discomfort and making fun of them for the amusement of the other students. More than three decades ago when this occurred, female medical students were in the minority making them easy targets. For the Professor, the drama made the lesson memorable and added to his thespian reputation. It is interesting to speculate how a narrative about the same event from one of the female students involved would differ from Derek's male version.
4.10.3 Professional lapses

Even for the younger participants, who had studied in the late 1980s and early 1990s when professionalism began to be formally addressed, it was rare for formal teaching sessions to be remembered. There is a suggestion that some memorable lessons were learned in ways that were unintended by the teacher. For example, in thinking about lessons on topics related to professionalism, Helena recalled:

As an undergraduate we had something [a teaching session] that I think was to do with ethics, but the only thing I can remember about it was that the guy who taught it got busted for sleeping with one of his patients (giggles), that’s the only thing I remember about it (loud laugh). (Helena: lines 324-327, 17-18 years previously)

What is memorable for Helena is the incongruence between the formal and the informal curriculum and the irony of an ethics teacher being caught out in blatantly unprofessional behaviour. The teacher demonstrated hypocrisy in not practising the principles he taught. Actions really do speak louder than words and even in the delivery of the formal curriculum the informal and hidden curriculum is operating.

4.10.4 Patient perspectives

Another key factor influencing notions of professionalism was watching doctors with patients. Participants often told stories of behaviour they did not want to emulate. Kevin demonstrates this when he tells a story about an interaction between a patient and doctor which he witnessed as a medical student.

I can remember one doctor running into a patient’s [room] and it was an older woman with bowel obstruction and he was examining her in such a rude and
unprofessional manner I was thinking. He pushed her breasts and feeling everywhere and then “OK bye” and went away. And he had the diagnosis and he was happy that he had the diagnosis, but I thought of this poor woman – didn’t know what hit her. (Kevin: lines 190-194, 14 years previously)

The picture Kevin paints here is of a very busy doctor behaving unprofessionally as he conducts a rough examination of a patient. Kevin speaks very rapidly as he tells the story, enhancing the rushed nature of the consultation. The issue of gender is again forefront in this narrative. The doctor is male and the patient is female, further widening the power differential recognised to exist within the doctor – patient relationship (Pilnick & Dingwall, 2011). The usual excuse of busy-ness to explain less than optimal behaviour is not explicitly used. Kevin, rather, presents himself as sensitive to the woman patient’s distress, maybe even signalling a generational change in gender politics. He describes the patient’s breasts being “pushed” and along with the term “feeling everywhere” making the examination sound intrusive, especially if the lady had a bowel obstruction which would suggest that an abdominal examination was sufficient, especially if time was short. The implication here is that the doctor dispensed with any meaningful communication with the patient since he was in a hurry. There is even a nuance of sexual assault. A patient with an acute bowel obstruction is very ill and so it is likely that this lady was in a vulnerable position. Again, this narrative shows the way in which students are exposed to professional issues from everyday interactions in clinical settings. The professionally socialised doctor can, if not careful, become callous (Rentmeester, Brack, & Kavan, 2007) and justify uncivil behaviour as caused by pressure of work. Neophytes to the profession are often very sensitive to what is acceptable and what is unacceptable remembering the values and expectations they recently held as lay people.
4.10.5 Teaching and learning relationships

A prominent finding of my study was that participants recognised professionalism in the personal relationships they had had with clinical tutors and supervisors who were involved in their training. This was distinct from the manifestation of professionalism (or its lack) in the observations they made of doctor-patient interactions. Harry told a story about how he experienced professionalism within the relationship he had with a group of consultants involved in his training:

I guess I was pretty encouraged when I did the term in [name of place] because it was just ourselves relating to the consultants and they would appreciate what you’d done and would acknowledge it and they’d give you the autonomy and the sense to be able to use your skills and would extend you somewhat.

KF: How did they acknowledge? What did they do to acknowledge what you’d done?

Harry: Um well I guess one, by praise, two, by increasing the loosening of the reins over time so that I guess you get more autonomy. You could deal with that [situation] and it would be fine, so more responsibility. I guess the acknowledgement to nursing staff and to your colleagues. (Harry: lines 416-428, circa 23 years previously)

In this general narrative Harry melds together experiences he had during this period to create the essence of what he felt was professional. Smaller hospitals or units enable the consultant to get to know at first hand the abilities of their young colleagues, because of the absence of intermediate grades of staff. It is possible, therefore, for a closer working relationship to develop between consultants and junior staff than happens in a large teaching hospital. Trainees can be offered
encouragement and assistance when needed and be challenged with more responsibility when appropriate. While this was excellent training for improving Harry’s diagnostic, procedural and patient management skills, this learner-centred approach also reinforced attitudes and techniques pertinent to patient-centred care (Pinsky, 2003). A further element highlighted here is the positive effect on self-esteem of the public appreciation of his work by the consultants. Being acknowledged as an effective member of the medical community in this way was important to Harry’s professional identity development (Jenkins, 2008) and this is an example of how to do it well. So the relationship with his supervisors was influential in Harry’s developing view of professionalism. This story also shows the contribution of the environment in which the learning takes place. Harry lived on site in a small, rural hospital (“There were just two of us and we lived in the quarters”) and this was important in the genesis of the relationship. So while it initially appears to be the size structure of the hospitals which is important in nurturing professionalism it also appears that the quality of the relationships which arise within that environment is equally important. Harry goes on to make it clear that the way he was treated in that job may also have been pivotal in his future career choice:

the [consultants] there were lovely men that were gentle and were from a rural background and that’s where it became very clear that that’s what I wanted to do. (Harry: lines 406-407, circa 23 years previously. He is now a consultant in the same specialty in a rural hospital in Australia)

Coming across men who could be described as “gentle” at an impressionable time in his career seems to have been very important to Harry. We already know from his narratives about going to medical school that he found the elitist competitive environment harsh and rigid. As can be seen and heard in the video he is a quietly
spoken man who seems gentle and content. Finding role models who demonstrated the sort of doctor he wanted to be was important for Harry. Perhaps had he not had the opportunity or experience to work closely with the “lovely men” he may not have followed in their footsteps. Molly, too, felt that the size of the teaching hospital and the number of students and trainees had an effect on her learning about professionalism. In larger hospitals she felt a lack of a real engagement with supervisors:

...you’re just one of 25 RMOs\(^{28}\) that circulate through every seven days and there’s no sense of personal relationships. (Molly: lines 361-362, 16 years previously)

By contrast Molly felt much more engaged and motivated when she worked in smaller departments:

...because I was part of a small cohesive team you do feel a greater sense of maybe em not so much commitment but you’ll pull that extra mile because of the personal relationships. (Molly: lines 358-360, 16 years previously)

Again, the quality of the relationship between supervisor and trainee was influential in development of professionalism.

### 4.10.6 Experience of teaching on understanding professionalism

The participants spontaneously talked about the way in which their own experiences as juniors has influenced their own teaching. Gemma, who had a tough

\(^{28}\) Resident Medical Officers are junior doctors in the first year or two of their specialty
time as a junior doctor, when she felt isolated and unsupported most of the time, talks about teaching junior staff:

It’s less teaching than trying to make them [trainees] feel as though they’re making the right decisions. And making them feel comfortable and capable of doing it. Because a lot of them have those anxieties about not being able to perform and not being up to scratch and so because I’m the master of knowing what that was like, (laughs) So it’s [the experience] been useful.

(Gemma: lines 365-368, contemporary and 18-20 years previously)

Gemma understands the importance of creating an atmosphere conducive to learning where learners feel safe and are encouraged to grow in both confidence and capability. She understands this because of her own experience of anxiety and of feeling unworthy. Lorna uses the memory of a consultant giving her encouraging feedback and acknowledges that she considers she should and could use the same tactic:

He would draw you aside at Grand Rounds and say something like “Nice job on such and such”. Little things like that. Things that I’m remembering as I’m training my juniors, I think I should do more ... I remember how much it made me swell inside with pride. You know “I could do that”. So that’s the kind of thing that he did that was supportive. (Lorna: lines 247-251, 15 years previously)

4.11 Discussion

In the first part of this chapter the thematic analysis showed that senior doctors conceptualise ‘professionalism’ in three different ways: personally, as related to themselves and their own identity as a person and as a professional; experientially,
as related to the way in which doctors behave and are expected to behave; and interactively, as an atmosphere existing between and around doctors and sensitive to context. The themes identified in the first thematic analysis reported in this chapter reflect a notion of professionalism as an underpinning principle and agent for good in medical practice. This is in accord with the many calls for increased attention to professionalism in medicine over the last thirty years (Coulehan, 2005; R. L. Cruess & S. R. Cruess, 1997; Ginsburg & Stern, 2004; D. Irvine, 1999; MacLeod, 1982; Stokes, 1973; M. K. Wynia, et al., 1999ABIM Foundation. American Board of Internal Medicine, 2002 #39). The subthemes demonstrate many different aspects of a multifaceted and complex concept. Identity theory (Stets & Carter, 2011) tells us that tensions can easily arise for doctors when self-interest (personal identity) and the interests of society (professional identity) clash. An example from my data is the tension between a feeling of superiority from having medical knowledge and skills and an awareness of the societal expectations of ethical practice and duty to patients. Furthermore, the centrality of interpersonal interaction to professionalism in my data suggests a complex and multidimensional entity created by the different personalities and contexts involved in and responsive to living, human situations. This differs from the concept of professionalism as a complex system by Hafferty and Castellani (Frederic W. Hafferty & Castellani, 2010), where categorisation within an organisational structure still attempts to provide a model for progress.

Looking next at factors influencing the meaning of professionalism, this thematic analysis of narratives has shown that personal, environmental and people factors are most influential in the process of developing an understanding of professionalism. Furthermore, these factors interact and influence each other over time creating a dynamism in the concept of professionalism for individual doctors.
depending on individual contexts and experiences. The two types of personal factors raised were: preconceptions of medicine resulting from personal experience of doctors early in life or vicariously through family or friends; and identity issues, particularly gender, social status and self-esteem. In other work, the process of professional socialisation and professional identity development has been closely linked with professionalism (T. Dornan, Boshuizen, King, & Scherpbier, 2007). The need for deeper understanding of how doctors develop their professional identity alongside other personal identities has been highlighted (Monrouxe, 2010). My study shows the very close link between personal and professional identities and that gender and self-esteem are important to both.

People factors were the second main theme emerging from my data as influential on professionalism. In particular, doctors as charismatic role models or being seen to lapse in their professional behaviour were perceived to have contributed to learning about professionalism. An overlap between the personal factors and the people factors emerged in the relationship subtheme. How doctors remembered having been treated in teaching and learning relationships and, to a lesser extent in working relationships contributed greatly to their understanding of professionalism. Furthermore, the effect of the experience is strong and long-lasting and the memory can affect their own teaching or supervisory behaviour. If the experience is constructive, supportive and nurturing the memory of the associated emotions may lead to similar behaviour in those who felt supported and nurtured. Unpleasant experiences, such as bullying or rudeness, on the other hand, are not acceptable but may be admired by newcomers for reasons such as wishing to please an authority figure or aligning oneself with a powerful or charismatic person. They may then be recreated when these doctors become clinical tutors themselves and perpetuate the non-supportive traits, behaviours and attitudes.
The environmental factors that participants described as having influenced them most over the years exist in the learning and working environment which can be hostile or supportive. On the one hand, a hierarchical, elitist, impersonal environment, especially in large teaching hospitals, where doctors felt insignificant and undervalued gave an impression of professionalism as uncaring and harsh. This accords with the literature where both students (White, et al., 2009) and faculty (Bryden, Ginsburg, Kurabi, & Ahmed, 2010) still feel vulnerable and powerless to change a medical culture lacking in professionalism and humanity. On the other hand, stories of collegiality and supportive treatment in a nurturing environment had a big influence on the understanding of ‘good professionalism’ and on self-esteem. A common assumption in medical education is that the caring, compassionate elements of professionalism are best learned by example from good role models (Fatovic-Ferencic, 2004; Steinert, Cruess, Cruess, & Snell, 2005; Herbert M. Swick, 2007). This is hard when there is little care or compassion shown to the learners themselves. In my research supportive and hostile experiences were remembered for many years, even decades, demonstrating the enormous influence of personal experience of being treated well or badly.

4.11.1 Implications of findings

Reframing of ‘professionalism’

The main implications of my thematic analysis are that a reframing of the notion of professionalism and a promotion of its importance to all doctors is needed. Currently medical education has focused largely on one of the themes in my data: the behavioural aspects of professionalism, which can be observed and assessed relatively easily. My participants also conceptualised professionalism as related to personal and identity issues, which are individual in nature and depend on experience. This, along with the ever-evolving nature of professionalism as a force
existing between and around doctors, warrants a broader view of professionalism than encouraged by a focus on attributes and behaviours, as is usual (Martimianakis, et al., 2009).

**Doctors taking responsibility for role modelling professionalism**

My research shows that learning about professionalism can occur in any interaction involving a doctor regardless of how insignificant it appears at the time. The implication of this is that all doctors are role models at all times and must take responsibility for the behaviour they exhibit, the attitudes and opinions they express and how they treat others. This is especially important as I have shown that impressions of professionalism, or its lack, may last for many years and influence a doctor's own clinical practice or teaching. Coulehan comments that the prevailing culture of medicine currently is of “arrogance, assertiveness and a sense of entitlement” and bemoans the unfortunate lessons this is teaching newcomers to the profession (Coulehan, 2010). It appears, therefore, that in order to improve professionalism, a change of culture throughout the whole profession is needed. This implication for medical education is discussed further in the final chapter of this thesis.

**Continuum in support of progress towards phronesis**

My study also demonstrates that senior doctors felt that experiences relevant to their learning about professionalism were likely to be in the postgraduate years and in the working environment of the clinical setting. The implication of this is that all healthcare personnel need to acknowledge or be made aware of their role in the hidden curriculum about professionalism. It also suggests that the current focus on pre-graduation medical students is insufficient and that the current separation of undergraduate and postgraduate medical education is counterproductive in
maintaining a longitudinal and stage-appropriate approach to the development of professionalism and progress towards phronesis.

**Development of alternative assessment modalities for professionalism**

Within the sociocultural milieu of health care, professionalism is a constantly changing and evolving notion as shown in Figure 4.3 where the three themes of personal, people, and environmental factors inter-react to produce a dynamic model of increased understanding of professionalism. Current methods are insufficient to assess this process of professionalism and more appropriate and ongoing assessment modalities are needed.

**4.11.2 Limitations**

Participants in the study are relatively culturally homogeneous in terms of ethnicity, despite the study being conducted in a city in Australia where there is a wide cultural mix in the population. My initial efforts to recruit doctors from other than white Caucasian backgrounds were unsuccessful. One doctor from the Middle East responded to the advertisement for participants and came to discuss the study. He chose not to proceed for unknown reasons. Of those doctors who took part in the study, two were trained in Europe (one in the United Kingdom and one in continental Europe) both to senior level before emigrating to Australia. A third doctor was trained in New Zealand and moved to Australia shortly after graduation. There seemed to be no appreciable difference in notions of professionalism or experience related to the location of medical education. This accords with the literature in which graduates of Western-based medical courses are found to have the same professionalism values regardless of country of origin (Kim & Lim, 2004; Shah, Summerhill, & Manthous, 2009).
A second limitation to this study is that it is the work of a single researcher. While this is necessary in doctoral research, more rigour would have been achieved by involving multiple researchers looking at the data. The insider status of the researcher as a medical doctor herself may also have influenced the interpretation (Chavez, 2008). The main limitation to this first study was that the coding process of thematic analysis does not take account of the language used or the way in which the subjects talk. Neither does it enable broader examination of the continuity and context within the interviews and as such interpretation is limited (Braun & Clarke, 2006).

4.11.3 Further work

The advantage of thematic analysis is that it is a systematic approach suited to a constructionist theoretical framework. However, having conducted all the interviews myself and spent many hours transcribing and viewing videos, I was aware that looking at content alone did not make the most of the richness of the data I had collected. Compared to definitions of professionalism from the academic literature as discussed in Chapter 2, the attempts by these working clinicians to articulate what the concept means to them personally appear, at first glance, simplistic. The more I reflected on the interviews, the more I felt that with more sophisticated analytical and interpretive techniques it would be possible to gain more meaning from what had been said.

In addition, the iterative nature of the research process raised other questions for me. The first related to the question of role models in medicine. My first study has shown that senior doctors remember role models as influential on their understanding of professionalism. I wanted to explore how this influence is mediated. The second area I wanted to explore further was the relationship
between professionalism and the culture of medicine, as my results thus far indicate that the two concepts are intertwined. I knew from my familiarity with the data that in telling professionalism-related stories participants had used various dramatic devices and language to explain and elaborate what they meant. I felt that narrative methods of analysis would allow me to delve deeper into my data, seeking further illumination of meaning. In the next two chapters the two further studies I conducted on my data will be reported and discussed. In Chapter 5 the characterisation of role model protagonists is analysed to look at what it reveals about the hidden curriculum and the culture of medicine. Chapter 6 focuses on analysing the metaphorical language used to gain insight into medical culture. Both studies give deeper insight into the meaning of professionalism for doctors, mediated by the environment in which it is learned.
5 Study 2: Insights on professionalism gained from characterisation of role models in senior doctors’ narratives

5.1 Introduction

In the last chapter I have shown that both people factors and environmental factors are influential in shaping the understanding of what professionalism means to doctors (Figure 4.3). In particular, doctors in supervisory or clinical teaching positions are strong role models for medical students and junior doctors in specialist training. Role models emerge as key to gaining an understanding of professionalism and as a major influence within the professional socialisation process and the development of professional identity. In addition to their one-on-one influence on learners, doctors contribute to the environment in which learning about professionalism occurs. Collectively doctors are key players in the creation and maintenance of the culture of medicine, or the way that doctors live and work, as discussed in section 4.9.1. In turn, the culture of medicine contributes to the clinical learning environment of students at undergraduate and postgraduate level through the behaviour of the many doctors encountered. In this chapter that process is explored in more depth. The thematic analysis of the first study looked purely at the content of the personal incident narratives about encounters with role models in the data. The second study uses narrative methods to look at how senior doctors construct or characterise role models to gain deeper understanding of medical culture and how this affects developing notions of professionalism.
Narrative is retrospective meaning-making (Chase, 2008, p 64). Through it, people make sense of events in their past experience. By focusing on specific aspects of the way in which the stories are told, the deeper layers of meaning hidden in the interviews can be exposed. Narratives are like performances which are produced by the narrator for a particular purpose and specifically for the audience in front of them. In the case of my study, I was the immediate audience to whom the participants told their stories about professionalism. They knew that I am a doctor and that the purpose of the research is ultimately to improve professionalism in doctors. All of this is relevant in the co-production of the narratives. A prominent part of story-telling is the way in which people are presented to add to the impact and meaning of the story. By analysing the way in which the senior doctor participants characterised the various clinical teachers and supervisors in the stories they told, this study adds to understanding of the relationship between role modelling, professionalism and the culture of medicine. The research questions answered in this chapter are:

- How are role models characterised in stories told by senior doctors about their navigation into the medical profession?

and

- What does the way in which role models are characterised in stories told by senior doctors tell us about the culture of medicine?

### 5.2 Methods

The same one hundred and thirty-three PINs forming the data for the thematic analysis reported in Chapter 4 were reanalysed using dialogic-performative analysis (Riessman, 2008 p105). The way in which stories are told reflects the
society and culture in which they are created (Riessman, 2008 p105) and, therefore, it is reasonable to assume that studying how senior doctors’ narratives are co-constructed and told will give insight into the culture of medicine. Dialogic-performative analysis acknowledges that in telling a story, and indeed in our interactions with other people, we are putting on a show for an audience with an “active presence” (Riessman, 2008 p106). The video-recordings of the interviews were additional data sources enabling exploration of the performative aspects of the story-telling. Each narrative identified by the method described in Chapter 3 was studied carefully both by reading the transcript and by watching the way it was told in the video. The main protagonists in each of the narratives were identified and the way their role was presented was looked at in detail. Dialogic performative analysis, in highlighting the importance of interpersonal interaction, fits well with symbolic interactionism theory (Riessman, 2008 p106). Goffman’s work links symbolic interactionism theory with personal and professional identity formation by highlighting the fundamental nature of interactions to the impressions we all create through our dealings with others. Goffmann asserts, using a dramaturgical framework that our interpersonal interactions are performances designed to give a particular impression of ourselves to our colleagues (Goffman, 2002 p51). He also suggests that within any establishment there is cooperation between the players in the performance and audience in any given social interaction in order to sustain an impression which has been previously projected to others (Goffman, 2002, p232). I found Goffman’s perspective on interpersonal interactions fascinating and it was influential in my interpretation of the characterisation of the protagonists within the context of medicine in which their narrative interactions took place.

Dialogic-performative analysis also looks at how the narratives are spoken and to facilitate this, an adaptation of Gee’s method of narrative analysis was used. An
advantage of Gee’s method is that it allows broadening of Labov’s strict definitions of what constitutes a narrative (Riessman, 2008 p93) and acknowledges the contribution of cadence, pace and patterns of talk to the meaning of a story (Crepeau, 2000). Gee’s method involves listening to the narratives and arranging them in lines and stanzas according to the way they are spoken. The result is often rather poetic in the sense that the rhythm and phrasing of the speech is retained. Indeed Gee’s method is one of the ethnopoetic approaches (Riessman, 2008 p93), since a fundamental element is that the speech patterns reflect the society or group from which the narrative emanates (Crepeau, 2000). I found that as I adopted Gee’s method of arranging the narratives by listening to the audio recordings of the interviews, the meaning of the stories became clearer. For each type of characterisation the verbal and non-verbal elements used in the telling of the story and the context of each personal incident narrative was noted. A lengthy interpretive phase followed, when the elements contributing to the various characterisations of protagonists were considered. This involved a repeated cycle of writing followed by discussion with two experienced qualitative researchers through which meaning was negotiated. Additionally their helpful critique ensured that the final interpretation was firmly grounded in the data.

5.3 Results

An early analytical step was to identify the voice of the narrator in each of the narratives. The voice clarifies the perspective and the context from which each story is told and is an important element in the construction of meaning. The voices are shown in Table 5.1.
Table 5.1: Voice or perspective from which narratives are told (n=133)

<table>
<thead>
<tr>
<th>Voice</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child or high school student</td>
<td>14</td>
</tr>
<tr>
<td>Medical student</td>
<td>33</td>
</tr>
<tr>
<td>Intern / JMO</td>
<td>41</td>
</tr>
<tr>
<td>Registrar</td>
<td>23</td>
</tr>
<tr>
<td>Consultant / Senior</td>
<td>18</td>
</tr>
<tr>
<td>Other health professional</td>
<td>3</td>
</tr>
<tr>
<td>Adult family member</td>
<td>1</td>
</tr>
</tbody>
</table>

With an initial research focus on participants’ experiences during their clinical education, I anticipated that the predominant voices in the data would belong to medical students or junior doctors. As shown in Table 5.1, the narratives were told from a wide range of life stages. I expected to hear more stories about bad role models than good ones, reflecting a medical culture where standards are high but compassion low (Brainard & Brislen, 2007; Kenny, et al., 2003; Maheux et al., 2000) and bullying is present (Larkin & Mello, 2010; Charlotte E. Rees & Monrouxe, 2011). Hafferty’s typology of different sorts of professionalism (Brian Castellani & Hafferty, 2006, p9) suggested to me that the senior doctor participants would identify a range of characters in their narrative recollections. Careful analysis of the protagonists in the one hundred and thirty-three narratives showed that in ninety-three (70%) they were characterised into only two broad groups: those constructed as ‘good’, demonstrating professionalism and those constructed as ‘bad’ characters, showing lapses in professionalism. My subsequent analysis explored the various ways in which good characters and bad characters were constructed within the narratives. I have used the terms ‘hero’ and ‘villain’ as shorthand for the two groups in the rest of the chapter and discuss the justification for this in section 5.11.
Although this is a qualitative study, there is value in looking at some numerical data to assist with understanding and interpretation of the narrative data. (Sandelowski, 2001). Overall there were equal numbers of hero and villain narratives but, on closer inspection, the ratio of hero-to-villain protagonists changed depending on the stage of development of the narrator at the time of the event in the story. As shown in Table 5.2, hero protagonists are more frequent in the narratives dating from childhood and school days. At medical student and junior medical doctor level, heroes and villains appear with equal frequency and stories told from the perspective of registrar or senior doctor are more frequently about villains and their lapses in professionalism.

<table>
<thead>
<tr>
<th>Stage of narrator when event took place</th>
<th>Protagonist constructed as hero (n=47)</th>
<th>Protagonist constructed as villain (n=46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child or school</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Other job prior</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Medical student</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Intern or JMO</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Registrar</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Consultant or Senior GP</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 5.2: Stage in training of narrator at the time of events in narratives with number of protagonists constructed as hero or villain

The reasons for this are unclear but, as will be shown through the examples, participants were usually able to recall their thoughts and emotions at the time of the incident.

The analysis of the roles of those who were characterised as the hero and the villain protagonists in the stories is shown in Table 5.3:
Table 5.3: Identity of hero and villain protagonists

<table>
<thead>
<tr>
<th>Identity of protagonist</th>
<th>Hero</th>
<th>Villain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Tutor / Supervisor / Senior doctor / treating physician</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>Other doctor e.g. peer or colleague</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Nurse</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Multiple people comprising the organisation(^{29}) or system</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Self</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Patient</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other – non-clinical teacher</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>46</td>
</tr>
</tbody>
</table>

It is clear from the data that the majority of hero and villain protagonists were doctors in positions of seniority or influence over participants at the time the narrative events took place. The numbers, though interesting, give only the bare bones of the results making it important to go on to look at the characterisation in more detail.

\(^{29}\) Whether this was medical school or health care system depended on the stage in career of the narrator at the time of the experience.
5.4 Good role models as heroes

Good role models in terms of professionalism were constructed as heroes in a variety of interesting and diverse ways. There was a common element of holding the role model in high regard, sometimes to an extraordinary and, therefore, ‘superhuman’ level. Words like ‘incredible’, ‘terrific’ and ‘fantastic’, all terms associated with comic superheroes, were commonly used in the narratives, especially those from childhood or from medical student days. Some stories originated from early in childhood. Molly,\(^{30}\) now a general practitioner, told the following story near the start of her interview when explaining her motivation to become a doctor.

5.4.1 Hero[ine] as beautiful person

1. And I remember going through being a patient in casualty aged five\(^{31}\)

2. and being looked after by a female probably Resident Medical Officer (RMO)\(^{32}\) at that time

3. and thinking, (1) particularly because she had lovely hair,

4. that she was the most fantastic person in the whole wide world

5. and that’s what I was going to be

\(^{30}\) All names are fictitious.

\(^{31}\) Narratives are presented with line breaks giving a rhythm to speech as in the way the words were spoken Riessman, C. K. (2008). Narrative Methods for the Human Sciences (1 ed.). Thousand Oaks: Sage Publications Inc.

\(^{32}\) doctor in 2nd or 3rd postgraduate year in medicine
6. because not only could you be a doctor but you could have lovely hair as well (Smiles and flicks head from side-to-side) (N8\textsuperscript{33}: Molly, 39 years previously)

As Molly recounts her story, she reverts to childlike language and voice as she recreates her five-year-old self. She performs an imitation of a model showing off lovely hair as she emphasises her dual ambition, foregrounding two of her identities: her personal identity as ‘woman’ and her professional as ‘doctor’. Children are recognised to identify preferentially with role models of their own gender (Zehnder & Calvert, 2004) and there is increasing recognition of the need for gender awareness among role models in medical education. Molly’s story suggests that female doctors can inspire very young female patients to aim at medicine as a career simply by being kind and looking pretty. It is not only little girls who are influenced by female doctors. Lorna, now a consultant physician, recalled being in her final year at high school and meeting a doctor heroine who made a big impact on her.

1. Lorna: When I was in year twelve\textsuperscript{34}

2. I got terrible glandular fever and I went –

3. I’d been a very well child, well adolescent. I had very little to do with doctors really.

4. My local GP was, is an inspiring beautiful woman, young woman.

\textsuperscript{33} Refers to the particular narrative (N) in the data in which the excerpt is found

\textsuperscript{34} Year twelve is the final year of high school in Australia when students are 17 or 18 years old
5. I was seventeen she was probably thirty, a GP, my local GP.

6. And there was a real sense – she was just lovely –

7. and she saw me regularly for a relatively short period of time while I got over my glandular fever

8. and I thought “I want to grow up to be like her” (N18: Lorna, 23 years previously)

In this narrative gender initially appears dominant as Lorna describes a “beautiful”, “young” and “lovely” woman (lines 4 and 6). However, it is also possible that “beautiful” juxtaposed with “inspiring” as Lorna uses it in line 4, is intended to describe the person as a whole, not just her superficial appearance. Lorna, at the time of this interaction, was already contemplating studying medicine. She was able to identify with the GP who was close to her in age and belonged to the profession to which she aspired. The interaction as described in the narrative was a good one for Lorna. Her GP inspired her, looked after her when she was sick and “was just lovely” (line 6). In seeing the doctor as a person, beautiful inside and out, Lorna created an early role model for herself. Such experiences also serve to construct a notion of professionalism, in this case as a beautiful person, to aspire to and thus contribute to professional identity development.

This experience was an early one in a series of supportive relationships for Lorna with older colleagues, many of them female. Later in the interview she talks about a current female role model:

1. Lorna: I’ve got one particular role model in my specialty who’s a woman who’s also a specialist in my department...
2. [Name] is a senior member of our, my specialty now and she ... is now a staff specialist and professor.

3. But she was always incredibly inspirational in terms of the mother/working juggle, the academic, the –

4. she always looked fabulous

5. and she was always wonderful and warm and a real person to emulate. So if there was ever another –

6. so you know I wanted to be my GP

7. and then when I wasn’t going to be my GP

8. I wanted to grow up to be like [this person]

9. And whenever I have crises of, at work, you know politics or grief

10. I think “What would she say? What would she do?”

11. And often I go and say, “What should I do?” to this particular person. I have a real mentor I think in her. (N21:Lorna, contemporary)

Women have been inspirational for Lorna not only because of their professional identities as doctors but through demonstrating the way in which their other identities intersect. In this narrative Lorna lists several of her own identities: mother; academic; specialist doctor; spouse; and outlines how important it was for her to have a senior colleague acting as a role model for all of these roles. The theory of intersectionality embraces the complexity of gender and identity formation (Tsouroufli, Rees, Monrouxe, & Sundaram, 2011) and is important, especially in feminist sociological studies. A fundamental premise of
intersectionality is that many identities make up the self and that gender may not be the dominant one. From her contemporary, more mature perspective, there is a richer description of the inner qualities Lorna also wishes to emulate and of the mentoring relationship she values.

The series of narratives discussed here also demonstrates an increasing complexity in the way that role models are constructed as the narrators themselves become more socialised into the medical profession. For example, in understanding professionalism Lorna has a memory of her schoolgirl role model that remains when she meets and talks about her current role model. Narratives do not stand alone but build on each other across time, giving a dynamic picture of how events from the narrator’s lived experience meld to produce their understanding of the world (Clandinin & Connelly, 2000 p 50).

5.4.2 **Hero as intrepid adventurer**

In general, male participants related more to actions in their heroes rather than to appearances and feelings. The hero as an adventurer who takes risks as he travels is a classical mythical character. Derek, now a rural general practitioner, had been attracted to medicine as a career as a child by a 1950s radio program:

1. As a small boy at about the age of eight
2. I decided I wanted to become a doctor.
3. I was very much influenced by a doctor who’d worked in Africa.
4. …A man who had spent a number of years in East Africa
5. working as a missionary doctor...
6. And in the fifties there was a program on the radio on Sunday afternoon that was called “Jungle Doctor” where he told many of the stories that surrounded his life as a doctor in East Africa. (N101: Derek, 47 years previously)

Like Molly’s childhood story, this PIN represents a somewhat naïve and idealistic view of doctors. Derek’s hero worked in an exotic place where he could combine jungle adventures with medicine and where his identities of doctor and of missionary intersected. To the eight-year-old Derek being raised in a household where the Christian faith was deeply held, this must have been an irresistible combination. Society reinforces this idealistic view of the medical profession often through media representations such as Dr Kildare, a selfless doctor played by a good-looking actor in a popular television show (Turow, 1996) or the medical staff of Seattle Grace Hospital in the television drama Grey’s Anatomy (http://au.tv.yahoo.com/greys-anatomy/) who save lives, often in dramatic circumstances. Such glamour and drama reinforces the notion of doctors as intrepid adventurers who strive for good among the general population. Thus, despite a string of high-profile and very real villains such as Harold Shipman in the UK and Jayant Patel in Australia (Elks, 2010; D. J. Smith, 2002), doctors are still currently highly regarded in every society and remain the most trusted of professionals (Ipsos MORI, 2006; Kmietovicz, 2002).

5.4.3 Hero as outstanding clinician

Medical students are known to be idealistic about their chosen profession and about doctors at the start of medical school and to become increasingly cynical as they progress with their studies and their socialisation into medicine (J. K. Smith & Weaver, 2006);(Inui, 2003). In my study, narratives told from the perspective of
medical students also tended to be idealistic. Helena, a general practitioner, recalled a professor who had impressed her as a medical student by the apparent ease with which he could accurately assess complex patient problems:

1. And I felt that this guy knew his medicine and...

2. he could really clinch it [the diagnosis]

3. in a few questions that you’d never even thought of.

4. I was amazed by his clinical acumen

High intellect and great knowledge confers heroic status (Featherstone, 1992) and Helena admits to being “amazed” by the professor’s ability to solve a case with only a few questions. Again, gender issues are interwoven. The male professor is an outstanding clinician in contrast with the beautiful, warm female physician in the previous section. As the story unfolds, Helena becomes more effusive in her adulation of this teacher, employing powerful, almost poetic, organisation to her speech:

5. and he just was passionate about medicine as well,

6. so his professionalism was that he lived for the students,

7. he lived for the residents

8. he lived for the other consultants,

9. he lived for education,

10. lived for medicine.

11. His passion was hard not to fall in love with.
12. He knew everyone and that makes a real difference

13. when a- when a senior teacher knows you by name

14. and that is a big influence on you. (N82: Helena, 16 years previously)

Here, Helena portrays the professor as someone who dedicated his life to his profession and to his students. The repetition of the phrase “he lived for” (lines 7–10) is a potent and dramatic device suggesting extreme altruism and construction of the ‘Hero as Martyr’. The word “passion” (line 11) further emphasises the intensity to Helena’s construction of this particular role model. Again, gender is a prominent feature. Overtones of infatuation in “hard not to fall in love with” (line 11) suggest that Helena idolised this man. Lines 12–14 of the PIN finally reveal what had impressed Helena most. Simply because he knew everyone’s name, including hers, as indicated in the penultimate line, she awarded the senior doctor heroic status. All the accolades Helena gives this consultant appear to be due to him demonstrating his respect for students in this way. It appears that for Helena at the time a consultant knowing her name was sufficiently unusual to be memorable.

5.4.4 Hero as caring doctor

Personal experience of being looked after by a doctor or being related to a patient was a recurrent factor in the stories told about professionalism. Ricky, now an academic surgeon close to retirement, told this story to demonstrate his understanding of the meaning of professionalism:

1. And also at the end of my final year at [high] school
2. I came home from the second last paper in the [school] leaving certificate

3. to see my mother being wheeled out of the house unconscious with a massive cerebral haemorrhage

4. and these two guys [family doctors] were part of the team that cared for her and I just was in awe of the way they were always so supportive in every sense of the word

5. and they appeared to be doing absolutely everything to both support us as a family but also to provide incredible care.

6. And realising we’re talking back in 1963. [Clears throat] a very long time ago

7. KF: When you say supportive in every way I mean obviously it was very good clinical care but you also said supportive in every way. What...

8. Ricky: Oh just dropping in home to make sure things were all right and things like this.

9. Seeing how we were,

10. and whenever we visited her [in hospital] there seemed to be one of them around from time to time

11. so it just showed me how enormously supporting you can be of patients.

12. KF: And they were dropping in to see you at home when was that?
13. Ricky: Oh usually in the evening on the way past on the way home or whatever. (N127: Ricky, 44 years previously)

In this PIN, Ricky tells the story from his perspective of being a schoolboy in the midst of final exams, who is suddenly faced with the trauma of his mother having a sudden and life-threatening illness. In line 3, using the term “cerebral haemorrhage”, Ricky illustrates how knowledge gained after the event can be inserted into narratives. He did not know the diagnosis at the time but learned that afterwards. However, in telling the story, especially to a doctor, using the term immediately conveys the seriousness of the situation. He portrays the doctors as heroes, relating how he was “in awe” (line 4) of them, that they provided “incredible care” (line 5) and emphasising that they were doing “absolutely everything” (line 5). Again, with a symbolic interactionist theoretical framework in mind, the language is symbolic of the extraordinary feats of superheroes. The content of the PIN suggests that personal experience of such remarkable care and support from doctors at this early and vulnerable stage in his life contributed to Ricky's understanding of the meaning of professionalism. It is likely that he remembers this scene after a very long time because of the shocking visual image of his mother being wheeled out of the house on a stretcher and the sudden and catastrophic nature of her illness rather than because of any thought of the professionalism demonstrated by the doctors involved. However, in choosing to tell this particular story from almost forty years previously in the context of a conversation about professionalism, Ricky interprets what was happening at the time in the light of his own experience of medical practice. In using his contemporary ‘voice’ as a senior doctor, he reveals something of his current view of professionalism and how it was shaped by personal experience prior to medical school. There are several components to what Ricky noticed about the family
doctors’ professionalism in the story: they were “part of a team” (Line 4); they “supported the family” and provided “care to the patient” (Line 5); they “made sure” things were all right (Line 8) and they “dropped in” to visit (Line 13). Some of these are actions but they are not simple behaviours. There is caring, humanity and taking responsibility exuding from Ricky’s story. Later in Ricky’s interview, another story from later in his career suggests that his own relationship and professional behaviour with seriously ill patients had been influenced by this early personal experience. In this narrative he casts himself as hero.

1. Ricky: I mean, one of those [humbling experiences] was a young woman who was dying of [disease] who (.) I’d been involved in her care

2. and she just struck me as being isolated,

3. so I made it my business to (1.0) see her clinically in the morning

4. but in the evening before going home just to go by and chat with her and (.) chat about any damn thing.

5. And the amazing thing was

6. one evening (1.0) this patient asked the nursing unit manager or the ward sister as it was in those days “was Ricky coming?”

7. and I went and saw her and talked with her

8. and this girl basically said,

9. instead of saying “See you tomorrow” basically said “Thank you and Goodbye”
10. I drove home and about twenty minutes after I’d got home the (1.0) ward rang and said that she’d died.

11. So this girl obviously knew that she was dying but it was something that said to me, well I must have touched that person or done the right thing. (N132: Ricky, approximately 15 years previously)

In this story too there is caring. He drops in on his way home to see a patient just as he described his family doctors doing many years before when he was a boy. Ricky gives a clear example of professional behaviour and notions of professionalism being shaped by experiences occurring prior to their formal medical education. Furthermore, in telling this story Ricky highlights the value of doctors relating with their patients as people and offering human contact as part of the medical care package rather than restricting their interaction to strictly clinical matters. In line 4, when he says “chat about any damn thing”, he emphasises that the evening talks with this patient were different from the morning ward rounds when medical matters were discussed. The video shows that Ricky leans forward and speaks quietly with feeling as he tells this story, suggesting that he was emotionally moved by the experience. Coming from a non-medical family, Ricky had little exposure to doctors prior to his mother’s illness and the observations he made of the two general practitioners were important in helping him learn how doctors interact with and behave towards patients. Personal experience of being a patient or a family member of someone who is ill is often the catalyst for doctors to re-evaluate the importance of the human side of medicine (Silagy, 2001). In Ricky’s case he appears to have incorporated the behaviour, which meant so much to him as a teenager, into his own practice as a consultant many years later. The advantage of personal experience of this nature is not readily available to the majority of young people starting out in a career in medicine.
5.4.5 *Heroes as caring teachers*

Teachers willing to take time to get to know their students or trainees featured recurrently as good role models across the narratives. Being treated as a whole person rather than simply a trainee impressed Alan, as demonstrated in a recollection from his time as a junior doctor many years before:

1. He [the professor] used to have lunch every Monday with his resident [Alan],
2. just his resident, that’s all, one to one.
3. You’d have an hour for lunch
4. and he bought the sandwiches and you got to sit and talk to him.
5. You know we’d talk about cases that had been under our joint care
6. and various other things, more personal things
7. but he was terrific and a really big influence. (N56: Alan: 38 years previously)

In line 1 Alan uses the third person, “his resident”, rather than the first, “me”, to stress the hierarchy integral to the relationship. In line 2 he repeats “just his resident, that’s all” indicating the exclusive nature of the lunch. This eminent doctor was afforded hero status for taking regular time to give attention to a junior colleague. Alan’s reference to them discussing cases “under our joint care” (line 5) indicates the degree of confidence he gained from the supportive nature of this interaction. The use of “our” emphasises that they were collegial or part of the same team. They also discussed issues outside clinical work. Alan felt valued as a
member of the team because the professor related to him not just as a full team member, but also as a person, in an activity as ordinary as having lunch.

Recollections of being noticed and treated as a person by consultants were common. Harry, now a rurally-based hospital specialist, recalled the support he had from his supervisors when he worked overseas as a junior doctor. Like Alan, he felt very involved in patient care:

8. And I think that’s where [in that overseas position] I enjoyed getting involved with,

9. not particularly very sick [patients],

10. but getting involved with [patients] day after day and the [relatives]

11. and having a lot of autonomy,

12. and a lot of responsibility and a lot of (.)

13. and the [specialists] there were lovely men

14. that were gentle

15. and were from a rural background

16. and that’s where it became very clear that that’s what I wanted to do.

(N 113: Harry, 24 years previously)

The atmosphere created in the telling of this story is calm and relaxed. Harry paints an idyllic picture of gentle, lovely men from a rural background. Listening to the tape, Harry’s voice is gentle almost as if, even in the present, he is emulating the specialists he’s remembering from years previously. He talks about the enjoyment of being involved in patient care and keeps patients and families central
to the story. There is a sense that Harry was trusted as a competent member of the team, which meant that he was expected to take a degree of responsibility, an important part of training. Harry’s description of the specialists as “lovely” and “gentle” is the antithesis of the characterisation in the narratives of Kevin and Roy, which will be discussed in sections 5.5.2 and 5.5.3.

As Harry’s story unfolds, we see that what he presents as enjoyable and encouraging was not only demonstrated by the characteristics of the supervisors but by the way in which they interacted with him:

1. I guess I was pretty encouraged when I did the term in [country]
2. because it was just ourselves relating to the consultant
3. and they would appreciate what you’d done and would acknowledge it
4. and they’d give you the autonomy and the sense to be able to um use your skills
5. and would extend you somewhat. (N113:Harry, 24 years previously)

In short, these heroes took an interest in Harry as a person and were courteous, polite and appreciative of his efforts. They took the trouble to find out what his abilities were and encouraged him to learn more by doing more. By valuing him as an active member of the team, the consultants treated Harry with respect and gave him a safe space to develop his skills. It was more than merely their behaviour in dealing with Harry which meant so much to him. It was something in the nature of their interaction with him, a warmth and humanity, which was key to this being a powerful and formative memory for him so many years later. The very fact that Harry was so enthusiastic about what are assumed to be essential behaviours in
supervisors suggests that they were not the norm form him and therefore worthy of mention.

All of these narratives were prompted by encouraging the narrator to think about professionalism. There is an increasing sophistication of the characterisation of heroes in these narratives reflecting a growing understanding of the complexity of the notion of professionalism as mediated through relationships in medicine. The heroes presented in PINs told in junior doctor and in registrar voices are more realistic and their actions generally explained in more detail than characters from childhood or medical student-based stories.

5.5 Poor role models as villains

A major element in experiencing the real world of medicine was contact with doctors who were constructed as villains. As shown in Table 5.2, constructing protagonists as villains becomes more frequent as the seniority of the narrator increases. Whether this is a function of increasing cynicism, which we know occurs (Inui, 2003), of higher confidence because of more encounters with different sorts of people, or simply being more comfortable with their own professional identity and able to admit that some doctors do lack professionalism is not certain. As with the heroes, there are several different ways of presenting lack of professionalism in the narratives and these were explored.

5.5.1 Villain as vandal

In the middle of telling me that she felt that her experience as a nurse prior to studying medicine had influenced her own behaviour as a doctor, Karen told the following extraordinary story. It seemed that, as she was thinking about seeing
doctors behaving badly when she was a nurse, she was reminded of this bedside tutorial when, as a medical student, she had found herself in a difficult position:

1. Karen: I did have a doctor who cut my stethoscope as a medical student.

2. KF: Why? Why did he do that?

3. Karen: Because I think I was the only medical student who was honest enough to say that they couldn’t hear a diastolic murmur.35

4. But it took me about three cuts of my stethoscope to realise that everyone else was lying and that I perhaps should lie too because then he’d stop cutting my stethoscope. [Laughs]

5. KF: Why was he cutting it?

6. Karen: He kept cutting it shorter so that I’d hear it better.

7. KF: Oh, I see.

8. Karen: But I couldn’t hear it.

9. KF: But then you had to say

10. Karen: But eventually I said “Oh yes, yes, there it is”.

35 Heart murmur audible when the heart is relaxed (in diastole). Murmurs are often caused by heart defects which can be differentiated by the sound audible on examination with a stethoscope. Ability to identify murmurs is a key clinical skill for medical students and doctors.
13. and I’m sure that, when we got out the others said “we couldn’t hear it either.”

14. KF: But we wanted our long stethoscopes

15. Karen: But I don’t think they even realised.

16. Medical students just lie.

17. They just lie so that the next person is the person in the hot seat.

18. Whereas I really wanted to learn how to hear a diastolic murmur

19. and I couldn’t hear it and I wanted to know,

20. I wanted to be given the time to be able to get it. (N50: Karen, 12 years previously)

In this story Karen constructs the clinical tutor as a villain who deliberately and irreparably damaged her stethoscope, although from the story his intention appears to be helpful by facilitating her hearing the heart murmur. In doing so he not only abused his more senior position to humiliate Karen in front of her peers and a patient, but he failed in his duty as a tutor to help her hear the murmur. In the narrative Karen portrays herself as the only one of the group of students who really wanted to hear the heart murmur and also as the only one who was honest. In this she is engaging in impression management. That is, she presents herself in a positive way. Karen characterises the other students in her group as villains, or at least as wimps, because they did not admit until after the tutorial that they could not hear the murmur either. She says “medical students just lie”. But there is more than dishonesty here. Another form of villainy alluded to in this PIN is that of self-protection, even at the expense of others. In the learning environment created by
this tutor he is inadvertently penalising honesty and rewarding self-serving behaviour.

Another element of this narrative is the higher status of the doctor in the medical hierarchy and the power it gives him over the students. A stethoscope is a very personal piece of medical equipment and an identifying symbol of a doctor. Cutting the tubing is therefore not only an act of vandalism but also symbolises a direct threat to the student’s developing professional identity. The clinical tutor in this narrative made not just one, but several cuts to Karen’s stethoscope without her or the other students doing anything to stop him. The relative status within the medical hierarchy protects him in the medical environment. Indeed Karen even seems to accept responsibility for the situation by saying that she should have realised earlier that the ‘right’ thing to do was to lie and say that she could hear the murmur (lines 12 and 13). From a situated learning perspective (Lave, 1991 p67), what was intended to be a lesson about heart murmurs turned into a demonstration that some doctors have little regard for the property of others and that, in clinical settings, they are allowed to get away with behaviour unacceptable in other walks if life. For the majority of the group, their decision to pretend that they could hear the murmur was based on fear of being quizzed by the teacher/villain and damage to their stethoscopes. Deceitful behaviour and passivity were, therefore, in effect, rewarded in a long remembered learning experience. In this instance, the informal curriculum effect was undesirable, which although not always the case, is highly noteworthy in the context of professionalism.

5.5.2 Roy’s narrative about being bullied

Roy’s story about his experience during a surgical rotation as a junior doctor is a very powerful one. The narrative begins with Roy's introduction to his new boss on
the first day of his new job and goes on to develop the character of the villain further by describing how he had observed his boss interact with others. The PIN leaves little doubt about the strength of the feelings he had at the time and indeed still has when he reflects upon his experience. Because of the complexity of this PIN, it is presented in stanzas. Each stanza, or section, presents the protagonist in a different way, offering a description of the various elements of villainy.

1. Roy: Sometimes I wish I could have my RMO 1 [second post-graduate] year over, or one day of it so I could tell one of the surgeons to fuck off.

2. I wish I had and never have.

**Villain as bully**

3. He was incredibly awful, you know,

4. I think his opening words to me

5. when I started the term were

6. “Are you going to cry? The last three have cried.”

7. So-and I didn’t – but

8. KF: You weren’t going to after that?

9. Roy: He was offensive to patients, very offensive to women and to registrars.

**Villain as incompetent clinician**

10. There was a very good registrar who actively hid patients from him

11. because he wasn’t a very good surgeon and so,
12. and I remember the hospital system dealt badly with him [the consultant]

13. It was known amongst the junior doctors,

14. this guy’s not a good surgeon,

15. that patients had to be protected from him

16. but it took a long time

In this narrative, Roy’s character develops from a bully meting out verbal abuse in line 6 and a sexist bigot in line 9, into a dangerous villain from whom patients “had to be protected” (line 15) in a classic plotline familiar from many fairy tales where the vulnerable are preyed on by monsters and other evil beings. Interestingly, Roy does not project himself as the hero of the piece but casts the “very good registrar” as hero. This suggests an important role for middle-grade medical staff as an ameliorating influence in the informal curriculum for interns, as has been found in other studies (Stern, 1998).

In the next section Roy talks about the strong feelings he remembers experiencing as a young doctor in a tough hospital environment. In this narrative the organisation (rather than the individual) is complicit in the villainy:

17. KF: So what effect did that have on you?

**Abusive environment – organisation as exploitative**

18. Roy: Um, I sort of knew what I didn’t want to be like

19. but it’s also something about how awful the system is
20. and how devaluing-dehumanising the process of being an intern and

RMO 1 is


22. KF: And you said you couldn’t do anything

23. Roy: Well because I was too scared to say anything

24. Now I just want to say “You’re a hopeless bloody surgeon

25. don’t take it out on me!”

26. KF: And you’re too scared to say something because?

27. Roy: Because there was no sense that anyone would stand up for me.

Here the feelings of fear and isolation that Roy felt as a junior doctor are vividly described, in stark comparison to the way he feels he would deal with the situation now as the more confident senior doctor he has become. The additional element in this stanza is that the junior doctors are constructed as victims of the ‘system’ which Roy presents as abusive, exploitative and “dehumanising” (line 19). In talking about the system he uses the present tense suggesting that he still finds this so. In the last stanza that follows the culmination of villainy is the reporting of physical violence against a member of staff.

**Villain as physical bully**

28. There was, you know,

29. he assaulted one of the staff –

30. I can’t remember who it was now,

31. but he actually hit them
32. so we were not empowered, not empowered as junior medical staff.

33. There's no way I'd tolerate it now. (N32:Roy, 15 years previously)

The climax of the story in physical violence justifies Roy's fear of danger within the healthcare system. After six years of university study to become a doctor he felt scared and threatened at work in an approved hospital training position for a profession that purports to be caring. It is salutary to remember too that, in Roy’s case, these events happened less than twenty years ago, at a time when the professionalism movement was well underway.

There is a great deal of anger evident in Roy's narrative. He is angry at the surgeon who greeted him in a very inappropriate way at the start of a new job. He is angry at himself for not standing up to the consultant at the time and he is angry at the 'system' for allowing the surgeon to behave in that way. He is also shocked and disillusioned. The realisation that doctors sometimes behave in less than ideal ways leads Roy to construct this doctor as an incompetent, uncaring and bullying villain; qualities quite the opposite of the hero characterisations discussed earlier.

The vehemence of his feelings of anger and distress is clear from the words used as Roy relates the story of the encounter. He curses twice (lines 1 and 23) recounting his story and describes the strong emotions of terror, isolation and powerlessness he felt in this abusive relationship (lines 22, 26 and 30). All of this is very powerful learning about what professionalism means both at the individual and organisational level for Roy. Indeed, Roy appreciated much about ‘professionalism’ in medicine through his personal experience of how other doctors and ‘the system’ dealt (or did not deal) with a poorly performing role model. Bullying and intimidation are known to be prevalent in medicine and to impact adversely on professional development (Hicks, 2000). Roy’s PIN demonstrates some of the
ways in which bullying is manifested towards junior doctors and is tolerated by the ‘establishment’.

5.5.3 Kevin’s being belittled narrative

Belittling of residents is known to be a rite of passage into the profession (Musselman, MacRae, Reznick, & Lingard, 2005). The next PIN from Kevin constructs a bullying villain who he felt belittled and excluded him when he was in the more senior position of medical registrar:

1. And when the older doctor came in

2. he actually crossed out all my [patient management] plans and changed it to the way he wanted it to be.

3. He said “You’re junior, you don’t know anything”.

4. and I went to the books

5. and I saw “wait a minute, I was right”.

6. Why didn’t he explain it to me?

7. Why didn’t he explain to me why he changed it? –

8. instead he crossed it through

9. and said “you’re junior”

10. It’s no way to treat doctor-to-doctor relationships I think.

11. So I learned from that –

12. I think you get pushed away by that
13. not talking to senior staff because you get pushed away. (N4: Kevin, 7 years previously)

Kevin creates a villain who is arrogant and verbally abusive in crossing out Kevin’s plans and saying “You don’t know anything” (line 3). His feelings of humiliation and of being excluded are highlighted by the use of direct speech which draws the listener into the narrative (Riessman, 2008 p112). The villain fails in his supervisory duties by not explaining the reasons for changing the plans. Kevin feels ignored and excluded from any discussion that would have been helpful to his learning about patient management. This is a more covert type of bullying than the direct verbal and physical bullying in the previous PINs. The undermining of his professional identity damaged Kevin’s relationship with his senior colleague at the time. He felt “pushed away” (lines 12 and 13) and discouraged from seeking advice from someone who was dismissive of his ability and knowledge but who, in reality, should have been helping him develop. This experience may well have affected Kevin’s relationships with subsequent supervisors.

5.5.4 Julie’s patronising and sexist teacher narrative

Julie’s story about a bedside teaching session when she was a medical student presents a different type of villain. This incident took place when a group of twelve students was taken to see a patient by a surgeon:

1. I remember a patient one day,

2. oh this was terrible.

3. She had varicose veins

4. and he [the surgeon] made her stand up on the bed
5. and had us all looking at her legs, kind of looking,

6. I thought “this is like we’re all peeping up her skirt.”

7. And he said “If you were my wife I’d throw you out of bed for complaining about these veins”

8. and then sort of slapped her on the (1.0) on the bottom

9. and I (1.0) you looked (1.0) [shakes head]

10. he just wouldn’t get away with that now. (N69: Julie, 22 years previously)

Julie characterises the surgeon as using his position of power to belittle the female patient in a patronising and patriarchal way. Julie not only uses direct speech to convey what the surgeon said to the patient but she also imitates the way in which he spoke to the lady. In the video, Julie fidgets and looks uncomfortable, almost as if she is reliving the way she felt when she observed the exchange all those years before. Witnessing the patient being “slapped” on the bottom (line 8), an aggressive act with sexual undertones, was traumatic for Julie. Seeing a member of the medical profession behave in a way which was not acceptable in normal life, and seeing that he got away with it, left her speechless. In telling the story more than two decades later Julie stutters slightly in a previously fast moving, fluent narrative, almost as if she can still hardly believe the experience. In line 10 there is a strong statement that Julies feels that contemporary professional standards have changed as she brings us right up to the present and indicates that, in her view, such behaviour would no longer be tolerated. Such a comment from her is especially meaningful, as Julie is herself now a consultant in a surgical specialty.
5.5.5 Alan’s smiling liar narrative

Trust is important in the doctor-patient relationship. Feeling pressured into covering up for substandard care was a common theme in the narratives. Alan told a story which had shocked him as a registrar during his surgical training when assisting a senior colleague at an outpatient clinic. A female patient had come back for review following a surgical procedure during childbirth. It was evident that one of the sponges used during the operation to mop up blood had been left in her vagina, a medical error, and one of which the patient was unaware.

1. You know I remember some terrible things,

2. like [surgeon’s name] left a sponge in someone after a repair and the patient came back a week later and complained about the smell and things

3. and said she’d taken out this sponge

4. and I was just stunned by his response to her.

5. He said. “What? You didn’t take it out did you? I left that there intentionally

6. I was going to take it out next time” (laughs).

7. And that was his mechanism for dealing with it

8. which was pretty quick thinking I have to admit

9. but it was just the way people covered things. (N62: Alan, approximately 36 years previously)
Alan introduces the story as describing “terrible things”, but in the end Alan is honest about his ethical ambivalence to this situation. He was stunned at the time by the consultant’s behaviour and becomes quite animated in the recounting of the story, whether by the way the surgeon lied so easily or by the brilliance of his rapid response is unclear. There is a suggestion that Alan feels the deviant behaviour was not only acceptable to the prevailing culture at the time but also worthy of admiration now. He admits to seeing the lie as “pretty quick thinking” (line 8). Not only was the surgeon lying to the patient, he was also belittling her and probably making her feel foolish because she had taken the sponge out herself. Even so, Alan’s excuses the behaviour by saying “it was just the way people covered things” (line 10) suggesting that he may still have a sneaking admiration for the way the surgeon handled the situation. This may be because the ability to think quickly in this situation demonstrates a skill also highly desirable for surgeons in the operating theatre. Another of Alan’s stories contains a theme common to several narratives: that of junior doctors dealing with professional lapses in their senior colleagues.

5.5.6 Villain as drunkard

10. Alan: There’s some things that left a big impression on me

11. like doctors coming in drunk.

12. There was one in [name of hospital] that used to get terribly drunk
13. and he’d come in and we’d as residents and registrars we’d say “you sit in the change room and we’ll go and do the operation”

14. and he did. He knew that he was hopeless and we’d do the operation, the ectopic or whatever it might be and come out and tell him the result and put him in his car to go home which wasn’t very smart but (Laughs)

15. KF: yes those sorts of things

16. Alan: Yes those sorts of things made you think “Gees, what am I doing?” You know, private patient and “where am I in this whole situation? It isn’t good to be doing, who should I tell?”

17. KF: yes all those kind of things

18. Alan: And ... there was a sort of protective thing, you protected people ... and that was, for me that was very, (1.0) I didn’t feel happy doing it (laughs). (N64: Alan, 36 years previously)

Alan’s current perspective on the issue of collusion among doctors was explored further in the interview. The following reflection shows that Alan’s professional socialisation almost four decades earlier still influences the way he views his responsibility to his colleagues.

30 A surgical emergency caused by a pregnancy occurring outside the uterus.
1. KF: Those are the sorts of things that I wonder whether, (.) well hopefully things as bad as that aren’t happening now, but you know, but whether things along the same lines are still happening?

2. Alan: Not to that extent

3. but that sort of protection is still ensconced in the mentality of the medical profession

4. that you protect your colleagues, from all sorts of things

5. whether it be from those personal things

6. whether it be relationships and interactions with other staff,

7. whether it be incompetence in a surgical sense or in a knowledge sense.

8. There just is that, I don’t know, people just have an in-built expectation that that’s part of their role

9. and the whole sort of culture of dobbing in and reporting and notifying under-performing Fellows is a very tricky one. Yes.

10. But what do you do about it? (Laughs) (Alan, contemporary reflection)

For Alan, the protection of medical colleagues is an integral part of professionalism and of being a doctor. He talks about protection of colleagues as “ensconced” or
“in-built” (lines 3 and 8) using words which suggests that, for him, the notion of covering up professional indiscretions is deeply ingrained in his professional identity. Alan’s references to “under-performing Fellows”, “reporting” and “notifying” are reminders of the bureaucratic processes being introduced by his own professional college (and other organisations) to deal with what he calls a “tricky” challenge in a systematic way. Using the phrase “dobbing in” for making such a report nuances Alan’s current opinion that perhaps reporting represents disloyalty to medical colleagues. This view, presumably informed by wide exposure to other doctors in his recent senior college role as well as his many years of clinical experience, is in contrast to the acute discomfort he describes as a registrar in his PIN about covering for a drunken colleague. There is a tension in the various narratives which make up Alan’s story between the needs of the public and the interests of the profession. Later in this reflection, Alan admits his uncertainty about whether the public should have access to information about professional misconduct. This reflects the broader tensions within medical professionalism between social justice and professional autonomy and, indeed, the nature of the social contract (D. H. Irvine, 2004).

11. Alan: everybody knows about them now,

12. whereas before those sorts of things [acts of serious professional misconduct] wouldn’t have been made public [in the past],

13. because they would have been hidden by the profession.

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37 Fellow is the term used for a doctor who has been admitted to the relevant professional college having passed the necessary assessment processes.
14. Now whether that’s good or bad I don’t know. (Alan, contemporary reflection)

Alan highlights the contemporary issue of open disclosure by using the present tense in some phrases of his narrative and by asking the question “What do you do about it?” In using the pronoun ‘you’, the generalised other, rather than the more personal ‘we’ or ‘I’, he appears to be distancing himself from the responsibility of looking for a solution. Or perhaps he is seeking help. In either case, Alan alludes to the complexity of the issue and the possibility that there is no straightforward answer. In terms of learning about professionalism, it appears that Alan’s is still exploring what it means in practice. For him the journey towards phronesis continues even after forty years.

5.6 Ambiguity: Role models as both hero and villain

Around ten percent of the PINs included both hero and villain protagonists, but in only three were these characterisations made of the same doctor. Although in the vast majority of cases participants clearly distinguished between heroes and villains, it was less clear how they made the decision as to whether or not to emulate the behaviour they observed. The ambiguous cases where a doctor was characterised as hero and villain may offer some explanation of the process. Two of the examples are discussed here.

The first ambiguous role model is one of Julie’s tutors from her pre-clinical medical student days:

15. Julie: when I did physiology

16. there was one particular lecturer who we all felt was quite hard.
17. And you know [in] the year book [his entry] was

18. “He stamped all over us with his seven league boots”38

19. But he actually made sure that you sat down and learnt the work

20. and he made you aware of how much detail you actually needed to know. (N66: Julie, 24 years previously)

The year-book entry, which Julie quotes, gives a graphic image of the way the students felt this particular tutor treated them. The symbolism of the magic boots suggests an ambivalence between the speed possible in the journey of learning and the risk of being crushed underfoot. This characterisation is of a tough tutor who works the students hard and is somewhat directive. However, Julie modifies this by implying that the tutor’s firm tactics ensured that students knew their work and thus justifies the tutor’s methods. Since the priority of most students is to pass exams (Muijtjens, Hoogenboom, Verwijnen, & Van der Vleuten, 1998), Julie’s ambiguity is probably, at least in part, due to his perceived help with this.

In another PIN, Roy expresses his simultaneous anger and admiration for a consultant:

1. Roy: I can remember not ringing a professor in the middle of the night when one of his patients died.

2. As an RMO you know

38 Magical footwear featured in fairy tales which enable the wearer to travel seven leagues (approximately thirty-nine kilometres) in one stride.
3. I just saved this guy [consultant] waking up at 2 am.

4. The guy [patient] had been dying for months and months

5. and he [consultant] was absolutely furious with me the next day

6. saying that he was the only one who could have helped the family through their grief.

7. It struck me at the time “how self-important he thinks he is”. He could have got the family through it,

8. but also how dedicated he was that at 2am he’d rather be woken up to speak to a family. (N26: Roy, 14 years previously)

Initially in the narrative Roy characterises his consultant as arrogant, bad-tempered and ungrateful. Almost as an afterthought, at the end of the PIN, he offers an alternative explanation (dedication to duty) as an excuse for the anger unleashed on Roy. From a symbolic interactionist perspective, interpretation of the situation depends not simply on what occurs at the time but also on other understandings which players bring based on their previous experience. In this PIN we have the opportunity to consider not only Roy’s standpoint, recalled from a junior doctor perspective but also his thoughts as he reflects on the event from his current consultant position fourteen years on. The junior doctor Roy is shocked, as he sees an inexplicably angry consultant and feels that he himself must be to blame. He is hurt that the consultant seems to disregard any possibility that Roy may have cared adequately for the patient’s family overnight. The junior Roy feels unappreciated and bullied, despite his best efforts to be self-sufficient and coping, reinforcing the impressions gained from his previous experience with a bullying supervisor (see section 5.5.2). The current consultant, Roy, sees the apparent
dedication to patients but, interestingly, this does not automatically confer hero status. Perhaps he also sees a desire for control, which was effectively removed because the senior doctor in the story was not informed of the patient's death. The sequencing of this PIN in the interview immediately after Roy raised the topic of acceptable working hours suggests that, for him, the issues of working hours and professionalism are linked.

In common with accepted current practice, Roy expresses the view that limits on working time are necessary for doctors. Knowing first-hand the way in which such events can adversely affect consultants and junior staff, he characterises the consultant ambiguously as part-hero and part-villain. While he recognises the dedication to the family of the man who died during the night, he also recognises the consultant’s responsibility to be able to treat other patients, and indeed, staff in a professional manner.

This example serves to illustrate the complexity in even a straightforward scenario and how previous experience can influence behaviour. Had Roy's internship the previous year been spent with a supportive rather than a bullying consultant (Section 5.5.2) he might have felt comfortable to discuss with his new boss the process in the event of the patient's impending death.

5.7 Institutional culture

The unsupportive side of the organisations has been presented in the narratives of Alan and Roy. There are also signs of supportive organisation, as in one of the very few PINs in the study where the narrating doctor casts herself as the villain. The following story dates from when Helena was an intern and although she appears relaxed, dialogic-performative analysis tells us a different story:
9. I blew up a crematorium by cremating a patient with a pacemaker.

10. That was probably my worst moment (laughs)

11. Um just in terms of guilt of what I did.

12. It was actually when I was a resident,

13. but the hospital handled it really well

14. KF: Yeah?

15. Helena: Yeah. I didn’t cop too much for that (laughs)

16. KF: That was because you were-

17. Helena: I was helping out.

18. And I think they recognised that I didn’t mean to do what I did and when I did I

19. KF: That (. ) was that signing a cremation [certificate]?

20. Helena: I was helping another resident;

21. I was doing nights and the patient died.

22. And I knew the patient from my last term

23. and when he died I certified him

24. and then an arrest was called

25. and I said to the staff “I’ll come back and do the paperwork later

26. because I know the patient”
27. So [when I came back] the patient had gone

28. and I flicked through the notes and couldn’t see an ECG\textsuperscript{39}

29. and there was nothing written in the admission

30. and so I just said “no” to a pacemaker.\textsuperscript{40}

31. But admin was very good about it. (laughs)

32. They said, “These things happen”

33. I mean they had to show me the paperwork,

34. and I’ll never do it again, I’ve learnt from it.

35. KF: That must have been awful for you.

36. Helena: Yes it was pretty awful;

37. I mean the whole hospital knew about it (laughs) I won awards

38. KF: What kind of award?

39. Helena: A terrorism award (giggles)

40. I blew out the side of the crematorium,

41. it cost the hospital about forty grand, (laughs) anyway. (N85: Helena, 13 years previously)

\textsuperscript{39} Electrocardiogram – a heart tracing.

\textsuperscript{40} If a body is to be cremated additional certification is needed. This includes a question about whether or not a pacemaker has been inserted.
Although this was a serious error on Helena’s part and one which had a major financial repercussion for the hospital, Helena perceives that the matter was dealt with well by administration. The organisation was “very good about” the incident (line 23) and accepted that she had not intended to cause an explosion. The dramatic nature and seriousness of the event are such that Helena’s learning about the importance of establishing the accuracy of facts before certifying them is virtually guaranteed. In telling the story Helena is very forthcoming and talks easily. However, the laughter paradoxically reveals her underlying distress and embarrassment at the enormity of this story. She laughs after saying it was “probably my worst moment” (line 2) and again after acknowledging that it was “pretty awful” (line 28). Laughter is a way of reducing tension in difficult circumstances and its use as a protective or coping mechanism has been reported in focus group discussions (C. E. Wilkinson, Rees, & Knight, 2007). In analysing talk it is important to look at such paralinguistic information as a pointer to underlying meaning. If it is assumed that in telling a story the narrator is reliving the experience (Elliot G Mishler, 1991 p82), then Helena is employing laughter as a mechanism to protect herself from the horror of the very serious potential consequences of her actions. Through using this strategy she can, for the most part, adopt the calm persona of an experienced medical professional as she recounts the story. Although she suffered embarrassment at the time, she is appreciative and even complimentary about the hospital administration’s handling of the matter. Rather than looking for an individual to take the blame for the incident, Helena portrays the institution as having dealt with the matter professionally. An environment where a serious incident can be openly and widely discussed in this way is conducive to development of healthy professionalism. It is interesting that Helena does not mention the patient’s family in her story although they must have been distressed by the events she is reporting. This may demonstrate a lack of
sensitivity or professional concern on her part or, in my view the more likely explanation, that her discomfort at recounting the tale was acute. I think that she presented the story in a comedic way sticking to the organisational aspects as a mechanism to protect herself from the enormity of the emotion involved at a personal and interpersonal level.

5.8 **Seniority, phronesis and the next generation of doctors**

Gaining experience in medicine can broaden a doctor's understanding of the complexity of human relationships and of the practice of medicine itself. This is not guaranteed and whether or not it happens depends on a variety of factors. My data suggest that with maturity the ability to recognise the many ways in which heroism and villainy can be manifested also increases. There is also recognition that early learning experiences influence the way doctors later teach others. Lorna states that, as a consultant physician, she notices more poor professional behaviour than she did as a junior doctor and she gives a possible explanation:

1. Lorna: perhaps this is a good time to time to say that I’ve had more interactions as I’ve got a lot more senior with people –

2. to be perfectly honest I’ve seen more modelling of what I hope I would never do.

3. I don’t know if I would ever have been in the situation had I not been (1.0) I think there are some issues, some situations where (1.0)

4. which one is only in at certain levels of seniority.
5. Some of the things I’ve seen, I’ve witnessed, I wouldn’t have seen had I been a JMO.

6. They might have gone whooska, [gesturing over her head]

7. I might not have been in the room.

8. It might have been in a meeting and I might not ever have seen it

9. and the other option is that I might have seen it and it may have made no impact on me when I was more junior.

10. But in more recent years when I have been more senior

11. I have seen some pretty unprofessional behaviour

12. and that’s had a very strong impact on me.

13. And I’d lie awake and think I never (1.0) I really hope I never would say something (1.0)

14. having seen the impact of that behaviour,

15. I really hope I would never do that. (N23: Lorna, recent years)

### 5.9 Influence of experience on own teaching

In some of the PINs there is a link made between the way the narrator remembers being treated as a medical learner and how they themselves interact with their own trainees. Lorna’s example of a caring teacher was mentioned in the thematic
analysis in Chapter 4 and is examined in more depth here. It is humbling to hear the powerful and lasting effect of a few thoughtful words:

16. He [the consultant] would draw you aside at Grand Rounds and say something like “Nice job on such and such”

17. Little things like that.

18. Little things that I’m remembering as I’m training my juniors,

19. I think I should do more. ... I remember how much it made me swell inside with pride.

20. You know I could do that

21. So that’s the kind of thing that were supportive.

22. KF: Yes

23. Lorna: Look, they were very little things.

24. It wasn’t like moving heaven and earth.

25. But they were really important.

26. KF: But obviously the way they made you feel was not little.

27. Lorna: But again it was a tiny thing at the time. Or the kind of thing that took about three seconds. (N22: Lorna, 14 years previously)

Grand Rounds is a clinical meeting in which many doctors discuss challenging patient cases for educational purposes.
As Lorna tells the story she smiles slightly, as if reliving the feeling of pride (line 5) and the boost to her self-esteem that the simple words of affirmative feedback from her consultant gave her. At the same time she is thinking about herself in a supervisory role and how she can pass on this feeling to the trainees for whom she has responsibility. In saying “I think I should do more” (line 5) and “I could do that” (line 6), Lorna seems to be convincing herself that she could give the same level of support to the trainees she now supervises. She seems to be persuading herself that this won’t be onerous or time-consuming. Phrases like “It’s not like moving heaven and earth” (line 10), repetition of “little things” (lines 3, 4 and 9) and a time estimate “it took about three seconds” (line 13), all point to this being a simple and quick thing to do. This may be to counter a prevailing view amongst clinicians that teaching and supervision are time hungry (Kilminster & Jolly, 2000) and hard work (McHugh & Thoms, 2005) and that treating trainees nicely is a unnecessary luxury in the busy world of medicine.

Benefit for the next generation of doctors can also be gained from reflection on adverse experience. Harry tells a story about a nurse making a complaint about his attitude as a junior doctor.

1. I remember one particular nurse who was older, wizened, very difficult to deal with.

Harry uses evocative language to conjure up a picture of a wizened old woman – a classic witch-like villain. After probing, his narrative goes on to acknowledge that he was probably the villain of the piece.
2. I was pulled up by admin\(^{42}\) for being passive aggressive towards this NUM [Nurse Unit Manager] ...

3. I guess they could sense you’re surly or you’re not communicating you know you’re holding things back or you’re doing things with some sense of reluctance.

In this narrative Harry admits that, at the time, he had the commonly held view in male-dominated workplaces, that women are over-sensitive and difficult to deal with (Hinze, 2004) (line 1). Looking back on the experience now, as a more mature doctor, he can see the nurse’s perspective. As the narrative unfolds he reveals how the experience has influenced the way he advises his current students:

4. I think everybody’s been pulled up once or twice in their life because of some personality difference,

5. but I guess that was an issue and I sort of realised that then,

6. when I talk to the medical students that we see here I think that they need an appreciation of how to interact with nursing staff...

7. I think that what I have learnt is that, especially where I work now,

8. is that getting on with the nursing staff is critical,

9. not just for making the workplace pleasant, but to do your job. To do your job. (N110: Harry, 22 years previously)

\(^{42}\) Abbreviation for administration. Harry is specific in noting that his medical supervisors did not give him this feedback
In saying “I sort of realised then” (line 5) Harry suggests that he did not appreciate that “getting on with the nursing staff is critical” (line 8) until later in the development of his professional identity. In line 9 he nuances two levels of benefit of improved interprofessional relationships: the superficial goal of a pleasant workplace and the more fundamental issue, indicated by repetition (Riessman, 2008 p113), of actually being able “to do your job”.

A third way in which one's own learning experience in relation to professionalism can later affect how one teaches others is alluded to by Gemma in a part of the interview discussed in chapter 4.10.6, when she talks about how she interacts with students during her current clinical teaching duties.

1. …it’s less teaching than trying to make them feel as though they’re making the right decisions.

2. And making them feel comfortable and capable of doing it.

3. Because a lot of them have those anxieties about not being able to perform and not being up to scratch

4. and so because I’m the master of knowing what that was like, (laughs)

5. So it’s been useful

6. KF: Certainly it’s useful, so what do you do in that vein with them?

7. GC: Well I tell them. I tell them they’re doing a good job.

8. And yes I tell them “that was good” and “this is what you could maybe do better” and “you need to ask”

9. and you know I go through the patient with them
10. and if they ask me something I follow it up if I can. And um yes. So at least they know, and at the end I'll tell them they're doing a good job.

(N121: Gemma, contemporary reflection)

Using narrative analysis gives a richer perspective than thematic analysis where this is simply classed as ‘creating an environment conducive to learning’. Gemma demonstrates that her memories of feeling “not being able to perform and not being up to scratch” (line 3) when she was a student herself have motivated her to be encouraging and reassuring to the students she teaches. The repetition of “I tell them they're doing a good job” (lines 7 and 10) suggests that Gemma may be over-compensating for her own experience, of receiving no positive feedback, by offering too much reassurance to students. In doing so she may compromise the principle of honest feedback which is fundamental to learning.

5.10 Derek’s reflective narrative of resistance

Derek gives a very clear account linking feedback he received from his seniors as a young doctor and the way he teaches now. In this narrative Derek eloquently captures the essence of professionalism – and of medicine:

1. I know that when I was being considered for advancement at [hospital]

2. the complaint was that

3. “He wasn’t a bad doctor but he spent too long with the patients.”

4. So that was the criticism that I had to endure as a young doctor,

5. so I suppose I set about my own path in medicine obviously influenced by this
6. but also from my innate sense of human worth and dignity
7. that people are important and they need to be listened to
8. and not simply talked at from the end of the bed.
9. So I suppose I sought to cultivate a practice that perhaps,
10. unconsciously or consciously,
11. was a little at variance with what I saw amongst the senior consultants
12. who talked over the patients
13. and for whom the patient was an object of (2.0)
14. just an object to be used as a teaching aid for students. (2.0)
15. I’m not conscious of any very bad behaviour.
16. KF: So how did you feel when you knew about that kind of report?
17. Derek: Well I felt somewhat wounded
18. and yet I thought
19. if that’s what they think of me they’ve at least perceived me for who I am.
20. I’m somebody who in fact is interested in people not just in diseases
21. and that has remained with me throughout my professional life to this day.
22. I often say to the students, “Don’t” – and to the postgraduates
23. “Don’t say there’s a myocardial infarct coming in,
24. there’s actually a patient who’s got severe chest pain
25. who is sure that he’s going to die
26. and all of that is happening within the matrix of a family deeply
27. concerned and in a wider society deeply concerned for his or her
28. wellbeing”
29. and I can say that notion of ‘an infarct coming in’ conjures up in my
30. mind
31. a palpitating myocardium on a silver platter surmounting a silk
32. cushion
33. and that is not what patients are. (N94: Derek, 30 years after
34. graduation)

In the account Derek makes it clear that he considers that his regard for the
importance of people was seen as a failing. The use of “complaint” (line 2) and
mention of the “criticism” he had to “endure” (line 4) and feeling “wounded” (line
17) signify the degree to which Derek feels he suffered because of his “innate sense
of human worth and dignity” (line 6), because he “spent too long with patients”
(line 3) and “is interested in people and not just diseases” (line 20). In this
narrative Derek relates how he resisted the depersonalisation of patients which he
observed as a young doctor by seeking to “cultivate a practice ... at variance with
what I saw” (lines 9 and 11). And he continues the resistance “to this day” (line 21)
in his own teaching.
5.11 Discussion

The notion of the competing forces of good and evil is deeply ingrained in the human psyche through storytelling. In the myths and legends of ancient Greece and Rome and the fairy tales of folklore, heroes face improbable tasks and take great risks to vanquish thoroughly evil villains. Originally, both heroes and villains were regarded as deviant or outside the normal range of human ability or character (Klapp, 1954) and there is resonance here with the somewhat dramatic use of beyond normal talk in the narratives, for example “most wonderful” (Molly, N 8), “incredibly awful” (Roy, N 32). Contemporary heroes typically are more complex in character and have a special weakness: equivalent to the classical concept of the Achilles heel. Superman, for example, possesses superhuman strength, the ability to fly at great speed and x-ray vision among other powers, but is vulnerable in the presence of Kryptonite, radioactive material from his home planet. This gives him a human frailty at least occasionally. Furthermore, a post-modern villain can be constructed as someone driven as the result of a harsh and unfortunate past to a state where the boundaries between good and bad are blurred. Two-Face, a villain in the Batman series, is a law-abiding district attorney driven to a state of psychological chaos by an acid attack and the resultant facial scars. He flips between good and evil just like the coin he flips to decide the nature of the action he will take in response to any given situation. This symbolism reflects the complexity of identity which is socially constructed and can be multiple in contemporary society (Jenkins, 2008, p17). This research illustrates that doctors

43 Achilles is a hero of Greek mythology who was invincible except for an area on his heel where his mother had gripped him as she dipped him, as a baby, into the magical River Styx.
are able to recognise that the role models in their stories can have multiple dimensions to their identities. As doctors move towards phronesis they become aware, through experience, that the distinction between hero and villain role models may not be as straightforward as it seemed early in their career. Applying a symbolic interactionist perspective to the broad dichotomy of ‘good’ and ‘bad’ amongst protagonists uncovers a wider variety of characterisation, reflecting the many different doctors encountered by an individual over years of training. The doctors studied came from different family backgrounds and had different life experiences prior to studying medicine. They have different personalities, different likes and dislikes and different skills and aptitudes. They are individuals. The increasing sophistication in the construction of the characters in the narratives depending on the stage of professional socialisation at the time of the experience featured illustrates the construction of meaning about the medical profession built from a combination of innate characteristics, reflection on experience and on observations of others. All of this adds to the theory that professionalism is dynamic, individual and constantly in flux through interpersonal interaction. Achieving an understanding of professionalism agreed by institutions, doctors and patients and accessible to learners requires not simply a statement of intent, but meaningful action role-modelled and demonstrated for all to see.

5.11.1 Gender as an issue in identity development

An overwhelming majority of the role models in the study are male and the characterisations in the narratives are heavily gendered. Several narratives are about mixed gender groups, usually of peers but only three specifically involve a single female doctor role model. These three stories, all told by women, present the female doctor as hero. The remaining twenty-nine good role model doctors are all male. All of the doctor role models characterised as villains in this study are male.
Four female nurses and one female patient are presented as ‘villains’ (N 7,16,41,44 and 110) dispelling any thoughts that men have a monopoly on villainy. It is not possible to ascertain from this study whether the lack of female doctor villains is due to fewer women in senior academic positions in medicine (Carnes & Bland, 2007), meaning that those interviewed had limited experience of women role models. Another consideration may be simply that men are more likely to be constructed as villains because they more commonly exhibit the behaviour associated with lack of professionalism apparent in the narratives.

5.12 Implications

A major implication of this work is a reframing of the meaning of professionalism. It has been shown to be much more than a list of qualities and attributes considered desirable but not essential in all doctors; it has been shown to be much more than a competency mattering only if it can be reliably and validly assessed. Professionalism is demonstrated in this study to be multifaceted, multilevel, humanistic and dynamic and to exist within interpersonal interactions and across time, within reflections and memories and in the thoughts, actions and relationships with and between doctors, patients, other health professionals and students. In short, every doctor communicates the values and culture of the profession whenever s/he interacts with another person.

All doctors, not only those who are clinical teachers and supervisors, need to be aware of the powerful and long-lasting influence of their behaviour on the professional identity development and the process of professional socialisation of those joining the profession.
While the long-lasting effect of the influence of good role-modelling is welcomed, the longevity of the influence of bad role model behaviour on students and trainees is a concern. The implication is that, in addition to awareness-raising among doctors ways must be sought to counteract inappropriate behaviour and promote a balance of humanistic and scientific values in the medical profession. We know that facilitating reflection on both good and bad experiences promotes learning (Baernstein & Fryer-Edwards, 2003). I found in this study that listening to senior doctors' stories was almost therapeutic as many participants stated that they had not previously had the opportunity to discuss their negative experiences before and were grateful for the opportunity to do so. Making the opportunity to discuss professional dilemmas widely available is a major challenge in the face of a time poor and biomedically dominated profession. An entire culture change is needed where discussion of issues of the wider meaning of professionalism are valued as an integral and essential part of socialisation into a caring profession.

Little attention is paid currently to the psychological and behavioural sequelae of mistreatment or bullying during medical training and this is an important area for further research.

### 5.13 Strengths and limitations of analysis

The strength of the approach used in this analysis is that it interrogates the data thoroughly and looks for depth of meaning beyond merely the content. The researcher’s insider status in medicine is a further strength. Dialogic-performative analysis acknowledges the interviewer’s role in constructing the data. In this study it is likely that knowing the interviewer had been through medical training encouraged participants in sharing their stories. A deeper sensitivity and understanding to the nuances of the data can be expected from a researcher who
has inside knowledge and experience in the field. Insider status can also be a limitation, as it may result in missing some themes which are familiar and not singled out. Being aware of this possibility, as is the case in this study, minimises risk of it occurring.

5.14 Conclusion

A major and entirely novel finding of this study is that the memories of both professionalism and lapses in professionalism witnessed prior to and during socialisation into the medical profession persist for many years, even decades, after the original event.

The study shows professionalism is not taught in classrooms, but is demonstrated by the behaviour of doctors. All doctors in the study characterised role models as a mix of heroes and villains and senior, male doctors as especially influential. In this study professionalism was linked with heroes who were beautiful, kind, daring, clever, capable, enthusiastic, supportive, caring, encouraging and appreciative, and lack of professionalism with villains who were bullying, abusive, exploitative, belittling, excluding, sexist and dishonest. Reference to gender was a theme running through the narratives, reflecting the relevance of gender issues to a traditionally male profession, especially now that equal numbers of women and men study medicine (Holge-Hazelton & Malterud, 2009).

The educational effect is particularly influential when an interaction with a doctor in a role model position evokes strong emotion in her or his student or trainee. Feedback from a senior colleague on a job well done builds self-esteem, contributes to development of a professional identity and reinforces good practice. Working in an atmosphere of fear and humiliation, on the other hand, inhibits learning and
destroys self-esteem (T. J. Wilkinson, Gill, Fitzjohn, Palmer, & Mulder, 2006). There is also substantive evidence that both supportive and aversive treatment during training can influence the way in which the doctors interact with their own students and trainees later in their careers.

The study reported in this chapter sheds light on how the hidden curriculum and role modelling influences doctors in training. It also provided information about the culture of medicine through the various ways in which role models were characterised. Working with the data so closely over a prolonged period confirms the richness of meaning to be discovered. My third study uses a different analytical method to further explore the culture of medicine within which medical education takes place with the aim of increasing knowledge and understanding the hidden and informal curriculum.
6 Study 3: Understanding the culture of medicine through metaphorical analysis of senior doctors’ narratives

6.1 Introduction

In this chapter I present the results of a metaphorical analysis of the data and offer further insight and richness to the findings presented in the previous two chapters. In Chapter 4 I looked at the content of the narratives in a thematic analysis and showed that, for senior doctors, the construct of professionalism had three dimensions: an inward-looking and reflective personal dimension concerning personal identity; an active people-focussed dimension related to the way in which doctors behave and are expected to behave; and an environmental dimension, creatively constructed as a nebulous but all-pervasive force existing around doctors and in the moment. I further demonstrated that these personal, people and environmental factors were influential for doctors in reaching their own understanding of professionalism. Of these, role models and the hidden curriculum were particularly relevant and the close relationship between developing notions of professionalism and the prevailing culture of the medical environment was established. The role of the hidden curriculum in learning in medicine is already known (Gaufberg, et al., 2010; Hafler et al., 2011; Karnieli-Miller, et al., 2010; Ozolins, et al., 2008). Much of the literature is focused on the effect that the incongruities between idealistic classroom medicine and real life, on-the-ward medicine have on medical students. My study is the first to explore how senior
doctors make sense of the numerous different, and sometimes conflicting, experiences they have to create a personal construct of professionalism. In Chapter 4 the environment surrounding newcomers as they grapple with acquiring knowledge and skills in medicine was identified as another main factor influential in the construction of the meaning of professionalism. The environment in which learning takes place affects the quality and nature of what is learned (Kember, Leung, & McNaught, 2008; Rogoff, 1994). In the context of this study, the ‘culture of medicine’ provides the broader educational milieu within which learning about professionalism is situated (Lave & Wenger, 1991).

In chapter 5, people factors were looked at in depth, at least on an individual person-to-person basis. In particular, the various ways in which role models operate as instruments of the hidden curriculum on professionalism was explored and new insights uncovered about the long-lasting influence of both good and bad experiences on professional identity development. I found that interpersonal interactions and the emotions and feelings they elicit are important elements of acculturation into medicine. I had been aware of metaphors in the data since the start of the analytical phase of the research. With the findings of my first two studies I now had reason to interrogate the data, exploring the broader environment in which participants’ learning about professionalism occurred. The third study is secondary analysis, looking in more depth at the metaphorical talk in the narratives. This gives an understanding of the various ways in which the medical culture within which professionalism develops is conceptualised by senior doctors.
6.2 Metaphorical analysis

6.2.1 Background

Language is a major component of interpersonal interaction through which human beings understand themselves and the world in which they live. An integral part of language is metaphor, a figure of speech in which a name or descriptive word or phrase is transferred to an object or action different from, but analogous to, that to which it is literally applicable (Oxford Dictionaries Online, 2012). More than this, metaphors are fundamental to abstract thought (Lakoff & Johnson, 2003, p272), giving them a cognitive as well as a linguistic function in terms of the way one kind of thing is understood or experienced in terms of another (Lakoff & Johnson, 2003, p5).

6.2.2 Rationale

The metaphors used in everyday talk depend on experience, interactions with the world and social and cultural practices (Lakoff & Johnson, 2003, p247). It is, therefore, reasonable to assume that by looking at the metaphorical concepts employed by participants as they tell their professionalism-related stories, insights can be gained into the culture of medicine in which their experiences took place. In terms of medical education, culture is the learning environment in which newcomers learn about professionalism. The research question addressed by this part of the research is:

- What is learned about the culture of medicine from the metaphorical language used by senior doctors in narratives about professionalism?
As in Studies 1 and 2, the originality of this study is that the participation of senior doctors makes it possible to look at the different perspectives of doctors on medical culture as they are socialised into the culture of the profession over time.

6.2.3 Conceptual metaphor

In the cognitive-linguistic view of metaphor, one conceptual domain is understood in terms of another conceptual domain, for example: CONCEPTUAL DOMAIN ‘A’ AS CONCEPTUAL DOMAIN ‘B’. The two domains involved in such a conceptual metaphor have special names: The one being described, domain A, is called the ‘target domain’ and domain B, which is being used to assist understanding, is called the ‘source domain’ (Kovecses, 2010, p.4). Target domains are typically abstract, hard-to-define concepts and source domains are more concrete, familiar and well understood. When words and phrases normally used in relation to the source domain are applied to the target domain they are known as ‘metaphorical linguistic expressions’ (MLE). In the study reported in this chapter, the target domain is the culture of medicine. In metaphors, frequently used source domains are entities of which there is common understanding. An example of a conceptual metaphor using war as a source domain is ARGUMENT AS WAR (Charlotte E. Rees, Knight, & Wilkinson, 2007). Here ‘argument’ is the target domain. That is, the concept of argument is being explored through likening it to war (the source domain) through metaphorical linguistic expressions (MLEs). Examples of MLEs manifesting the conceptual metaphor ARGUMENT AS WAR are: He attacked every weak point in my argument (Lakoff & Johnson, 2003, 4) or I defended my

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44 By convention, conceptual metaphors are written in capitals.
point strongly.\textsuperscript{45} The use of such expressions compares the concept of ‘argument’ to that of ‘war’. Because of common knowledge about war other associations between the two concepts can be made. When knowledge about the source domain is applied to the target domain the result is a metaphorical ‘entailment’ (Kovecses, 2010, p325). For example proposing the conceptual metaphor ARGUMENT AS WAR implies that those who are arguing adopt adversarial positions and that there will be a winner and a loser, that there may be violence or a truce. Thus, through an associative process based on experience of the source domain, metaphors add to meaning and understanding of the target domain.

\textbf{6.2.4 Meaning from metaphors}

In day-to-day language, people usually use metaphoric linguistic expressions (MLEs) which accord with their own experience. For example, someone who uses the metaphoric linguistic expressions (MLEs) she \textit{surrendered} to him; he was \textit{captivated} by her; he \textit{fought} for her, is invoking the conceptual metaphor LOVE AS WAR, where once again WAR is the source domain. This gives a very different impression of the notion of ‘love’ from one given by someone who uses expressions such as; the lovers were \textit{inseparable}; he’s my better \textit{half}; it was if \textit{two became one}. In the latter examples, the conceptual metaphor LOVE AS UNITY suggests that the speaker has experienced love differently from the person who uses the LOVE AS WAR metaphor. Alternatively, the speaker may use metaphor rhetorically in a conscious attempt to influence the listener’s impression of love in the particular context (Charlotte E. Rees, et al., 2007). Either way the range of MLEs used by participants in the current study help in understanding the concept of professionalism as it imbues the culture

\textsuperscript{45} By convention, metaphorical linguistic expressions are italicised.
of medicine. In preparation I searched the metaphorical literature to identify conceptual
metaphors previously reported in relation to medical topics. The findings of that review will
be used in the results and discussion sections of the chapter.

6.3 Method

The data collection methods are given in the main methodology chapter of the thesis in
sections 3.7 and 3.8. The analytic method for this third element of my research is
adapted from Schmitt’s systematic metaphor analysis (Schmitt, 2005). The first step was
to identify systematically the metaphorical expressions used in the narratives pertaining
to the target topic. Each transcript was studied carefully and words and phrases used
metaphorically in talk about professionalism within the culture of medicine were
highlighted (Lakoff & Johnson, 2003 p65). During this process it was important to check
that the expressions were metaphorical rather than literal in meaning, as this is known
to be a challenge (Charlotte E. Rees, et al., 2007). For example, when Derek says, “I’m
consciously impelled by my negative experiences”, it is not immediately obvious whether
he is using ‘impelled’ metaphorically. Using the Pragglejaz group’s method (Pragglejaz
Group, 2007), I compared the meaning of the word as used in the context of the
narrative with its basic meaning in ordinary use. In this case, the contextual meaning of
‘impelled’, as used by Derek, is to indicate that he was moved or driven towards a course
of action and the basic meaning is to be moved forwards by an external force. Since there
is no real difference between the contextual and basic meaning of ‘impelled’ in this
instance, then the word is not being used metaphorically. If, however, the contextual
meaning in this particular instance had added to the usual, basic meaning, then the use
would be determined as metaphorical. Once identified in the data, metaphorical
expressions were grouped according to the source domain used.
6.4 Results

6.4.1 Metaphors and medical education

The six major overarching conceptual metaphors identified within the narratives were MEDICINE AS FAMILY, MEDICINE AS JOURNEY, MEDICINE AS WAR, MEDICINE AS HIERARCHY, MEDICINE AS MACHINE and MEDICINE AS SPIRITUAL EXPERIENCE. Each of these will be explored in turn, looking in particular at the metaphorical entailments arising from each conceptual metaphor and the way in which these add to the understanding of the culture of medicine as a major influence on learning and teaching about professionalism.

6.4.2 MEDICINE AS FAMILY

A widely used and novel conceptual metaphor in my narrative data is MEDICINE AS FAMILY. I first noticed it when discussing ways in which participants had gained support throughout their medical training and beyond. A mentor or role model seen as a father figure or as a surrogate mother or peers as brothers and sisters seemed to be ways in which participants had found support as they learned how to be a doctor. PATERNALISM and PARENTALISM have previously been described as source domains for understanding doctor-patient relationships and assessment relationships (Charlotte E. Rees, Knight, & Cleland, 2009). The MEDICINE AS FAMILY metaphorical expressions in my data included a wider range of family relationships, such as medical students and junior doctors as young children, often siblings, and senior doctors as parents or grandparents. Examples are given in Table 6.1.
| Table 6.1: Quotations illustrating the MEDICINE AS FAMILY conceptual metaphor |
|---|---|
| 1. There used to be this thing known as the ‘[Hospital name] Family’ which was really all about the fact that lots of people came here and stayed here for long periods of training so there was a **big, strong** kind of corporate memory. | Lorna |
| 2. …very senior nurses regarded the interns as somewhat **troublesome infants** that had to be put up with | Derek |
| 3. …you see those people that you’re working with as **your brothers and sisters** as opposed to co-workers and the barriers get blurred sometimes. | Helena |
| 4. The interaction with your colleagues was fantastic, to the extent that when we had our forty year reunion this year in January of our year of graduation which was 1966, you know, some people you mightn’t have seen for twenty or thirty years but because you lived together and worked together and had been around so much together for those one or two or three years it’s, you just get straight back to like a **brother and sister** | Alan |
| 5. Between the guys and the girls, the medical girls and guys there wasn’t (sic) really any issues at all and there was a strong sense of **looking after each other**. | Molly |
| 6. We [junior doctors] did things like having breakfast or lunch together, before we started our work for the day. So there was an environment where it **almost was our home** and many of us **seemed to live here** [in the hospital] for those three to five years. | Ricky |
| 7. You know it’s really silly and it’s just like listening to a **triple P positive parenting** program, but he [professor] might ring you up from time to time and say ”I’ve just read the file notes on Mr. Bloggs – you did a great assessment of that” – and it was so little, so simple but it’s that pos, it’s that out of the blue unrequested small act of **positive parenting** – is really what it’s like. | Lorna |
| 8. My registrars, you know I’m getting to the age, you know, I’m forty four, where I feel sort of middle-aged so they’re **almost like children**. …so I treat them like that and I try and, they’re not **like children** in the sense that I tell them what to do, but like children in the sense that they need to be **supported** … Yes **nurtured**, that’s the point. | Gemma |
| 9. And I think I probably, I think my style has been um to be, I don’t know if overbearing’s the right word but to be too supervisory when maybe in some cases it’s not required as much. Knowing when to **cut the cord** sort of thing | Julie |
As in real families, relationships can vary. In Table 6.1: MLE 1, Lorna continues the MEDICINE AS FAMILY metaphor by using the word “family” in relation to the people at the teaching hospital where she trained. Linguistically she adds to the metaphor. The word “corporate” draws attention to the large size of the hospital, while the words “big and strong” used metaphorically nuance a protective father or a big brother rather than workers within an organisation. In contrast, Derek (Table 6.1, MLE 2) refers to senior nurses regarding him and his intern colleagues as troublesome infants. Thinking about what we know of infants helps our understanding of Derek’s way of explaining the culture of medicine at the time. Infants are very young and helpless. They must grow and develop in order to function independently in the world. In this there are clear similarities with interns who are embarking on their profession but still have much to learn from the ‘adults’ in their environment as they mature. Qualifying “infants” by describing them as “troublesome” extends the interpretation. Troublesome infants can be boisterous and loud. They can be clumsy and unpredictable, but they also need looking after preferably by a loving and caring person. Infants require time, patience and love from adults in order to grow and develop. This MLE draws attention to the relative immaturity of doctors in their first year after graduation in medicine and their need for caring, nurture and assistance. It encapsulates the tensions which can arise within the healthcare team, especially between medicine and other healthcare professions.

The prominence of the MEDICINE AS FAMILY metaphor in the PINs makes sense in terms of the traditional view of medicine as vocation or a way of life. Colleagues were described as brothers and sisters, metaphorically speaking, by Helena and Alan (Table 6.1, MLEs 3 and 4). Sibling relationships can be
supportive, loving, competitive or acrimonious but in my data the signs are mainly of good rather than strained relationships with peers. Indeed, Alan refers to the long-lasting camaraderie among medical classmates who forged bonds so close that, even after several decades, they can interact as if they had never been apart. Alan is clear that living together and working together as was the norm at the time he trained was the reason behind the very close relationships he had with his classmates. Ricky remembers the mundane things like having breakfast or lunch together before starting work as important components of the prolonged exposure to each other which built lasting family-type bonds between the junior doctors:

So there was an environment where it almost was our home and many of us seemed to live here [in the hospital] for those three to five years.  
(Ricky: Table 6.1, MLE 6)

For Ricky, living and eating together, just as some families dine together made the environment resemble home. Combined with long hours working together the effect was to forge close relationships, especially with peers. Molly, a more recent graduate, is clear about the sense of looking after one another between the young doctors, which again is like family relationships. (Molly: Table 6.1, MLE 5)

Another family-type relationship, that of parent–child is likened to the relationship between a senior professor and junior doctor, in which Lorna highlights the inherent power differential. The professor takes a paternalistic approach to the young female intern and tells her that she’s done a good job in assessing the patient, as if he is following the instructions giving in a parenting program.
The parental entailments of the MEDICINE AS FAMILY metaphor are also seen in narratives about participants’ own teaching practice. In this situation, study participants are in the parent role rather than the child role of the previous examples. Gemma likens her relationship with her current specialty trainees to that of a mother nurturing and encouraging her children’s development (Table 6.1, MLE 8). After probing, Gemma is very clear in explaining that, when she refers to treating the junior doctors “like children”, she does not mean “telling them what to do”. She stresses the word “supported” and clarifies it in the sense of “nurturing”. Julie also focuses on the parent–child relationship as she describes the dilemma faced in balancing adequate supervision with increasing autonomy of surgical trainees as “knowing when to cut the cord”. This MLE emphasises the very close relationship between supervisor and trainee. So close that it resembles the life-giving umbilical connection between mother and baby which has to be cut so that the youngster can survive in the world independently.

In my data, the MEDICINE AS FAMILY metaphor brings a warmth and sense of humanity not immediately obvious in the other five conceptual metaphors prominent in the data. The entailments explicit in the MLEs are all good ones of support, encouragement and looking after each other. The use of this metaphor suggests the high level of support offered to doctors in training by their learning and working environment and the people in it. It may be that since the introduction of shorter working hours that this family-like level of support is no longer available with implications for the wellbeing of students and junior doctors. Since FAMILY is a familiar concept to all of us it is a useful source domain. What was not apparent in this data were any explicit negative entailments of the metaphor MEDICINE AS FAMILY. The very use of
the metaphor, however, implies also such concepts as sibling rivalry or family feuds.

6.4.3 **MEDICINE AS JOURNEY**

Movement and travel are basic experiences universally and are commonly used source domains in many conceptual metaphors; for example, “Look how far we’ve come”, or “I don’t think this relationship is going anywhere”, in the conceptual metaphor LOVE AS JOURNEY (Kovecses, 2010, 6). Several examples of the expressions used in the narratives are outlined in Table 6.2. Within the conceptual metaphor MEDICINE AS JOURNEY, the travellers represent the learners and using what is known about the source domain of JOURNEY, the metaphor can be elaborated upon to add further to meaning. In education JOURNEY been described as a source domain in relation to teacher education (Goldstein, 2005), to surgical training (Fabri, 2003) and to assessment relationships (Charlotte E. Rees, et al., 2009). In all of these the destination of the journey was taken to be qualifying as a teacher or as a doctor or as a surgeon. The MLEs participants use in the conceptual metaphor MEDICINE AS JOURNEY in my study similarly suggest that the participants are moving towards a destination. In medicine, as a lifelong pursuit, the journey may be never-ending with a new goal appearing as soon as a destination is reached. The data shows uncertainty among doctors about where or what constitutes their destination (Table 6.2, MLEs 12&13).
<table>
<thead>
<tr>
<th>MLEs illustrating MEDICINE AS JOURNEY metaphor</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. I set about my own path in medicine.</td>
<td>Derek</td>
</tr>
<tr>
<td>11. …helping young people to get to where they need to go or where they should go and to try to put them on a career path.</td>
<td>Ricky</td>
</tr>
<tr>
<td>12. So I didn’t really have an idea of where I was heading or what it really involved.</td>
<td>Gemma</td>
</tr>
<tr>
<td>13. I was a bit lost. I didn’t know what I wanted to do</td>
<td>Roy</td>
</tr>
<tr>
<td>14. …if they’re on the wrong track and they’re doing things badly…</td>
<td>Roy</td>
</tr>
<tr>
<td>15. Just take it a step at a time.</td>
<td>Gemma</td>
</tr>
<tr>
<td>16. and then somebody said there’s [specialty] and I thought well that’ll be good so I sort of just stumbled across it</td>
<td>Gemma</td>
</tr>
<tr>
<td>17. Did I enjoy my clinical training. I think I had my ups and downs. I was quite stressed. KF: What was stressing you? The feeling of being at sea because we weren’t supervised like we are now</td>
<td>Gemma</td>
</tr>
<tr>
<td>18. as a doctor you may well make a shipwreck of your life</td>
<td>Derek</td>
</tr>
<tr>
<td>19. Most of the medicine was actually just running around trying to do the things that had been told to you on the ward round and feeling out of my depth</td>
<td>Roy</td>
</tr>
<tr>
<td>20. I suppose they’re my worst memories, of being thrown in the deep end … But I don’t really dig being thrown in the deep end when you learn because you have to</td>
<td>Helena</td>
</tr>
<tr>
<td>21. it was the first time I actually felt, “I’m actually part of this team, actually part of the crew”</td>
<td>Julie</td>
</tr>
<tr>
<td>22. because anyone can be pushed to that limit. It takes a while to get me there.</td>
<td>Karen</td>
</tr>
<tr>
<td>23. Interns don’t carry as much responsibility as they thought.</td>
<td>Ricky</td>
</tr>
<tr>
<td>24. That was all he said, and I’ve carried that with me right till now.</td>
<td>Gemma</td>
</tr>
<tr>
<td>25. Students thought that interns and residents were all knowing but I quickly realised that wasn’t true. Um I just realised that they were pack horses</td>
<td>Helena</td>
</tr>
</tbody>
</table>

*Table 6.2: MLEs illustrating the MEDICINE AS JOURNEY conceptual metaphor*
**The Route**

Some expressions involve a path or track, suggesting that there is an approved route to take and that it is possible to stray from this and go the wrong way. Some, like Derek, allude to finding their way independently: “I set about my own path in medicine” (Table 6.2, MLE 10). Others, like Ricky, speaking as teachers, talked about “helping young people to get to where they need to go or where they should go and to try to put them on a career path” (Table 6.2, MLE 11). Roy reflected on the professional responsibility to assist students or junior doctors “if they’re on the wrong track and they’re doing things badly” (Table 6.2, MLE 14).

**Getting lost**

Gemma remembers feeling, “I didn’t really have an idea where I was heading or what it really involved” (Table 6.2, MLE 12) at the beginning of her medical studies. Even when newly qualified as a doctor Roy recalled “I was a bit lost I didn’t know what I wanted to do” (Table 6.2, MLE 13), which fits with the notion of a novice who knows nothing about medicine needing signposting and guidance to find the appropriate direction.

As above, Gemma describes herself metaphorically as a traveller who doesn’t know which way to go at the start of her medical studies. She goes on to use the MEDICINE AS JOURNEY conceptual metaphor several times. This metaphorical coherence adds weight to the interpretation. For example, once she found her way she decided to “Just take it a step at a time” (Table 6.2, MLE 15) as she completed her degree. Despite her careful approach to her journey she describes how she decided to become a specialist in the discipline she now works in:

and then somebody said “there’s [specialty]” and I thought “well that’ll be good” so I sort of just stumbled across it. (Table 6.2, MLE 16)
By using this metaphorical talk, Gemma applies the accidental, unplanned or serendipitous aspects of journeys to the way she determined her career in medicine.

**Challenging and hazardous journeys**

Many of the expressions used by participants are about difficult or challenging journeys, reflecting feelings of stress or hardship as well as isolation. When discussing her clinical training, Gemma’s metaphorical talk specifies the JOURNEY as a sea voyage:

Gemma: Did I enjoy my clinical training? I think I had my ups and downs. I was quite stressed.

KF: What was stressing you?

Gemma: The feeling of being at sea because we weren’t supervised like we are now. (Table 6.2, MLE 17)

Gemma talks about the ups and downs of clinical training, immediately followed by an admission that she felt stressed. She uses the expression being at sea to describe how she felt as an unsupervised junior in clinical practice. References to sea voyages were common entailments of the MEDICINE AS JOURNEY metaphor. **Being at sea** is used idiomatically to mean ‘confused’ or ‘unsure what to do’ and relates to the metaphorical concept of being on a boat in the open sea, moving up and down on the waves. It also evokes a feeling of being lost if there is no land in sight to help with orientation and finding direction. There is also a notion of instability because of the repetitive up and down movement suggested by the use of the plural form ups and downs. In the context of being “at sea”, as in this narrative, a feeling of sea-sickness and of danger is invoked. Derek employs the sea
voyage metaphor dramatically when he warns that “as a doctor you may well make a *shipwreck* of your life.” (Table 6.2, MLE 18) Here the conceptual metaphor is LIFE AS JOURNEY and deeper insight into how Derek’s professional life in medicine affected his life in general is gained by looking at the wider context in which he uses the phrase. Here he employs an ontological metaphor when he personifies non-human ‘medicine’ by giving it human characteristics (Lakoff & Johnson, 2003, 33)

And medicine is *very demanding* … Is it going to be medicine *for the sake of medicine* or is it going to involve much more important considerations of human relationships and family? And I am firmly of the view that unless the latter pertains, as a doctor you may well *make a shipwreck* of your life. So I consciously sought to cultivate relationships within the family and children rather than see the professional life of the doctor as being all-important. (Derek: lines 415-421)

In reading the whole passage it is clear just how important Derek’s family life is to him. It also demonstrates the interlinking of ontological metaphorical talk. The personification of ‘medicine’ in “*medicine is very demanding*” and “*for the sake of medicine*” reinforces the tension between work and family. It is reminiscent of the phrase ‘being married to the job’, a recognised cause of marital tension and here Derek’s job in medicine is presented as a competitor to his family in vying for his attention. As listeners or readers, we use our existing understanding of shipwrecks to help in understanding the meaning of the feelings Derek is trying to convey. The metaphor makes me think of stormy weather, high seas overwhelming a vulnerable vessel, the panic of near-drowning, destruction and the uncertainty of rescue. Looking at the MLE in context also shows that Derek is discussing the similarly serious consequences of letting work (in this case medicine) dominate his life. In
doing so, he highlights the importance of life balance to professionalism, learned from his own experience and observations over time as a doctor.

Journeys can be risky and dangerous and Roy refers to two modes of travel in his MLE. Roy felt *out of his depth* as a junior doctor: “Most of the medicine was actually just *running around* trying to do the things that had been told to you on the ward round and feeling *out of my depth*” (Table 6.2, MLE 19). Through mixing metaphors by talking about swimming and running in the same phrase, he conjures the feeling of panic and being out of control. The phrase *running around* suggests lack of direction and an effort to escape the risky situation and the lack of coherence between the metaphors adds linguistically to the sense of chaos in the story. Helena describes a similar feeling when she recalls being a junior doctor put into a registrar role when the consultants and registrars went to a conference. She felt untrained for the higher ranked position and helpless in the situation forced upon her without consultation. As she puts it:

> I suppose they’re my worst memories, of *being thrown in the deep end* ... I mean that is the way to learn. But I don’t really dig being *thrown in the deep end* when you learn because you have to. (Table 6.2, MLE 20)

This notion, of being picked up and pitched into the deep end of a swimming pool, is another watery entailment of the MEDICINE AS JOURNEY where the ‘journey’ has an involuntary element. The metaphor allows vicarious understanding of how it feels (Periyakoil, 2008) as a junior doctor to be put into the situation of working as a higher grade of doctor in a busy ward with very sick patients. The metaphor equates the feeling of being, unexpectedly and against your will, in deep water (having been thrown) and knowing that you may drown if you cannot swim and help is not available. The panic Helena felt and the sense of urgency to survive
being left on her own in a busy ward, can be understood by most people through the use of this metaphor. Thus, it is not necessary to have actually been in the same position as this junior doctor to feel the nature of the experience. Both these examples give a vivid understanding of what professional life in medicine felt like for these doctors. They also illustrate how they learned what was accepted as a level of professionalism not only in relation to themselves and the way they themselves were treated but in relation to the patients who were being cared for on those same wards.

**Group or team journeys**

Julie introduces another entailment of the JOURNEY metaphor when she talks about a clinical teacher who had high expectations of students as far as work and study go:

you were *being pushed* all the time so I felt that he challenged you and he made you do the work. And also that feeling of, it was the first time I actually felt, “I’m actually part of this team, actually part of the crew”. (Table 6.2, MLE 21)

It is not clear whether Julie’s crew are on a ship or an aircraft, but this entailment acknowledges the professionalisation of students who are separate from the passengers (patients) on the journey and working under supervision of the captain, in this case their clinical teacher. In terms of professionalism, the metaphor emphasises the responsibility of each crew-member to work collaboratively to ensure that the vessel reaches its destination and that everyone on board arrives safely, just as in medicine there are experienced crew from whom newcomers can learn. The passengers need assistance and care from everyone and do not necessarily differentiate between levels of experience in the crew. The aircraft or
ship’s captain and officers have authority as well as expertise and can help or hinder careers, just as consultants and supervisors can in medicine.

**Burdensome journeys**

Carrying something is another JOURNEY entailment appearing in the data as a common way in which the challenge of medicine is conveyed. In Ricky’s example he alludes to the continued need for guidance: “Interns don’t carry as much responsibility as they thought” (Table 6.2, MLE 23). For Gemma it is the memory of a few words of encouragement from a senior doctor, that she carried with her for many years almost like a talisman: “That was all he said, and I’ve carried that with me right till now” (Table 6.2, MLE 24). In another entailment of the JOURNEY conceptual metaphor junior doctors were seen as overburdened. For example:

Students thought that interns and residents were all knowing but I quickly realised that wasn’t true. Um I just realised that they were pack horses (Helena Table 6.2, MLE 25)

Not only did Helena see junior doctors as extremely hard working and overburdened, but casting them as working animals in the MLE suggests coercion and their inability to voice complaints. Although only tangentially associated with the JOURNEY source domain, but echoing slave-like conditions and hard work, Lorna remembers working as one of a group of junior doctors in a large teaching hospital as:

...there was a good sense of being in the salt mines together.(Lorna, line 191)

In talking metaphorically about being in the salt mines Lorna invokes an image of backbreaking work in tough conditions, of being there against one’s will and an
element of punishment. At first glance, therefore, Lorna’s juxtaposition of the word “good” seems paradoxical. However, looking at the broader context of this quotation suggests that Lorna was not really thinking about hardship at all when she used this metaphorical expression. Rather she was remembering the way in which bonding occurred between junior doctors working in difficult circumstances:

We had fun parties though there was a good sense of being in the salt mines together sort of concept. I mean I remember it as a fun time. I met my husband here, all that kind of stuff. I remember it as a fun time I do. I do remember it as a fun time. (Lorna, lines 190-193)

The word “together” emphasises the collegiality and mutual support born of being united in adversity and which spilled over into social activities. The repetition of “fun time” three times in two sentences does suggest a degree of self-persuasion and perhaps a conscious effort to balance the salt mines image in the context of the interview. Whether or not that is the case, there is a sense of camaraderie known to be helpful in surviving tough times (Sinai, Tiberius, de Groot, Brunet, & Voore, 2001). For Lorna socialising with colleagues outside work further fostered collegiality. Like Julie’s crew mentioned earlier, this suggests a new metaphor of MEDICINE AS TEAM.

6.4.4 MEDICINE AS WAR

War is widely used as a source domain with common target domains of politics, argument and sport. In healthcare, war is a common source metaphor for treating illness (Hodgkin, 1985; Periyakoil, 2008). MEDICINE AS WAR metaphors were commonly used in the narratives. The use of war as a source domain for the culture of medicine is a novel finding as far as I am aware, although it has previously been used in relation to the target of the doctor–patient relationship (Charlotte E. Rees, et al., 2007) and also in assessment relationships between medical teachers and students.
The war-related entailments found within my study include both the dangerous and destructive aspects of war and the organisational and hierarchical elements associated with military precision. Table 6.3 gives examples of MLEs from the data.

<table>
<thead>
<tr>
<th>MLEs illustrating MEDICINE AS WAR metaphor</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. I'm sure its [keeping positive] helped me battle medicine with enthusiasm because it is a battle.</td>
<td>Helena</td>
</tr>
<tr>
<td>27. Well I felt somewhat wounded.</td>
<td>Derek</td>
</tr>
<tr>
<td>28. he just targeted the junior staff</td>
<td>Helena</td>
</tr>
<tr>
<td>29. Whistleblowers have traditionally been hammered</td>
<td>Harry</td>
</tr>
<tr>
<td>30. you didn't want to come across as a whinger and a whiner and … the culture as you know was just get on with it and this isn't for the weak willed.</td>
<td>Julie</td>
</tr>
<tr>
<td>31. someone who may be regarded as not cut out for the cut and thrust of a certain specialty</td>
<td>Julie</td>
</tr>
<tr>
<td>32. It was known amongst the junior doctors, this guy's not a good surgeon. That patients had to be protected from him but it took a long time – years for anything to happen</td>
<td>Roy</td>
</tr>
<tr>
<td>33. didn't know what hit her</td>
<td>Kevin</td>
</tr>
<tr>
<td>34. the change from just doing what you thought was best to now the defensive medicine practice in the medico legal sense.</td>
<td>Alan</td>
</tr>
<tr>
<td>35. But I'm conscious of those sorts of disparities and have fought to minimise them</td>
<td>Derek</td>
</tr>
<tr>
<td>36. And defuse the situation with the nursing staff</td>
<td>Harry</td>
</tr>
<tr>
<td>37. Mopping up the damage sometimes … Mop up the damage. I think, yes I guess learn on the job.</td>
<td>Roy</td>
</tr>
<tr>
<td>38. and I was sent to [city] Casualty which was a bit of a war zone</td>
<td>Karen</td>
</tr>
<tr>
<td>39. when you are a junior and … the senior orders something</td>
<td>Kevin</td>
</tr>
<tr>
<td>40. Anyhow it's very hard to know the chain of command</td>
<td>Helena</td>
</tr>
</tbody>
</table>

Table 6.3: MLEs illustrating the MEDICINE AS WAR conceptual metaphor
In some MLEs doctors are likened to soldiers in action. For example, Helena refers to the effect of her attitude to making progress through medicine, as “I’m sure it’s [keeping positive] helped me battle medicine with enthusiasm because it is a battle” (Table 6.3, MLE 26). This entails regarding medicine as an adversary to be conquered, again pointing to the dangers involved. Derek tells of his response to end of term feedback from senior colleagues that, as a doctor, he talked too much with patients: “Well I felt somewhat wounded” (Table 6.3, MLE 27). Metaphorically he felt as though he had been physically assaulted by the supervising doctors. Rees et al. also found this talk of violence towards medical students when an assessor talked about sticking the knife in and metaphorically killing their students (Charlotte E. Rees, et al., 2009). Within medical student–patient relationships, metaphorical talk of violence has been described in both directions (Charlotte E. Rees, et al., 2007). In my study there were also violent MLEs, but these were usually enacted between members of the medical profession. Helena’s MLE is about personality clashes and an uncaring registrar targeting everyone disrespectfully. The text preceding and following the MLE illustrates the situation:

Helena: I felt his [registrar’s] lack of respect for junior staff was fairly clear and that was just a personal clash in that respect.

KF: How did he make that clear?

Helena: I’m not sure he respected anyone so I’m not sure that he just targeted the junior staff per se, but he, you know, you would ring him about a problem and he didn’t care. (Table 6.3:MLE 28., Helena, lines 273–278 )

While targeting suggests some training and expertise, as in archery, shooting or darts, Harry uses a violent MLE when he discusses the frustrations of dealing with
doctors who behave badly: “Whistleblowers have traditionally been hammered” (Table 6.3, MLE 29) and comments on his perception of the relative ineffectiveness of the formal curriculum by adding “I can’t see how it would change with a bit of teaching [about professionalism] involved”. (Harry, line 624)

As in other studies where WAR is a source domain (Hodgkin, 1985; Charlotte E. Rees, et al., 2009; Charlotte E. Rees, et al., 2007), much of the metaphorical talk was adversarial or oppositional. There were, however, other entailments in my work adding richness to the MEDICINE AS WAR conceptual metaphor in previous reported studies. Julie points out the need to be strong like a soldier and, in doing so, alludes to a cultural expectation within medicine of self-sufficiency and toleration of hardship:

you didn’t want to come across as a whinger and a whiner and ... the culture as you know was just get on with it and this [medicine as a profession] isn’t for the weak willed. (Table 6.3, MLE 30)

Julie invokes another violent image when talking about the need for doctors in training to be tough lest they “may be regarded as not cut out for the cut and thrust” of a certain specialty (Table 6.3, MLE 31).

Protection and defence

In addition to the adversaries in a war there are also the innocent victims of war and, metaphorically, these were often the patients. For example:

It was known amongst the junior doctors, this guy’s not a good surgeon. That patients had to be protected from him. (Roy: Table 6.3, MLE 32)

Roy’s use of the term “protected” alludes to the need to preserve others in a hostile environment or from hostile people. Physical injury can result and Kevin talked
about a sick woman being hurriedly and roughly examined as not knowing *what hit her* (Table 6.3, MLE 33). Alan’s MLE is more about self-protection as he describes the change he has seen in medicine over the years:

the change from just doing what you thought was best to now the *defensive* medicine practice in the medico legal sense. (Table 6.3, MLE 34)

Derek’s MLE is about fighting for equality and fairness within the profession:

I was dealt with as a very junior, almost irrelevant, person on the team in the ward but outside I was an equal. And I found this duplicity very difficult to take. That was partly the culture of medicine ... But I’m conscious of those sorts of disparities and have *fought* to minimise them. (Table 6.3, MLE 35, Derek, lines 527–530)

**Peacekeeping and recovery**

The notion of junior doctors as peacekeepers between various factions or disciplines was another entailment of the MEDICINE AS WAR metaphor, illustrated by the metaphorical talk. Harry refers to the dangers of this particular military activity when he describes one of his tasks as a junior doctor being to “*defuse the situation with the nursing staff*” (Table 6.3, MLE 36). Harry’s mention of his role as a registrar following the consultant who did not communicate well with patients also conjures up an image of relief teams going in after a war or other disaster:

*Mopping up the damage* sometimes ... *Mop up the damage*. I think, yes I guess learn on the job. (Harry, Table 6.3, MLE 37)

I was interested that doctors of both genders used MLEs related to the MEDICINE AS WAR conceptual metaphor and I would contend that this is because working in
medicine is a confronting and often raw experience. In support of this argument Karen is very clear in describing an Emergency Department: and I was sent to [name] Casualty which was a bit of a war zone. (Table 6.3, MLE 38) The comparison of the way junior doctors are allocated to placements with soldiers being deployed to various trouble spots is suggested by the word “sent”.

**Confrontation and chaos**

The MEDICINE AS WAR metaphor helps to explain just how confronting Karen found the Emergency placement. It conjures up a picture not only of injured patients but of fear, chaos and working in dangerous circumstances. In comparison, the hospital where she worked as an intern was an easier place to be:

I didn’t really enjoy that [working in Emergency] although I’m really glad that I had the experience. It sort of convinced me that the [internship] hospital was a nice place to be. (Karen, lines 355-356)

Again, this throws up the tension that is present for doctors in relating to professionalism. Karen may also have used this metaphorical device to justify her choice to retreat (and here I continue the metaphor) to the less challenging medical environment of wards where there are no very sick patients. It is safer to avoid the dangers of ‘war’ and concentrate on self-preservation. Professionalism includes a collective agreement among doctors to ensure that everyone has access to necessary medical assistance.46 To use another MEDICINE AS WAR metaphor, Emergency departments and primary care are the *front line* and may, therefore, be

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46 This is usually referred to as the social contract.
difficult, unpredictable and challenging areas. To provide a proficient service wherever they work, doctors must survive and keep themselves healthy so that they are, literally, fit for practice. Karen’s view highlights the tension arising from the notion of altruism as an important part of professionalism (Frederic W. Hafferty, 2002), where the doctor puts the patient first regardless of personal cost. Karen’s conceptualisation of MEDICINE AS WAR gives insight into why she chose not to return to work in the Emergency Department. Thinking of it as a war zone associates it in her mind with the WAR entailments of life-threatening danger from bombs, snipers and machine-guns wielded by enemy soldiers. Within this frame of reference, her own safety is paramount and it becomes appropriate not to put herself at risk. Had she used an alternative MLE, for example calling the Emergency Department a schoolyard, the associated entailments of playground games and bullies as the main dangers would involve a much lower level of risk. For Karen and for others, the option of working in a place like a schoolyard is a much more attractive proposition than working in a war zone. This example demonstrates how metaphorical talk can influence attitudes and behaviours.

A violent MLE additional to those in Table 6.3 is from Julie’s narrative when she explains that the lecturer she describes as “hard” actually helped them with their study:

There was one particular lecturer who we all felt was quite hard. And you know the yearbook was “He stamped all over us with his seven league boots.” But he actually made sure that you sat down and learnt the work and he made you aware of how much detail you actually needed to know. (Julie, lines 105-109)
This ambivalence of crushing a group of students underfoot (metaphorically speaking) for their own benefit is interesting. It is reminiscent of the concept of ‘tough love’, or ‘you have to be cruel to be kind’ and, thinking back to Chapter 5, raises the questions of ‘hero or villain?’ It is also possible that there is a large element of professional socialisation effect underpinning the sentiment. That is, that through being socialised into the medical profession Julie has come to make allowances for the ‘hard’ behaviour because he was also helpful with the students’ study. This pattern of ignoring or even justifying unacceptable behaviour because the person has other desirable qualities or skills is not uncommon in medicine. The classic example is the technically excellent surgeon with poor communication skills for whom it is customary to make allowances. In doing so, the hidden curriculum message is that technical skills are more important than communication skills. In reality both sets of skills are essential (Kao & Reenan, 2006 p218).

**Orders and commands**

There were also some entailments of the MEDICINE AS WAR metaphor using references alluding to the non-consultative, regimented style of the army. Kevin uses the term “orders” to describe the way in which consultants ask junior doctors to assist them: when you’re a junior and ... the senior orders something. (Table 6.3, MLE 39) Here there is a sense of having no choice but to obey the orders given by a senior clinician. Harry uses military metaphorical talk in describing some of the difficulties he found as a junior doctor working in a hospital: Anyhow it’s very hard to know the chain of command. (Table 6.3, MLE 40)

There is a sense of powerlessness in having to obey the orders or commands. The idea of a chain of command leads to the third conceptual metaphor found in the data, that of MEDICINE AS HIERARCHY.
6.4.5 MEDICINE AS HIERARCHY

In my study the hierarchy was within the medical profession and the clinical team rather than simply between assessors and students (Charlotte E. Rees, et al., 2009) or doctors and patients as reported previously (Charlotte E. Rees, et al., 2007).

<table>
<thead>
<tr>
<th>MLEs illustrating MEDICINE AS HIERARCHY metaphor</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. As you get higher up the ladder</td>
<td>Kevin</td>
</tr>
<tr>
<td>42. only once or twice ever to go to a higher authority</td>
<td>Derek</td>
</tr>
<tr>
<td>43. Whether he was reminding me “you’re below me”</td>
<td>Julie</td>
</tr>
<tr>
<td>44. through the hospitals there were different levels of relationship ... The sort of pretty classical senior person is God</td>
<td>Ricky</td>
</tr>
<tr>
<td>45. being stratified into different pecking orders</td>
<td>Harry</td>
</tr>
<tr>
<td>46. in a university teaching hospital it was very hierarchical and egos were large. You knew your place ... We used to say that we were ‘less than the dust on the floor’</td>
<td>Derek</td>
</tr>
<tr>
<td>47. I speak to consultants; they have nothing but respect for a GP and don’t go on about it being a lowly profession.</td>
<td>Helena</td>
</tr>
<tr>
<td>48. different layers of staff and students and physios and OTs and ward assistants etc</td>
<td>Harry</td>
</tr>
</tbody>
</table>

Table 6.4: MLEs illustrating the MEDICINE AS HIERARCHY conceptual metaphor

Dominant positions in the hierarchy are referred to as ‘up’ and ‘high’ as in Kevin’s example, “as you get higher up the ladder” (Table 6.4: MLE 41) and Derek’s “only once or twice ever to go to a higher authority” (Table 6.4: MLE 42). Subordinate roles in the hierarchy are, therefore, ‘down’ or ‘low’. In her narrative about the

47 Abbreviation for occupational therapists
consultant making fun of her in the lift by showing where the top of her head came up to on him, (Chapter 4.9.2), Julie muses “Whether he was reminding me ‘you’re below me’” (Table 6.4, MLE 43). Here she is speaking both literally, as she is physically shorter than he is, and metaphorically, highlighting the hierarchy in medicine. Ricky talks about different levels of relationships within hospitals:

through the hospitals there were different levels of relationship ... The sort of pretty classical senior person is God (Table 6.4, MLE 44)

The entailment of the top level being equated with God makes it clear just how much power there is within the hierarchy of medicine. Harry’s description of different training grades of doctors “being stratified into different pecking orders” (Table 6.4, MLE 45) gives insight into how he views the nature of the hierarchy of the profession. His example of the ‘pecking order’ refers to a social system among poultry where the dominant chicken in a group asserts her authority and thus has first pick at food by pecking the more subordinate chickens to keep them in their place. This double MLE of stratification and pecking order emphasises just how ingrained the conceptual metaphor MEDICINE AS HIERARCHY has become for Harry during his professional socialisation. In talking of his experience as a trainee specialist, Derek makes the notion of hierarchy explicit:

in a university teaching hospital it was very hierarchical and egos were large.

You knew your place (Table 6.4, MLE 46)

Here, size is introduced with ‘large’ equated with dominance and being at the top of the hierarchy. The corollary is, of course, that smaller would be less dominant and have a lower, and thus more subordinate place in the hierarchy. In explaining how he and his student colleagues felt in a teaching hospital, his MLE makes them infinitesimally small: “we used to say that we were less than the dust on the floor”.

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Kevin displays his resistance to the hierarchical dominance of senior doctors over junior doctors when he says:

*A senior person who just says a junior person should shut up and that really makes me angry because we are all together thinking of the best solution for the patient* (Kevin, lines 246-148)

As one of the youngest participants in my study, Kevin displayed recognition that real involvement of junior doctors in patient management teams is recognised as important for the juniors' learning. It is, nevertheless, concerning that the MEDICINE AS HIERARCHY metaphor is strong in my data obtained from doctors qualifying over a thirty-year period.

### 6.4.6 MEDICINE AS MACHINE

The fifth metaphor emerging from the data is that of MEDICINE AS MACHINE. In common parlance machine is commonly used as a source domain for targets such as MIND AS MACHINE (Lakoff & Johnson, 2003, p27) and COMPLEX SYSTEM AS MACHINE (Kovecses, 2010, p156). Examples are shown in Table 6.5.

<table>
<thead>
<tr>
<th>MLEs illustrating MEDICINE AS MACHINE metaphor</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>49. I started to figure out you know what it was that <em>made me tick</em></td>
<td>Gemma</td>
</tr>
<tr>
<td>50. Without really <em>looking underneath at what the dynamics are</em></td>
<td>Harry</td>
</tr>
<tr>
<td>51. that was <em>his mechanism</em> for dealing with it</td>
<td>Alan</td>
</tr>
<tr>
<td>52. this <em>great academic train would move through the wards</em></td>
<td>Derek</td>
</tr>
<tr>
<td>53. I loved the whole hospital thing of us <em>all working</em> – lots of people <em>working</em> – the big hospital <em>system</em> of it all</td>
<td>Lorna</td>
</tr>
<tr>
<td>54. you are very much balancing up the <em>different forces in the system</em> and it has clear parallels to the <em>way a hospital works</em></td>
<td>Roy</td>
</tr>
<tr>
<td>55. how can I make this <em>work a bit better</em>?</td>
<td>Roy</td>
</tr>
</tbody>
</table>

*Table 6.5: MLEs illustrating the MEDICINE AS MACHINE conceptual metaphor*
Metaphorical talk related to the MEDICINE AS MACHINE conceptual metaphor specifically removes emotions and feelings. Gemma referred to herself with the expression: “I started to figure out you know what it was that made me tick” (Table 6.5, MLE 49) This compares the functioning of a living human being to the inanimate workings of a clock or watch. The associated entailments of this particular metaphor are of precision, of constantly moving cogs, an intricate mechanism, of regularity, reliability and rhythm. BODY AS MACHINE is a common conceptual metaphor reported in the literature (Coulehan, 2003; Lakoff, Espenson, & Schwartz, 1991). The body breaks down and the doctor comes to fix it. Harry likens a consultation with a patient to a mechanic troubleshooting with a car when he talks of looking underneath at what the dynamics are (Table 6.5, MLE 50), as if he is the mechanic carefully inspecting under the bonnet of a car to investigate an engine problem. The metaphorical talk draws a parallel with the way doctors probe beneath the surface to make a comprehensive assessment of a patient’s problems. In many of the MLEs in my data the machine source emphasised the mechanistic aspects of medicine. For example, Alan summarises a narrative about a senior colleague lying to a patient over his actions, saying: “that was his mechanism for dealing with it” (Table 6.5, MLE 51). The MEDICINE AS MACHINE metaphor removes emotion from the interaction and makes it sound controlled, ordered and organised in a technological way. Derek gives a vivid example of the metaphor when talking about the teaching hospitals rounds:

so again with the professor and then the senior lecturer and his senior registrar, registrar, resident or senior resident and this great academic train would move through the wards (Table 6.5, MLE 52)

Likening the large group of different grades of doctors following the consultant on the ward round to a great academic train harks back to the MEDICINE AS
JOURNEY metaphor. Because of our common knowledge of trains, the metaphor links other ideas via entailments. The unstoppable nature of a large locomotive, the notion of being fixed on one track, moving fast and of being hard and insensitive like steel are all features. In the case of a train, the engine at the front leads the carriages wherever it goes and at the same speed. The carriages have no choice but to follow the engine in the same way that junior medical staff must follow their consultant. So a rich picture is created through the metaphor helping us, as listeners or readers, to understand the meaning.

**Machine and factories**

Several MLEs involve the concept of machines working together within a system which, in turn, may function smoothly or not, depending on the forces applied.

In my data there were references to the ‘system’ in medicine. For example:

> I loved the whole hospital thing of us *all working* – lots of people *working* – the big hospital *system* of it all (Table 6.5, MLE 53)

Lorna’s MLE entails the large size of a hospital and the numbers of people involved. The word “working” is metaphorical too in the context of a system where it nuances functioning together collaboratively and successfully and not simply performing work or labour. When Roy says:

> you [as doctor] are very much balancing up the *different forces in the system* and it has clear parallels to the way a hospital *works* (Table 6.5, MLE 54)

he acknowledges the complexity of the multi-machine system of health care and the various pressures and forces involved. A new metaphor of HEALTH CARE SYSTEM AS FACTORY would be a possible development of the various entailments of MEDICINE AS MACHINE, but there was no further suggestion of this in my data.
6.4.7 MEDICINE AS SPIRITUAL EXPERIENCE

The final conceptual metaphor emergent from my data is that of MEDICINE AS SPIRITUAL EXPERIENCE. In this context the entailments of the source ‘spirituality’ have ritualistic and religious connotations. I have already placed the metaphorical linguistic expression *senior doctor is God* within the MEDICINE AS HIERARCHY metaphor because it was used in relation to the levels evident within medical hierarchies (Table 6.4, MLE 44). Metaphorically doctors are sometimes thought of as god because of their perceived power over life and death. Since god is a spiritual being the MLE is also an example of MEDICINE AS SPIRITUAL EXPERIENCE metaphor. Other examples are given in Table 6.6.

<table>
<thead>
<tr>
<th>MLEs illustrating MEDICINE AS SPIRITUAL EXPERIENCE metaphor</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>56. people … probably don’t have the faith in doctors that was there forty or even twenty years ago</td>
<td>Julie</td>
</tr>
<tr>
<td>57. Then you have certain <em>iconic</em> [specialists] that I guess you can relate to</td>
<td>Harry</td>
</tr>
<tr>
<td>58. this kind of <em>reverence</em> towards the consultant was good in that I think it was good for patient care</td>
<td>Julie</td>
</tr>
<tr>
<td>59. That they had this <em>aura</em> of knowledge, and that’s pretty good, pretty good for a patient and certainly pretty good for a student to think that their professors know a lot</td>
<td>Helena</td>
</tr>
<tr>
<td>60. you did have to have this sort of <em>initiation phase</em> that you had to prove yourself with predominantly the nursing staff</td>
<td>Molly</td>
</tr>
<tr>
<td>61. the student in the short coat signifying the diminished nature of his knowledge with his half size coat (laughs) whilst everybody had the <em>long white priestly robes</em> of the full white coat</td>
<td>Derek</td>
</tr>
<tr>
<td>62. that were being <em>anointed as golden children</em></td>
<td>Molly</td>
</tr>
<tr>
<td>63. ‘Collegiate’ is the word that comes up again and again because there was a real <em>sisterhood / brotherhood thing</em></td>
<td>Lorna</td>
</tr>
<tr>
<td>64. To leave the <em>hallowed halls</em> of [well established teaching hospitals] and to go to [new hospital].</td>
<td>Molly</td>
</tr>
</tbody>
</table>

Table 6.6: MLEs illustrating the MEDICINE AS SPIRITUAL EXPERIENCE conceptual metaphor
Within this conceptual metaphor the students and trainees are initiates or novices undergoing a spiritual transformation under the supervision of consultants and professors. Julie notes that patients believe in or have faith (Table 6.6, MLE 56) in these senior doctors. The notion of consultants and clinical teachers being iconic or revered (Table 6.6, MLEs 57 & 58) reflects the high regard in which senior doctors are, or would like to be, held, especially by junior doctors and medical students. It also acknowledges the connection between medicine and religion as two of the oldest professions. Entailments of the spirituality metaphor include the consultants having an aura of knowledge (Table 6.6, MLE 59), almost as if it is a magical power, and new interns proving their worth at the start of a new job, especially with nurses:

> you did have to have this sort of *initiation phase* that you had to prove yourself with predominantly the nursing staff. (Table 6.6, MLE 60)

One of the symbols of modern medicine, the white coat, is referred to as priestly robes, again adding a spiritual element to the profession (Table 6.6, MLE 61). Here students and junior doctors are metaphorically the initiates who are ritualistically admitted to the cult of the medical profession by the high priests distinguished by their aura and iconic status. Molly’s MLE narrative, previously discussed in another context in Chapter 4.8.2, suggests that some initiates are specially treated. Metaphorically, they are anointed as golden (Table 6.6, MLE 62), signifying that Molly perceived some of her peers receiving special attention and being highly valued by the anointing consultants. This is at odds with Lorna’s talk of the collegiality of a real sisterhood/brotherhood thing (Table 6.6, MLE 63) where, as junior doctors, they more equally valued as members of a spiritual sect. The wards and lecture theatres in old and well-established teaching hospitals are referred to
as *hallowed halls* (Table 6.6, MLE 64), suggesting the sacred places in which spiritual ceremonies and experiences take place.

### 6.5 Discussion

Six conceptual metaphors for the culture of medicine were identified in this study. These are relevant to my research because the culture of medicine is the learning environment in which professional socialisation, construction of professional identity and understanding of professionalism occur.

Metaphorical thought is unavoidable and ubiquitous (Lakoff & Johnson, 2003 p272); the metaphorical talk used by participants in this study reveals a lengthy process happening within a network of interpersonal relationships, strong emotional forces and organisational mores. Single conceptual metaphors have limited ability to communicate meaning and the multi-layered nature of complex concepts such as professionalism can be more effectively explained using several metaphors (Kimmel, 2010). The six source domains of family, journey, war, hierarchy, machine and spirituality emerging from my data highlight different aspects of the culture of medicine. All of them have influenced the development of professionalism in the study participants.

MEDICINE AS FAMILY, MEDICINE AS JOURNEY and MEDICINE AS WAR are the dominant metaphors in the study. MEDICINE AS HIERARCHY, MEDICINE AS MACHINE and MEDICINE AS SPIRITUAL EXPERIENCE are less dominant but, as I have demonstrated, are still robust across the participants. Different stages of family life are illustrated by the metaphorical expressions shown in Table 6.1. From the very start of life, *cutting the [umbilical] cord* (Table 6.1, MLE 9), through *troublesome infant* (Table 6.1, MLE 2) to childhood (Table 6.1, MLE 8),
sibling relationships (Table 6.1, MLEs 3 and 4), and parenting (Table 6.1, MLEs 7 and 8) the LIFE AS JOURNEY is represented in the metaphors. In the data there is much about doctors caring for each other either as peers or as teachers and supervisors. The journey metaphors are exclusively about travelling and striving to progress often in adverse conditions. None of my participants was retired from medical practice and so the lack of talk about reaching a destination in any of the narratives is unsurprising.

The references to MEDICINE AS JOURNEY were of two main types. Firstly those harking back to early in their medical education when participants were unsure of where they were going, lost (Table 6.2, MLEs 12 & 13), encountering hardships or hazards on the way (Table 6.2, MLEs 17, 18, 19, & 20), or being overburdened (Table 6.2, MLE 22). The second group of ‘journey’ metaphors comes mainly from stories told by the doctors when they are teachers and relate to helping the juniors “get where they need to go” (Table 6.2, MLE 12).

We know from life experience that relationships between parents and children and brothers and sisters are not always harmonious. There may be disputes, disagreements and even feuds. We also know that family ties are strong and that, despite internal rifts, families tend to support each other against outside threats in time of stress. It is a longstanding tenet of professionalism in medicine that colleagues support each other against outside criticism. The perception of closing ranks to protect less scrupulous colleagues is responsible, at least in part, for the increasing public mistrust in doctors, which led to calls for professionalism from both inside and outside the profession across the world. Within the family environment sibling rivalry and family quarrels allow youngsters to develop coping strategies to deal with competition and conflict within a safe environment (Noller, 2005). It is interesting that the war-related metaphorical expressions in the data
are equally about victims and aggressors: feeling wounded; protecting others; or defusing the situation (Table 6.3, MLEs 27, 32 & 36).

The prominence of the MEDICINE AS HIERARCHY metaphor within participants’ narratives (see Table 6.4) suggests that a strong influence from early involvement in a strict medical hierarchy continues to influence senior doctors. In my data the predominant notion of hierarchy is remembered as one in which people were made to feel inferior (Table 6.4, MLEs 43, 46 & 47). One of the effects reported in the literature of a clear hierarchical structure within a large organisation is burgeoning bureaucracy, rampant rules and regulations and a lack of accountability (Ray, 2006). Reframing the metaphor from (unfeeling) organisation to (caring) family may alter perceptions of the devaluing effect of the hierarchy on the professional learning environment.

The MEDICINE AS SPIRITUAL EXPERIENCE conceptual metaphor introduces the sense of ritual to the mix. This is a novel conceptual metaphor in the context of medical practice and professionalism and reflects the traditional idea of doctors being special or extraordinary. Talk of initiation ceremonies retains an element of secrecy and intrigue. The white-coat ceremony indicating a medical student’s entry to the profession at the beginning of medical school, as discussed in section 2.4.4 is a modern example of medical ritual (Huber, 2003). The MEDICINE AS MACHINE conceptual metaphor has been described before as representing the doctor/student relationship (Charlotte E. Rees, et al., 2007) but in my study the metaphor is primarily used in reference to medical organisations, for example, the big hospital system of it all (Table 6.5, MLE 53). The MEDICINE AS MACHINE metaphor represents the technological aspects of medicine. In terms of professionalism this is not enough. The mechanical and technically ‘correct’ relationship is not what patients want in their relationships with medical professionals (Epstein, 2006).
It is striking how much fear, anxiety, violence, dominance, loneliness and other stresses are contained within the metaphors analysed in the study. The first impressions on entering the world of medical education for the participants in this study were, in the main, lonely, stressful and harsh. The support came later, through successful negotiation of adverse conditions and building of relationships with peers or with caring teachers. An awareness of the ubiquity of metaphorical talk and the effect it can have on developing learners is important for all doctors. Newcomers to medicine, hearing the aggressive talk of MEDICINE AS WAR, quickly learn from the metaphorical quality of the terminology. Coulehan points out that even the common phrase ‘taking a history’ has violent connotations as if the ‘history’ is extracted from the patient with some force (Coulehan, 2003). When embedded among other medical metaphors such as “fighting the disease aggressively”, “doing all that it takes to win the battle”, or “not surrendering to the illness”, being gentle or thoughtful or peaceful seems worlds away. For patients, the need for doctors to be caring and display humanity is just as important as their having knowledge and technical expertise (Coulter, 2002) and my metaphorical analysis illustrates how differently the culture of medicine can be depicted, depending on the metaphorical language used in discussion. Heightened awareness of this phenomenon among medical educators is essential if the current culture is to be modified to promote professionalism.

In the next chapter the results of the three studies will be synthesised and implications for medical education discussed. The strengths and limitations of the studies will be explored and recommendations made.
7 Implications and recommendations

7.1 Introduction

In conducting this research I set out to illuminate the process of learning about professionalism in medicine. My aim was to contribute to improvement in the teaching of professionalism to medical students and junior doctors. What I have discovered is that what is learned about professionalism is much more relevant and memorable than what is taught about professionalism. Moreover I discovered that lessons learned about medical professionalism at an impressionable stage, early in or even prior to a medical career, can not only be long-lasting but also continue to influence attitudes and behaviour many years after the original encounter or experience.

In this final chapter of the thesis I bring the results of the three analyses together and discuss the implications of the findings for medical education. The limitations of the study will be discussed along with suggestions for further research in the field before presenting my recommendations and drawing final conclusions.

7.2 Synthesis of findings

The results of all three analyses combine to reveal three dimensions of professionalism relevant to the way in which it is learned about and practised by doctors:
• Individual professionalism closely associated with professional identity development;
• Interpersonal relationships, including the ‘atmosphere’ existing between people as they interact;
• Environmental professionalism produced by the community, or the culture, in which doctors are working, learning and living.

Each of the three analyses contributed to the overall findings and in doing so each acts as a kind of corroboration of the results. When similar results are derived from different analytical methods it adds authenticity and plausibility to interpretation (Clandinin & Connelly, 2000, p189). The thematic analysis revealed that personal identity is closely related to professional identity. The data contain a great deal of talk about events from childhood, often remembered vividly. There is an awareness of the varying individual circumstances of people depending on, for example, family background, school, social status and gender, which all impact on the notion of self. Support from seniors built self-confidence and self-esteem and in doing so helped identity development (Fryers, et al., 2006). In the more sophisticated analysis looking at characterisation of role models this same support was perceived as demonstrating and promoting professionalism. Lack of support and bullying impacted negatively and were portrayed as examples of a lack of professionalism. Sometimes, as in Roy’s story of being berated on his first day as an intern (Roy N 32 in chapter 5.5.2), this was presented not only as an issue of an individual’s want of professionalism but also as a lack of organisational professionalism in the hospital management’s failure to deal with a senior staff member widely known to be functioning poorly.
On deeper exploration, the extent of the range of doctor role models who were influential in passing on the principles of professionalism, both good and bad, to newcomers to medical practice was shown. Heroic qualities in relation to professionalism were embodied by people who are beautiful, kind, daring, clever, capable, enthusiastic, supportive, caring, encouraging and appreciative, while people who were bullying, abusive, exploitative, belittling, excluding, sexist and dishonest were deemed to be lacking in professionalism. Furthermore, the analysis demonstrates that principles and values can be communicated in any interaction a doctor has with another person and that influential impressions are made at all stages of life, including childhood.

My analysis of the metaphorical talk used by participants in relation to the environmental culture of medicine produced six main metaphors for professional life in medicine: MEDICINE AS FAMILY, MEDICINE AS JOURNEY, MEDICINE AS WAR, MEDICINE AS HIERARCHY, MEDICINE AS SPIRITUAL EXPERIENCE and MEDICINE AS MACHINE. These different conceptual metaphors give insight into the myriad of impressions held by doctors and is based on their experience of the medical world. The advantage of metaphorical analysis is that a rich picture of the topic under study is formed through analogies, and comparisons with, other more familiar, areas of life (Kovecses, 2010, p121). In my work, the deeper understanding gained by examining the various metaphors employed by the senior doctors, is about professionalism within the culture of medicine. I use the terms environment, community and culture almost interchangeably to describe the learning environment in which doctors learn how to be medical practitioners.

Three of the six conceptual metaphors used by participants in my study for the environment or culture of medicine echoed notions of harshness and power, but also of encouragement and compassion. War, hierarchy and machine as source
domains bring with them entailments of brutality, suffering and inflexibility. These are balanced by the metaphors using family, spiritual experience and journey, where humanity, empathy and progress towards goals are some of the associated entailments. Just as the hero and villain dichotomy was exposed in the narratives, so are the opposing forces of good and evil. There have been calls for more good role models embodying the highest standards of professionalism to be involved in clinical teaching (Brainard & Brislen, 2007; Maheux, et al., 2000). Much more than virtue among individual tutors is needed. My findings are that the various environments in which doctors learn and work have a powerful influence on professionalism. Anyone wishing to be a successful member of any professional group must adopt the collective values of that group. And once a member of the group, individuals take on a shared responsibility with others in contributing to the embodiment of group values. This is how professional culture develops. Roy learned as a junior doctor that the ‘system’ did not deal with bullies in senior positions, even if they were also risking patients’ lives (Chapter 5.5.2). Helena learned a different lesson when her employing institution took collective responsibility towards her when she made a mistake as a junior doctor (Chapter 5.7). Despite the financial expense of repairing a crematorium wall, the hospital management supported Helena through the experience. Depending on the nature of the culture or environment and the openness within it to discuss such matters, the learning about what professionalism actually is may be very different.

7.3 Discussion

Collectively my three studies show how notions of professionalism are built up over time and through experience. Each study gives more insights on professionalism and how it is learned than the preceding one. I have shown that for senior doctors,
understanding of professionalism is influenced by three main factors: by preconceptions of medicine held from an early age, by the totality of the environment in which learning takes place and by the interpersonal encounters along the way. Influential factors in shaping their understanding of professionalism include observation of and interaction with role models and the process of being socialised into the culture of medicine. Actions really do, it appears, speak louder than words.

### 7.3.1 Importance of Informal and hidden curricula to professionalism

My data and analyses demonstrate that in the majority of narratives learning about professionalism was from the informal or hidden curricula. There was only one mention in the entire study of a lesson about professionalism being learned from the formal medical curriculum. On that one occasion, the lasting learning was not from the long-forgotten formal session, but from the lecturer’s subsequent lapse of professionalism, which students had found highly amusing and which stimulated discussion about hypocrisy and double standards within the teaching faculty (Chapter 4.10.3). In most narratives told to illustrate professionalism, the feelings and emotions inherent in the experience are almost palpable. Some of the good experiences recounted in the narratives were humbling in their simplicity: for example, a few words of encouragement from a consultant (Harry: chapter 4.10.5) and being included as part of a team (Molly: chapter 4.10.5). Similarly, bad experiences ranged from highly traumatic for the participants to being merely uncomfortable. At both ends of the spectrum experiences were influential. The striking finding was the length of time over which memorable exchanges or experiences lasted. Both good and bad experiences from many years, even decades,
previously continued to affect participants both in their current practice and in their teaching of more junior doctors.

### 7.3.2 Teaching the next generation

The study participants are ordinary working clinicians who are involved in teaching medical students and in the training and supervision of junior doctors. The data shows that they were all aware of the impact of charismatic or caring clinical teachers on their own development as junior doctors. During the interview most participants reflected on the way in which memories from their own learning experience influence how they themselves interact with medical students and junior doctors in the present. For example, Lorna muses that she could give words of praise to her juniors so that they could “swell with pride”, just as she had done as an intern (Chapter 5.9, N 22); and Gemma remembers how miserable she felt trying to do the right thing with little support, and now, because of that, consciously encourages her registrars (Chapter 5.9, N121); Narrative methods are highly suited to demonstrating this temporal aspect to experience which is not a usual component of contemporary pedagogy.

### 7.3.3 Gender issues and professionalism

Although the question of whether notions of professionalism are related to gender was not an explicit research focus in this study, many of the narratives were heavily gendered. For the women in my study their professional identity was integral to their identity as a person and their role models were carefully chosen as successful in several aspects of life. They told of actively seeking older female role models from whom they could learn as they successfully managed the combination of family and professional life. By contrast the male participants were able to focus entirely on medicine. None of the male participants talked of the need to consider
identities other than that of ‘doctor’. It was only with female participants that responsibilities outside medicine were obvious: two of the female participants (Molly and Helena) were interviewed at home because they were looking after their children on an afternoon off, and a third (Lorna) had to leave work immediately after the interview to collect her children from childcare. Gemma seamlessly wove talk about her marriage, her four grown-up children and her mother’s long-term illness into the interview. For all of these women the family was just as much an aspect of their identity as their professional identity as a doctor. It is interesting that despite this, it was not only the female participants who employed the MEDICINE AS FAMILY metaphor. Men, and especially the most senior men in the study, used the metaphor often (Table 6.1). This suggests that in the macho and still male-dominated world of medicine men are socialised to consider family as less acceptable for them to discuss openly, unless they are speaking metaphorically.

### 7.3.4 Effects of emotion

In my study, stories about role models and their interactions with patients or others were common and graphic, and the emotions aroused by them highly charged. Even after many years, feelings of all sorts were near the surface as doctors talked about relationships and encounters with role models. Some emotions were good, such as satisfaction with a job well done, the joy of camaraderie or being trusted by a senior colleague. Others were more problematic, for example, anger at unfair treatment, fear of failure and frustration. The ease with which they could bring feelings back to the forefront of consciousness even after many years attests to the powerful effect of emotions within the relationships in medicine. Most studies look at emotions evoked through doctor-patient relationships (Benbassat & Baumal, 2004; Kasman, Fryer-Edwards, & Braddock,
In my study, doctors seen as exhibiting professionalism were associated with fostering good emotions within peer, teaching or patient-doctor relationships and those associated with a lack of professionalism were associated with invoking problematic emotions.

### 7.3.5 Reframing of Professionalism

In the first two minutes of one of the earliest interviews, Molly responded to my request to tell me what professionalism meant to her by saying:

(6)\(^{48}\) I think about (4) an all-pervading theme that goes through your work, that means that over and above any personal concerns, anything else that’s happening in your life, that your approach to your patients is objective, um with their interests at heart. (Molly lines 24-27)

At the time I heard Molly’s answer as being about altruism, clinical competence and patient centred-ness. At the time I was developing my own list of professionalism attributes fundamental to medical practice, similar to the ones I had read about while conducting my literature review and I simply added my interpretation of Molly’s perspective. Now, as I write this final chapter after long immersion in the entirety of my data, three intense analytical studies and much scholarly discussion and debate with others in the field, I have a different view. I believe now that “all-pervading” is the key word in Molly’s sentence and that what we mean by professionalism is the atmosphere or aura which exists around doctors.

\(^{48}\) Denotes a six second pause
This notion was reinforced in Chapter 5, in which the conclusion was that a reframing of the notion of professionalism in modern medicine is needed. The characterisations of role models were imbued with feelings and emotion, adding a very human element to the behaviours and attributes described. The narrative methodology was helpful in exploring the complexity of the characters by attending to context. Heroes were those who took trouble to care about their colleagues as well as their patients: for example, Harry’s “gentlemen consultants” who supported and challenged him (Chapter 5.4.5); and Lorna’s consultant who made sure she was aware when she’d done a good job (Chapter 5.9). Villains were those who demonstrated little regard for other people’s feelings: Roy’s surgical consultant who taunted him in front of the team; Kevin’s boss who scored through his patient management plans with no explanation (Chapter 5.5.3); and Karen’s consultant who vandalised her stethoscope (Chapter 5.5.1) are all examples. There are some stories where a role model is presented as a hero but the behaviour described appears more villainous. What makes the difference is the underlying attitude towards others in the story. When the teacher’s motivation is perceived as supportive and born of a genuine interest in the learner achieving their highest potential, then he or she is more likely to be presented as a hero. Julie gives an example of this in her story about the tough teacher who had high expectations for students and who really helped them study (Chapter 5.6).

7.3.6 Atmospheric professionalism

I was finally convinced of the concept of atmosphere as I listened to the metaphorical talk used by participants as a way of trying to explain the complex nature of professionalism and the ways it is learned and manifested in medicine. Again the notion was holistic and all-encompassing, like the source domains identified: family, war, journey, hierarchy, spiritual experience and machine. The notion of professionalism being in the air of universities and hospitals and not only touching
every activity but being inhaled into an individual’s very being is novel. It takes to a new dimension Castellani and Hafferty’s concept of professionalism as a complex system made up of competing types that operate at personal, interpersonal and organisational levels (Frederic W. Hafferty & Castellani, 2010). Theirs is a convenient structure to express the multiple elements of professionalism which lends itself well to diagrammatic representation. My concept of atmospheric professionalism is one in which the notion is less formed. It is part of us but also all around us, it simultaneously nurtures us and drives us. Metaphorically speaking, atmosphere conveys the notion of something all-enveloping, life-giving or noxious depending on circumstances. A culture of medicine which does not value relationships and feelings is poisonous to the growth of professionalism. And to be without professionalism is to exist in vacuum – mechanical but not human.

7.4 Originality

This project brings several innovative and original ideas to the research community.

7.4.1 Different participant group

Most previous academic studies on professionalism involve medical students or doctors in their first or second postgraduate years. This translates into a focus in the literature on teaching, learning and assessment of professionalism largely at undergraduate level and relatively uninformed by the reality of working in clinical practice. The originality of my research lies in exploring the perspectives of senior doctors. Not only are the participants in my study senior doctors with at least ten years post-medical qualification experience, but they are also all themselves actively involved in the clinical supervision and teaching of medical students and postgraduate doctors on a day-to-day basis.
7.4.2 Novel methodological approach

The narrative approach using interpretive methodology underpinned by a symbolic interactionist theoretical position within a sociocultural framework is innovative. Symbolic interactionism (SI) is based on three premises: that we know about things through their meanings; that meanings are created through social interaction and that meanings change through social interaction (Fine, 1993). In a chequered history SI has been charged with taking both micro and macro sociological perspectives. It is agreed, however, that SI is about the creation of collective meaning and the connection between authority within organisations or groups and individual identity (Dennis & Martin, 2005). This theoretical perspective was for me a useful lens through which to view the process of individual professional development within the culture of medicine. The SI lens has focused on the power differential inherent in the tutor/student or supervisor/trainee relationship and its impact on effective lifelong learning. It has enabled me to ponder on ways in which to improve professionalism through the relationships which are so crucial to its development.

7.4.3 Innovative methods

Making use of video to examine visual cues arising during interviews to enhance interpretation is a further original aspect of my work. Video is increasingly, though still not commonly, used in research looking at doctor-patient consultations (Henry, Forman, & Fetters, 2011; Mjaaland, Finset, Jensen, & Gulbrandsen, 2011) or healthcare team interactions (Carroll, Iedema, & Kerridge, 2008). There is little reporting of video-data being used in the analysis of narrative interviews. I would argue that relying exclusively on audio recording of interviews in interpretive research risks missing nuances in the data. Even at a very basic level, looking at video enhances the accuracy of my transcription. This has been shown to be an issue especially when
someone other than the interviewer transcribes (Elliot G Mishler, 1991, p50). Human interaction is complex and keen observation of the non-verbal cues people exhibit as they talk is an important part of communication (Mehrabian, 2007). Complex scoring systems have been developed to try to analyse facial expressions and gestures (Knapp & Harrison, 1972), but these are labour-intensive to record and of dubious utility. In the spirit of narrative analysis I chose to marry the visual images of participants with their stories to enhance the meaning. I annotated my transcripts with notes on body movements, facial expressions and gestures observed through watching the video. Sitting up straight, looking directly at the camera and becoming more animated were all found to indicate a strong statement being made. It was also helpful to see what was happening during silences. For example, on most occasions the participant can be seen looking pensive before going on to talk further, but in one interview the silence occurs because the doctor gets up to close the door before telling a story he clearly felt was confidential. Thus video use was helpful in interpretation and it is a method which should be explored and developed further in future.

7.4.4 Multiple analyses on the same data

Another unusual aspect of my research is that three separate analyses were conducted on the same data. This multiple analytical method evolved as part of the iteration of my qualitative research process. Each of the three studies looked at a different facet of professionalism that came together to give a rich picture of the phenomenon. This re-interrogation of the data using a different lens gave a rich and multidimensional picture of professionalism. The discovery of similar nuances served to support findings and strengthen them. This is necessary in studies where different facets of social action and culture are actively sought (Atkinson & Delamont, 2008, p288).
7.4.5 Limitations of the study

The study was conducted within one state of Australia with participants from a variety of medical training settings in the Eurocentric developed world. It would be helpful to repeat the study with doctors trained in the United States or in developing countries to ascertain differences from my findings.

All participants were volunteers already interested in the topic of educating for professionalism and willing to talk about it. This may not represent all doctors, in particular those who are unreflective (Frederic W. Hafferty & Castellani, 2010) and who tend to accept the status quo. In qualitative research where deeper understanding of a topic is sought, it is most helpful to collect data from people who are likely to be involved in, or knowledgeable about, the topic, or both (Silverman, 2005, p129). This means that my findings are likely to be more meaningful as they are based on data from doctors who are genuinely interested in, and value professionalism. It would be interesting, in a future study, to elicit narratives from doctors who have been identified as poor role models or have displayed behaviour considered unprofessional by patients or by their peers. One way of obtaining such data would be as part of a professional support program to help these doctors reach the standards of professionalism required by training institutions, registration bodies and, of course, the public.

7.5 Implications

The implications of my research cover the continuum of medical education from beginning to end of practising life. I regard this as justified because of the seniority of my participants and because my data show that early learning experiences have a long-term and continuing impact. Medicine is a vocation in which caring and compassion are fundamental. My findings are that senior doctors regard care and
compassion towards others as a major component of professionalism. Knowledge, technical skills, ethical practice were taken as given in that everyone had attained an adequate standard.

7.5.1 The importance of the way doctors are treated in training

My study shows that doctors are no different from other people in their need for emotional support. The nature of interactions with role models and, in particular, the feelings aroused are influential in the development of professionalism in doctors. The way in which medical students and doctors are treated gives them a very tangible idea of the nature of the profession they are entering. Every one of the participants in my study included comments about their emotions in the professionalism-related narratives they told. It is commonly asserted in the existing literature that the conflict over professionalism for medical students and doctors in specialty training is the result of a mismatch between what they learn in the classroom and what they see at the bedside, together with their lack of power within the hierarchical structure of medicine (Rosenbaum, et al., 2004; White, et al., 2009). Coulehan and William argue that conflict arises from the difference between the explicit values, including empathy, compassion and altruism, expounded by the profession of medicine and the more tacit, but obvious, commitment to an ethic of detachment, self-interest and objectivity (Coulehan & Williams, 2003). My research shows that doctors at all stages of their career are treated well in some situations and badly in others. Stories about heroes and villains were equally told, but villain stories were more common in the more senior years suggesting that with experience participants become better at recognising lapses in professionalism. This somewhat unpredictable mix of virtuous and villainous ‘professionalism’ is hard for them to reconcile with the noble expectations they have of themselves and which society has of doctors. In Australia in my experience, it is still the norm for university medical schools to value highly the biomedical model of
medicine and to undervalue the psychosocial aspects of healthcare. This can also be
the case in the health service within the specialty training of doctors, as can be seen
from the experiences of my participants. Training doctors of the future with objectivity
and a lack of humanity makes little sense if they are expected to be warm and caring
towards others, including patients. As my research shows treating people with respect,
encouragement and genuine caring within a supportive environment is not only seen
as exemplifying professionalism, it provides a formative hidden curriculum promoting
and valuing these same qualities and values. Treating medical students or doctors in
training with contempt or engendering fear produces a hostile, uncaring environment
consistent with an entirely technical view of medicine and one in which emotional
detachment is seen as necessary for competence (Coulehan & Williams, 2003).

7.5.2 Doctors remember how they were treated for a long time

A striking finding in my study is the length of time over which instances of both kind
and encouraging and rude or abusive treatment were remembered. A cross word from
as senior role model can be a devastating experience which lives on in the memory for
years bringing distress each time it is recalled (e.g. Roy N32, Derek, N103, Harry
N114). A kind word of encouragement similarly lives on and continues to inspire those
who hear it (e.g. Lorna N 17, Gemma lines 247-253, Harry N112).

Almost all participants admitted that they still felt upset or angry when they recalled
instances of what they had considered unfair or harsh treatment, either towards
themselves or towards others. Even after many years emotions are remembered with
intensity. The persistence of strong memories for a long time suggests that the
emotional impact at the time was substantial, and that learning came at some cost.
Boud describes “attending to feelings” as an essential step in reflecting on, and hence
learning from, experience (Boud, 1985). In a busy clinical area paying the necessary
attention to feelings presents a challenge and may be simply forgotten. Several participants in my study appeared to find therapeutic the opportunity to talk about the experiences they had bottled up for years as they had not had the chance to discuss their reflections with others in the profession before. Feelings not attended to, Boud suggests, act as barriers to learning (Boud, 1985) and it is reasonable to assume this applies to knowledge and skills as well as to professionalism.

7.5.3 Learning from the Informal curriculum how to treat others

Most participants in the study talked about recalling their own experience as medical students and learners when engaged in their own teaching practice. Virtually all doctors in large hospitals are involved in teaching to some extent and with the current expansion of clinical teaching to a wider range of healthcare settings, more will be involved in future. This means that there are almost infinite ways in which doctors in training and beyond can be affected by the informal curriculum of the professional atmosphere. Like Helena’s hero who remembered her name, the action may be very small but the effect enormous. Because Helena remembers how important it was to her that a senior teacher knew her name, she tries to do the same in her own teaching. Some informal curriculum lessons may not be so obvious. A common practice in many hospitals is to use a kind of code so that patients are not aware of what is being spoken about. “Mrs Brown needs attention” was a code for “It’s time for a cup of tea” when I was a junior doctor. At the time I thought it was harmless fun, but later I realised that the subliminal message was that it was acceptable to mislead patients and keep up a façade of doctors selflessly working all the time. It was a deception to keep doctors looking good, but it eroded the trust and mutual respect needed for a good doctor-patient relationship. It was arrogant of us, and somewhat disrespectful, to think that patients didn’t see through the ruse, particularly when we returned twenty minutes later looking revitalised. While this seems a small issue in comparison to death and
serious morbidity, such apparently harmless habits can unwittingly set a precedent. Simply relying on every doctor to know where the line is drawn in deciding when it is and is not acceptable to lie to patients is risky. “Professionalism must be taught” (S. R. Cruess & R. L. Cruess, 1997) is the rallying cry responsible for formal curricular material on medical ethics and on worthy behaviours. But although it is desirable that doctors be able to identify maleficence and beneficence and know about the ethical and moral principles underlying medical practice, it is equally important that they have a consistent message from colleagues and from training organisations (e.g., university medical schools, teaching hospitals, specialty Colleges). Alan admitted in one narrative that he had a sneaking admiration for the quick-thinking doctor who not only lied to his patient about his intention to leave a swab inside a wound, but also had no qualms about making her look foolish (Chapter 5.5.5). Almost forty years on, he tells the story as an example of the way it was customary for doctors to cover up mistakes. Alan goes on to talk about how, in his view, things have changed, giving the example of open disclosure as a mark of professionalism in contemporary medicine. I think he, along with a large proportion of the profession, assumes too much. There is current literature about ethical conflicts felt by junior doctors over telling the truth, preventing harm and addressing the performance of others (Rosenbaum, et al., 2004). Being honest is fundamental to a strong bond of professionalism between physician and patient and also to the relationship between colleagues. The time has come for the medical profession to be honest with itself. Transparency and honesty are needed in order to raise standards of professionalism throughout the medical world where the explicit values taught in the classroom are frequently diametrically opposed to the implicit values put into practice (Brainard & Brislen, 2007). By abiding by a policy of honesty in interactions with patients, with colleagues and with students, doctors can foster a culture of trust where they can admit their fallibility and other human frailties
and in which genuine care and compassion can flourish. In such an environment tea-
breaks for tired doctors would be well tolerated.

7.6 Recommendations

I will start with general principles and then elaborate on each more specifically
with practical suggestions and recommendations. These are intended primarily for
all doctors who work with medical students or postgraduate trainees, for medical
schools and for senior management of all clinical training facilities. They will also I
hope be of interest to all stakeholders who have an interest in the outcomes of
medical education.

7.6.1 General

• An expectation that all doctors do their best for their fellow human beings
  as members of a broader team of healthcare professionals.

• Raising the profile of and acknowledging that professionalism is
  fundamental to medical practice and as essential as medical knowledge and
  technical skill.

• A reframing of the notion of professionalism from a list of anonymous
  attributes and attributes within a complex system to that of a dynamic force
  for good evident in the highest standard of medical practice.

• A shift from the notion that professionalism is taught to a realisation that
  professionalism is learned through interaction with good doctors and
  through experience of effective and caring healthcare organisations.

• A change in the culture of medicine to one that acknowledges the
  importance of emotions and feelings to the health and wellbeing of
  everyone whether they be patient or health professional.
• Acknowledgement that it is the prevailing culture of medicine that provides the content of the informal and hidden curricula and all doctors play a part in creating that culture.

7.6.2 Specific recommendations and practical suggestions

What follows are practical suggestions based on my research findings to actively implement the changes necessary to promote professionalism in medicine. Specific recommendations are made under each of the general headings given above.

Expectation that all doctors do their best for their fellow human beings

This may sound naïve to some but a desire to help others is the primary motivation for most people to embark on a medical career. Currently idealism in students is gradually worn down during medical training at both undergraduate and postgraduate levels (C. H. Griffith, 3rd & Wilson, 2001);(C. H. Griffith & Wilson, 2003). Making the expectation explicit at key points during the education and training process and providing role models who exemplify this in practice is essential.

Raising the profile of professionalism

It is important to introduce explicit discussion about the concept of patient-centredness early in medical courses to show newcomers just how fundamental it is. In addition I recommend that discussion of professionalism be included in all faculty development programs and in supervisor training through professional Colleges. If nothing else these people must be made aware that careless comments from senior doctors can be very damaging as well as very inspiring. Some of the narratives from this thesis provide authentic case studies to illustrate this and could be used to promote discussion and convince the sceptical. Reflection by
group members on their own early experiences of professionalism through storytelling could then lead, with the help of a skilled facilitator, to development of strategies to create a supportive and productive atmosphere of professionalism.

**Reframing and professing professionalism**

My research has given me a broad view of professionalism as a dynamic, collaborative process to achieve excellence in holistic patient care in an atmosphere of sensitivity and compassion; an ambience where colleagues support each other rather than compete. I am talking about an ethos, a philosophy or an environment within which people are cared for and partnerships exist in place of power struggles. What is needed is real integration of professionalism, not just to lessons but to the entire medical education ambience.

**Professionalism is learned not taught**

The powerful influence of experiential learning is well known and my research has shown how doctors in training are influenced by the way they are treated, not just by role model doctors but by training organisations. The culture of the healthcare training environment is influential in conveying the organisation’s philosophy towards healthcare and in turn towards patients and staff. Medical schools and teaching hospitals must pay specific attention to creating a learning environment where aspects of professionalism are demonstrated by clinical teachers and role models as well as encouraged in trainees. Appreciation and support of students has been shown to be important for nurses (Papp, Markkanen, & von Bonsdorff, 2003) and there is no reason to assume that trainee doctors are different. Learning in the clinical environment is a social process (Tim Dornan, Hadfield, Brown, Boshuizen, & Scherpbier, 2005) and treating each other well is fundamental to the development of a culture where care, compassion and sensitivity to others underpins excellence in the more scientific aspects of patient care. There are both
individual and institutional responsibilities to creating such an environment. Medical educators and medical education institutions must collaborate to ensure that only the highest standards of integrity and professionalism are exhibited at all times. This involves everyone and all procedures, administrative, medical or otherwise. A recent study showed that lack of feedback on performance by supervisors remains a significant source of stress to junior doctors (Ochsmann, Lang, Drexler, & Schmid, 2011). It is clear from my data that even small supportive comments are remembered for many years and this is crucial information for tutors, supervisors and any doctor who is a role model. As shown by my study doctors do not always realise that the words they say, their behaviour and their attitudes are influential on the next generation. An atmosphere of professionalism is necessary to provide the culture within which experiential learning can be most effective.

A people-centred approach to staff throughout medical schools and healthcare settings: everyone including reception and administrative staff in addition to academic, medical, nursing and allied health staff must be people-centred in all interpersonal interactions. For example, all personal or telephone interactions should be courteous, respectful and clear; written communication sent out from the institution shows professionalism by being helpful and polite; content should be accurate. Organisational professionalism is demonstrated by attention to detail. Patients, new staff and visitors should be made to feel welcome and a secure, supportive and caring environment should be fostered at all times. Even something as apparently simple as clear and helpful signage can demonstrate care for others and is a key component of professionalism. Reception staff and other staff who may be approached for assistance must be helpful and kind – not a word often associated with modern healthcare. Facilities being clean, tidy and well resourced;
respect for others shown by being courteous, punctual and honest, are all simple ways in which organisations can demonstrate that they take professionalism seriously.

**Wellbeing – emotions, feelings and individuality**

The importance of wellbeing to doctors as well as to patients needs to be clearly understood. As members of a caring profession doctors must value each other more and dispel the notion that they are in some way immune to the need for emotional support. This is especially important in view of the increasing complexity of medicine. In my data much of the mutual support stemmed from the long hours spent in hospitals together when social bonds were forged which were helpful in times of adversity.

The importance of support of peers not only at the student stage but on into medical practice is highly evident in my data. All of my participants graduated before the reduced hours working week for doctors was introduced. There is concern that fewer hours impacts negatively on learning for doctors in training by significantly reducing the time spent with patients (Elbadrawy, Majoko, & Gasson, 2008; Lancashire, Hore, & Fassett, 2009). The place of collegial relationships in surviving the travails of medicine was elucidated in the MEDICINE AS FAMILY metaphor, emphasising the strength and nature of the bonds during long hours spent working together. Such connections are less likely to be formed in the new shift systems that ensure shorter working hours with the aim of reduction in fatigue and also in medical errors. My study suggests that fragmentation of the social network of large hospitals will be detrimental to doctors by reducing a major source of support when they may have to cope with adversity in their work.
A change in culture

My research shows a culture of medicine which is tough, sometimes supportive and sometimes adverse. Without an opportunity to discuss the contextual complexities in a supportive environment this duality can have a long lasting effect on doctors. My study also shows that the way in which individual doctors act and the values they profess are strong influences on the perceptions of the meaning of professionalism and contribute to the culture of professionalism within medicine. Every doctor, therefore, must take responsibility for embodying professionalism in its widest meaning (Chapter 4.11.1). At a practical level this responsibility needs to be explicitly addressed with all faculty involved in student and trainee education.

Two particular aspects of medical culture that need attention are sexism and elitism. For the participants in my study, elitism was prominent and although gender issues were raised, sexism was not spoken of explicitly. My contention is that it was subsumed in an elitist culture where women were simply regarded as second rate.

There are currently equal numbers of men and women entering medicine in Australia. Despite this, male values such as competitiveness, strength and aggression dominate the culture to such an extent that female values such as nurture, conciliation and collaboration disappear, giving rise to the term ‘andronormative’ to describe the nature of medicine (Holge-Hazelton & Malterud, 2009). There is evidence that male and female doctors bring different attitudes and values to the profession (L. Cooke & Hutchinson, 2001; Holge-Hazelton & Malterud, 2009) and that patients are more satisfied with women doctors (Lagro-Janssen, 2008). Men and women are different and this applies to doctors just as much as it does to the rest of the population. Professionalism requires that this be acknowledged so that patients can have the gender-sensitive management they
need. The female participants in my study were acutely aware of their gender as an 
integral part of their identity. They did not have separate identities of ‘woman’ and 
‘doctor’ but rather the identities merge to form one of ‘woman doctor’. This notion 
of intersectionality (Tsouroufli, et al., 2011), the recognition that the overlap of 
identities affects how life, in this case medicine, is perceived has influenced my 
analyses and discussion. My recommendation is that appropriate consideration be 
given to doctors of both sexes over gender-related issues. Currently popular ways 
to do this are to provide flexibility in working hours and increased part-time 
working opportunities for those with child care or carer responsibilities. Taking 
advantage of such schemes however reduces promotion success. Those who 
continue on their career trajectories are usually men and are known to undervalue 
the importance of gender issues in medicine (Risberg, Johansson, & Hamberg, 
2011). A more equitable attitude towards the gender difference and its value to 
medical practice must be made apparent to the men and women embarking on 
medicine. This requires a change in the culture of medicine from the current but 
out-dated culture of male domination. This will not be easy to achieve, but is an 
important part of the more general culture change to one in which individuals are 
valued and treated with care and respect.

7.7 Conclusion

In the clinical setting doctors are increasingly immersed as legitimate peripheral 
participants (Lave & Wenger, 1991) in a harsh world where there is no time for 
caring interpersonal relationships in the rush for efficiency and meeting key 
performance indicators. The idealistic view of medicine held by students entering 
medical school is still considered naïve and an objective formal curriculum focuses 
on the application of knowledge and skills in a digitally run environment.
Evidence-based medicine is a dominant force for doctors currently and in comparison to its objectivity, certainty and hard facts, the concept of professionalism is ‘soft’ and imprecise.

Professionalism is demonstrated through the actions of doctors whose behaviour is profoundly influenced by the particular culture of medicine to which they are exposed as they study and work. In particular the way doctors and other health professionals are treated in their formative years has a long-lasting effect. A hostile, bullying and hierarchical environment encourages development of anger, frustration and fear. A caring, supportive, challenging and just environment encourages the development of competence and compassion and a caring professionalism in doctors. If we cannot look out for each other as doctors, how can we do so to the extent needed to provide a caring and compassionate health service for patients?
Epilogue

We are complicit in the world we study. Being in this world, we need to remake ourselves as well as offer up our research understandings that could lead to a better world (Clandinin, 2000, p 61).

My research is about the way in which doctors in training learn about the meaning of professionalism from those around them. In the prologue to this thesis I outlined the motivation for the research and the personal and professional qualities that I brought to the task. Now, having completed the project I am aware that the whole process has changed the way I think about life in general and medicine in particular. In these last few pages I reflect on how the research effort has affected me and what I have learned from the experience.

Combining PhD study with full-time academic work has undoubtedly been a challenge and I have to admit to periods of self-doubt, even tears, especially in the middle years. More frequently though, I have delighted in immersing myself in the topic and developing the new skills needed to enable me to answer my research questions. I have learned an enormous amount about the research process but I am also inspired to continue research in this field, especially in partnership with others.

Research process

I look back on my research journal and wonder at the naivety of my thinking in the beginning. At the start of the project I was tentative about my hypothesis that emotions and feelings were relevant to the understanding of professionalism. I was eager to acquire skills in qualitative methods but at the same time nervous that I may be unable to sustain the momentum to carry out a significant piece of
research. My fears dissipated as I engaged with other qualitative researchers who opened up a whole new world to me and were generous in sharing their expertise. Once embarked on my research journey I gradually gained confidence in my ability to embrace the exploration. As my study progressed I felt renewed enthusiasm to bring my findings to the medical education community. The senior doctors I spoke with recounted experiences that, although different from my own, had made a deep impression on them similar to the effect I had felt. Furthermore, these influences remained with them impacting their thoughts and actions years later. As I transcribed my interviews I could sense how rich the content was and I felt I owed it to my participants to delve into the data more deeply. This spurred me on to learn to employ more sophisticated methods of analysis to make the most of every ounce of meaning and I believe that I have achieved that aim in this thesis.

Reflections

Having immersed myself in my research for six years I find that I am even more highly attuned to the way people speak and act. I see that there are many interpretations of every interpersonal interaction depending on the innate qualities of the people involved and their previous experience. I have described an atmosphere of professionalism, intangible but, at the same time, palpably present when people are together. Perhaps it is related to the notion of ‘chemistry’ between people or of the ‘vibe’ in any given situation. Whatever the atmosphere of professionalism is, it appears to have a positive effect when it is good and a negative effect when it is bad.

In the Prologue I told two stories, both about occasions when I felt ashamed that members of my profession seemed unable or unwilling to feel for fellow human
beings. Now, at this point in my research journey, I have a better understanding of what may have been happening. In Mrs Campbell’s case, the Professor and the registrars coming to examine the very breathless and ill Mrs Campbell were treating her, not as person, but as a malfunctioning machine. They employed the MEDICINE AS MACHINE metaphor and simply forgot that she was a warm, living person with emotions and feelings. Rather they treated her like an inanimate, insensitive engine waiting to be fixed. Had they employed another metaphor, for example, MEDICINE AS FAMILY their perception of Mrs Campbell may have been as a person in need of help and their resultant behaviour and interpersonal interaction with her is likely to have been very different from what actually transpired.

My second prologue story where a young doctor dismissed patients from a poor background as unworthy of a new medical centre with pleasant surroundings suggests the MEDICINE AS HIERARCHY metaphor. When strong hierarchies exist within the profession itself it is easy for attitudes of superiority to flourish. As shown in Chapter 5, in such an environment villains and bullying thrive. From what I now know from my research I suspect that young doctor had been acculturated to see himself as part of a medical hierarchy where some people are better than others and competition abounds. That young doctor was not inherently villainous and neither was Mrs Campbell’s Professor. But they were certainly not heroes. They were self-centred and unreflective displaying little or no empathy and a definite lack of professionalism. Both were, I would argue, products of a medical education system which puts little value on relationships. The emotional dissociation from patients ostensibly to maintain objectivity in assessment and management is a myth perpetuated in a predominantly scientific milieu where emotions and feelings are seen as sign of weakness.
The state of medical professionalism in Australia

For the duration of this research I have, by necessity, considered and reflected upon my findings in the context of my everyday work in a large clinical teaching facility of an Australian medical school. This includes discussions with students and clinical teachers and observations of interactions in meetings, teaching sessions and during clinical exams. Despite an extensive academic literature on the topic, professionalism is still largely considered a non-essential luxury in the education of medical students and trainee doctors by most hospital doctors. Beyond medical ethics there is little grasp of the importance of relationships within medicine. With the exception of an enthusiastic few professionalism, in the broad sense, is considered a soft subject. By contrast, less emotionally charged subjects such as surgery, therapeutics and pathophysiology are considered essential in the objective, evidence-based world of medicine. One major exception is the discipline of Primary Care Medicine, a specialty where the doctors who practise understand the importance of relationships to good medical practice. Primary care is also referred to as ‘Family Medicine’ emphasising perhaps an unwitting move towards a different metaphorical framework. It is through my own specialist training in primary care and my long clinical experience in that area of medicine that I was drawn to this type of research. Among my participants it was not only the general practitioners who had pondered long and hard about professionalism. Every doctor in my study was committed to improving professionalism but it was only through discussing the elements of the concept and looking back at their own journey that they could see the link between the way they were treated as novice doctors and their own perceptions of professionalism. My work has shown that the emotional tone of interpersonal relationships is fundamental to the nature of the atmosphere within a working or learning environment. As the stories told by the participants in
my study show, the emotional atmosphere of an experience is a significant component and this is highly relevant to the notions of professionalism gained from the informal and hidden curriculum. Increasing the numbers of medical students as has occurred dramatically in Australia in recent years means less potential to build the supportive relationships which the participants in my study relied on to get them through tough times. Shift work means that junior doctors in training no longer live on the premises spending leisure as well as work time together. As workplaces become ever busier there is less time for the human aspects of relationships either with patients or with colleagues. A friendly chat over a cup of tea with an exhausted and overwrought colleague who has spent hours dealing with multiple victims of a road traffic accident, including a teenage fatality, is considered a wasteful inefficiency; a kind word with a stroke patient’s worried family is low priority in comparison with increasing bed occupancy rates and achieving key performance indicators. Colleagues vie against each other for promotion, research grants and compete for patients. We are in danger of losing the humanity from medicine unless the next generation of doctors is alerted to the risk and reasserts caring, compassion and an atmosphere of true professionalism as fundamental to medical practice. I agree wholeheartedly with Cruess and Cruess that “Professionalism must be taught” (Cruess & Cruess 1997) but the formal curriculum is not the place. It is the throwaway remarks, the actions and the professional atmosphere within the relationships of all doctors which create the informal curriculum and the culture of medicine where the meaning of professionalism is learned. We need a balance between the science and the art of medicine. My hope is that the work reported in this thesis can assist in achieving that balance and in moving ever further towards phronesis.
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Participant Information

Introduction
You are invited to take part in a research study which will investigate the factors influencing development of professional behaviour in junior doctors. The aim of the research is to unravel the complexity of the many different educational influences on doctors’ professional behaviour in order to tease out those which have most impact generally. The study is being conducted within this institution by Dr Kirsty Foster, Medical Educator, Women and Babies, and PhD Candidate at the Centre for Innovation in Professional Health Education and Research, University of Sydney. The research will be carried out under the supervision of A/Prof Chris Roberts and Dr Patricia Lyon.

Study Procedures
If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to arrange a mutually convenient time to be interviewed for about 60 minutes about your own early clinical experience. The interview will be audio and video recorded for purposes of analysis.

Voluntary Participation
Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

Confidentiality
All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to the data. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Further Information
When you have read this information, Kirsty Foster will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on 02 9515 6778 or 02 9536 7211.

This information sheet is for you to keep.

Ethics Approval
This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Secretary on 02 9515 6766 and quote protocol number X06-0094.

Version No.: 2
Date: 18 May 2006
Recruitment Notice

The University of Sydney
NSW 2006 AUSTRALIA

Centre for Innovation in Professional Health Education and Research
Faculty of Medicine

Recruitment

Exploration of the factors influencing development of professional behaviour in doctors study

Doctors needed – for interview.

Dr Kirsty Foster, Medical Educator in RPA Women and Babies, is undertaking research looking at early clinical experiences and their influence on the development of professional behaviour in doctors. This work is for a PhD in Medical Education at the Centre for Innovation in Professional Health Education, University of Sydney and is supervised by A/Professor Chris Roberts and Dr Patricia Lyon.

In the first phase of the study, doctors who have been in practice for at least ten years are invited to talk to Kirsty about their early experience as a doctor. This interview will take around 1 – 1.5 hours and take place at a mutually convenient location. Audio and video recordings will be made for analysis purposes only and transcripts of interviews will be checked with participants.

Only the principal investigator will know the identity of participants and confidentiality is assured. In any publications resulting from the study all data will, of course, be deidentified.

If you are interested in taking part please contact Kirsty Foster, 9515 6778, pager 80600 or email kirstyf@med.usyd.edu.au
Exploration of the factors influencing development of professional behaviour in doctors study

Semi structured interview guide

After settling participant start with general warm up question to orientate to the topic the following questions indicate the topics which will be covered:

1. Tell me what ‘professionalism’ means to you as a doctor.
2. Describe some of your early impressions of the medical profession from your clinical training.
3. What can you remember of the hospital culture?
4. Were there any people who made a particular impression on you at that stage in your career?
5. Can you recall any particular events during your training which made you think about professional issues?

Each of these will be explored in detail looking at the relationship to participant, characteristics which made them memorable, any particular events etc in detail.

Each of these will be explored to discuss context, other people involved, and how the participant felt about them.
6 Did you enjoy your clinical training? What aspects did you enjoy / not enjoy?

7 Do you think these experiences influenced your own behaviour as a doctor?

8 If so, how?

9 Were there any other influences on your own development as a young professional which you think would be relevant to this study?

Depending on the response to each question the interviewer will explore the answer in more depth and take any leads which emerge.