Becoming Doctors: the formation of professional identity in newly qualified doctors

Dr Deborah Gill

MBBS MRCGP MMEd FHEA

Institute of Education, University of London

Submitted in part fulfilment of the requirements of the degree of

Doctor of Education

April 2013

Supervisor: Professor David Guile, Institute of Education, University of London.

Abstract

This enquiry concerns the professional identities of newly qualified doctors, exploring how early years practitioners form their sense of self-as-doctor and the structural, educational, social and personal influences on this formation.

With identity formation and professional development framed as situated, socio-cultural and developed within and through practice as an iterative process of becoming, this qualitative study, conducted in the interpretivist tradition, uses life-history interviews and brief periods of observation with recently qualified doctors. It reveals that new doctors begin to establish their professional identities through the interlinked processes of learning, belonging and becoming. Developing professional competencies, learning 'medicine' and a re-contextualisation of existing knowledge allows them to 'figure' who they are and what is expected of them. Belonging, although always partial, affects not only what can be made of experiences but also what can be carried forward. Becoming orientated to being a 'good doctor' has both outward-facing and personal aspects and is stimulated by responsibility, influenced by the personal history and planned trajectory of the doctor and the affordances of workplaces and delayed by the fragmented nature of the early years of work. Much of this learning, attempting to belong and to become a good doctor is not directed at their eventual doctor role but at the here and now.

This work provides telling insights into the socio-cultural dimension of becoming a doctor and the potential effects of recent workplace and education reform on identity, professional formation and ultimately, practice. It provides ways of theorising how medical professional identities develop, questioning notions of a simple novice to expert trajectory and suggesting novice doctors maintain a legitimately peripheral period of participation in their communities during the early years of work. Both pedagogical approaches in medical education and the conceptualisation of the medical workplace as a site of learning and formation would benefit from review in light of these findings.

I hereby declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own.

Dr Deborah Gill, April 2013

Word count *(exclusive of abstract, titles, appendices, references and EdD Statement)*: 44,996 words.

Contents

List of figures and tables

Becoming Doctors: the formation of professional identity in newly qualified doctors

Overview statement of the Ed D Programme

This thesis forms part of a professional doctorate and this chapter aims to provide a reflection on the Ed D journey as a whole: identifying what I have learned during the course of programme and highlighting the links between this learning and my professional and academic development.

Over the last six years I have used the analogy of a journey in many conversations with my fellow Ed D students, with professional colleagues, in supervision meetings and in previous reflective documents prepared for my annual review and the submission of my portfolio at the end of my second year of study. In this chapter I build on this notion of a journey and attempt to highlight the transformative impact of the experience: and how the journey has provided not only a series of learning opportunities but a new way of seeing the world:

"One's destination is never a place, but a new way of seeing things."

Henry Miller, US Author – 1891-1980

Starting the journey: Summer and Autumn 2006

The journey towards achieving a higher degree had been many years in the planning but 2006 saw a unique set of personal and professional circumstances that made the journey at this time a possibility rather than a pipe dream. Coming to the Ed D from a 'scientific' background and then being immersed in the rich and complex world of thinking and studying from a social sciences perspective was exciting, enlightening, terrifying and frustrating in equal measures. I very quickly realised that my research, scholarship and practice to date had been rather pragmatic and superficial and that I lacked the theoretical and analytical tools to be able to use education theory and research to ground my work as I embarked on the Ed D.

The first module of study was the most unsettling for a number of reasons. I was returning at the age of forty to being a learner again and I was squeezing in a very demanding course of study into a very busy and demanding personal and professional life. The subject matter was conceptual and contested, the literature was in a language and style that was wholly

unfamiliar and used theoretical concepts and methods that were quite foreign. Most disturbingly I began to question my previous securely held world view as an education academic with good understanding of the field. The architecture holding up my positioning as a relatively senior academic who knew what she was doing was beginning to wobble.

Despite this period of discomfort I was sure I had embarked on an important journey and tried to get the most out of the rather bumpy and challenging ride. The module and assignment, although difficult at the time, encouraged me to reflect on my professional roles and the subject chosen for the assignment, the supposed 'de-professionalisation' of medicine, later became a focus for further thinking outside of the module including a publication in a peer-reviewed journal and a series of workshops at medical education conferences.

Important points along the way: Years 1 & 2

Methods of Enquiry 1 & 2 felt more like safe territory. As an experienced researcher at least I understood the language and completing these modules and assignments helped me to become familiar with a wider range of research tools and to experiment with some new and unfamiliar approaches. These modules also gave me the confidence to draw on my 20+ years of experience as a medical practitioner and my highly developed consultation skills to consider using interviews in more creative and nuanced ways and to bring my understandings of narratives and 'storying' of self as a practitioner into my research work. This new understanding of meaning making from, and within, interviews formed the basis of my approach to my final thesis project.

I selected my choice module in the territory of policy and post-compulsory education and this helped me to understand the importance of policy makers, policy levers, and the subsequent policy documents produced in medical education and encouraged me to consider the policy perspective to all of my research work. The assignment also encouraged me to consider organisational culture and, together with my emerging understanding of the complex relationship between policy articulation, policy enactment and space for agency, I began to design an institutional focused study (IFS) concerning how professional development curricula are constructed and enacted, mindful of the forces at play that shape curricula.

Important points along the way: the Institution Focused Study (IFS)

By year 3, with the help of my supervisor I was beginning to understanding how to pin down my research questions more precisely, to use the literatures in a more targeted way, to interweave theoretical concepts and how declaring a worldview in positioning the research (indeed I now even had a term for it in 'my theoretical perspective') was central not only to defining the area of interest but also the entire research approach. The consequent difference in approach to the professional development curriculum question pursued in the IFS to that which I had put forward in my Ed D proposal for this work two years earlier was enormous and an indication of how far I had come already. By now I had a range of new understandings and I recognised that viewing my research area through a sociocultural 'lens', acknowledging the importance of the people, the context in which they were operating and the policy milieu allowed me to investigate what I *really* wanted to understand and make meaning from. This research work impacted significantly on my practice as a lead for the professional development curriculum in my institution; encouraging me to focus more on pedagogical approaches that supported socialisation and formation rather than trying to 'teach' professional development and giving consideration to the education environment in its broadest sense in trying to bring about change. The experience of conducting this study and reflecting on the findings also 're-routed' my plans for my final thesis away from the curriculum designers and policy makers towards the learner's experience and sharpened my problematic to encompass formation, expertise and identity as part of personal and professional development.

The final leg: the thesis

The thesis stage of this journey has been described in chapter 6. The work undertaken was substantial; both literally and figuratively. I learnt about every aspect of conducting good quality research in education: from the first steps of clear conception of the problematic to writing clearly and persuasively about the findings. I have become familiar with new literatures and ways of thinking about learning, identity, professional development, professional formation and developing expertise: all key areas in my work as a programme lead in an undergraduate medicine course. Although conducted with postgraduates the finding have significant implications in the all areas of medical education.

Like all doctoral students I am frequently asked by colleagues: 'Why did you study that?' Or 'So what did you find?' Or 'What's the answer?' Sometimes it is hard to say anything in

response other than *'It's rather complicated'*. When I am struggling to define why I undertook this research and what I found I turn to this simple but important quote from a young doctor who is telling me, in a single sentence, why this research was important in the field of healthcare education:

> *Because actually it's funny when you're used to someone, you're*
> *used to a place, and you're comfortable with your environment, I*
> *think your medicine's better as well.*
> Saffron

My fellow passengers

The cohort of Ed D students, which became considerably smaller in number as the years progressed, consisted of a tightly knit and doggedly determined group who were a great source of inspiration and a sounding board for ideas. Meeting educators outside of medicine was an enriching experience and provided many highly charged opportunities to discuss the impact of context, policy and agency on education practice. I have also been fortunate to meet a number of colleagues from within medical education from cohorts ahead and behind me who have acted as a further source of learning and encouragement and who have become co-authors in a number of publications and presentations. We now form a tightly knit network of education practitioners who have been through the 'IOE experience' and who want to continue to work and learn together.

Most importantly I enrolled on the EdD with two close colleagues, one of whom who has been with me every step of the way; sharing my celebrations and disappointments, listening to my tentative discussion and eureka moments, reading and commenting on drafts, proposed theoretical and analytical frameworks and data analysis themes. Having close colleagues to share the journey, who inhabit 'my world', who understand my strengths and weaknesses and the stresses and demands my workplace puts upon me and who have acted as a 'critical friend' has really made me raise the bar in my own efforts and achieve something I don't think I would have done by my own efforts alone.

My guide

Much is said about the importance of the relationship with your doctoral supervisor. It is all true. This was the most frustrating/supportive, illuminating/confusing, laid-back/intense professional relationship I have ever had. Over the course of the Ed D I went through

endless cycles of forgetting him to hanging on his every word, from being disappointed in him to seeing him as my saviour, from agreeing to disagreeing, to thinking he did not understand my work to being humbled that he considered and understood every word of it. By the end of this journey I began to know and trust that although he wouldn't say very much in supervision, every word would be important. Continuing the rest of the journey without him will be a less rich experience but I thank him for getting me this far so that I can take the next steps on my own.

The journey ahead

A mind once stretched by a new idea never regains its original dimensions.

Oliver Wendell Holmes, physician and writer 1809 –1894

There is no doubt that I have been transformed as a researcher, practitioner and scholar over the last six years. As well as learning a new language and a new skill set, the significant intellectual challenges and experiences of the Ed D have been ontologically re-orientating and I now approach my work as a practitioner and researcher from a more considered perspective. The practitioner-researcher aspect to the Ed D programme means that I have been able to undertake a number of moderately sized projects in a range of areas of importance to my every day work. This has not only allowed me to generate new perspectives and insights in a range of problem areas of my practice, but also to publish and present along the way.

Over the last six years I have developed new research skills, new areas of research interest, new collaborating colleagues and acquired a significant new library! I am now in a position to move onto the next stages of the journey. I need to disseminate the findings of this study, both externally; by means of presentations and publications, and internally; to impact on local practice and to consider interventions and actions at both the policy and practice levels from a more informed perspective.

In this thesis I explore and develop the concept of professional formation in medicine; examining how the professional identities of newly qualified doctors are formed and the structural, educational, social and personal influences on this formation.

Chapter 1:   Introduction

This chapter sets the scene for the enquiry: providing the rationale for the study and an orientation to the empirical field in which it was carried out. By outlining some key perspectives in thinking underpinning the research, it also provides an introduction to the conceptual and theoretical framework that underpins the research question and the research approach.

Chapter 2:   Theoretical perspectives and literature review

Chapter 2 further explores and develops the key concepts relevant to the study in an attempt to identify how novice doctors develop their professional identities and professional expertise, and the likely influences on this formation. It places the study within the relevant empirical, theoretical and policy literatures and argues for a framing of professional development and identity formation as situated and socio-cultural; an iterative process that is dynamic, dialogic and linked to participation in practice.

Chapter 3:   Theoretical and analytical framework

This chapter identifies the key theorists whose work has influenced the 'lens' used to focus this research. The framing of professional development and identity as situated and socio-cultural is further developed and used as a basis to illuminate the thinking and positioning that underpins the research question and approach, the methodological choices and the interpretation of the findings. This chapter also details the aims of the study and the research questions; identifying how my theoretical positioning has led me to frame these particular questions in this way.

Chapter 4:   Methodology

Chapter 4 outlines the methodological approach to the study; highlighting the consistency of this approach with my theoretical perspective. It describes the research design, the selection and recruitment of participants, the research tools used and how data were

generated, managed and stored. It also outlines the approach to analysis and interpretation of the data, identifying the ways in which I have attempted to find meaning from the many interesting and complex stories and observations. It concludes by identifying methodological and ethical issues and how these affected both the nature and quality of data generated and how data has been interpreted.

Chapter 5:   Findings and analysis

In this chapter I present an account of these doctors' participation and experiences in the world of doctoring as they enter practice. Building on their narratives and my observations of their work, I suggest identity develops in relation to learning, belonging and becoming and I unravel each of these; identifying how and why they impact on developing expertise and professional identity.

Chapter 6:   Doctors' professional formation: questions and issues

This chapter draws us back to the purpose of the study and the specific research questions and identifies how this study provides a meaningful insight into the socio-cultural dimension of the professional development and identity formation of novice doctors and how personal, structural and situational factors shape their identity, development and practice. I propose ways of theorising how and why resultant identities develop and the effects of recent workplace and education reform on professional identity formation. I highlight the distinct contribution to professional and academic knowledge and the practical implications of the research findings; both for me as a practitioner and for the field of medical education in general.

Chapter 7:   References, acknowledgements and appendices

Chapter 7 provides a list of references, an acknowledgement of the contribution of others to the study and the resulting thesis and appendices that provide the reader with more detailed information of how the study was conducted.

Becoming Doctors: the formation of professional identity in newly qualified doctors

Chapter 1: Introduction

This study explores how professional identity and expertise develops in newly qualified doctors, and the influences that affect this identity formation. This chapter sets the scene for this study; providing both the rationale and an orientation to the empirical field in which it was carried out. By highlighting some key perspectives in thinking underpinning the field of study, it also provides an introduction to the conceptual and theoretical framework used to underpin the research question and the research approach.

1.1 Rationale for the study

My interest in how people become doctors arises from my work as an educator in a London Medical School. In this role as undergraduate programme lead I have a responsibility to ensure the provision of optimal learning activities and experiences for almost 2,000 medical students; supporting them to develop into doctors fit for practice in the world of 21st century healthcare. The majority of planned activities in the undergraduate medical curriculum focus on the body of scientific knowledge, the clinical and professional skills and the 'know-how' that underpin medicine and medical practice. However it has long been acknowledged that during the undergraduate years there are powerful, tacit aspects of learning how to be a doctor that take place and in recent years there have been attempts by all medical schools to address some aspects of this professional learning more explicitly. During previous research work, completed as part of a Professional Doctorate (Ed D) at the Institution of Education, London, I explored the efforts of educators to develop this new focus for learning, usually termed personal and professional development (PPD), by means of curriculum endeavours. Whilst the study revealed a considerable consensus in curricular approaches, this consensus appeared to arise from historical, cultural and policy restrictions that impact on all medical undergraduate programmes rather than from a common recognition, or indeed understanding, of how professional formation in medicine might occur: educators were limited in their efforts by the constraints of the dominant pedagogical discourse that casts medicine, including PPD, as series of competencies that can be taught, acquired and measured.

This research created some questions for me as a medical educator. With many aspects of professional development cast as a series of learnable behaviors and others as taken-for-granted, automatic by-products of learning medicine, and the contribution of participation, socialisation and professional formation somewhat overlooked by the undergraduate curriculum, I became interested in how people *do* learn to become doctors. When and where is a sense of self-as-doctor developed? Is medical identity partly established before entry to medical school, and if so, how enduring is this initial identity? What is the effect of the medical school experience in this formation? Do medical students learn to become doctors through formal curriculum activities or outside of the taught curriculum through a process of planned or unplanned socialisation in the clinical learning environment? Do students emerge from undergraduate programmes simply knowing the behaviours, competencies and values expected of them but with no real sense of identity as a doctor? What impact does this lack of attention to formation have on the professional identity, and indeed on practice, of doctors as they enter the profession? Does significant identity construction only really take place in the early years of independent practice as expertise develops? Or is the growth of self-concept as a doctor a continuum?

From these questions concerning the *what*, *when, why* and *how* of identity formation, a significant enquiry arises for me as a medical educator; namely, what influence, if any, do educational experiences, in their broadest sense, have on this formation? What are the other factors at play? Is the inattention to the support of professional formation in the undergraduate years also pervasive in the postgraduate years? And does this matter: does formation happen despite the inattention of educators? If it does, is it the formation, expertise and identity we are presuming or is it some alternative identity? And what action, if any, should educators, employers, and indeed the profession, take in the light of the answers to these questions?

Based on my professional experience and my understanding of the literature on professional formation it is my contention that this *does* matter; that the ways in which people *become doctors* is of central importance in how novices develop expertise and effective practice. In my judgment insufficient attention is paid to this process in medical education planning, delivery and policy and it remains marginal in the research literature. Furthermore, fundamental changes in undergraduate educational focus (GMC, 1993, 2003, 2009), postgraduate training (GMC, 2009, 2011) and work patterns (DoH, 2008) of junior doctors over the last decade may have unanticipated impacts on any established

mechanisms of professional formation and the development of expertise, making this inattention even more problematic.

I also suggest policy, curriculum guidance and much of the literature in medical education presupposes two flawed assumptions with regard professional formation. Firstly, that 'the curriculum' provides not just the knowledge and expertise but also creates the professional identity and secondly, that this identity is well formed on qualification and then simply taken into the workplace and augmented in the early years of practice in an unproblematic way. In contrast to these assumptions, the socio-cultural literature suggest that while aspects of professional identity are formed in these workplace-based learning opportunities, any developing professional identities are merely fledgling and the work novices *do* is central in professional formation (Eraut, 2004, Bleakley, 2002). The remainder of this chapter identifies why I have made these assertions, presents a compelling argument for undertaking this research work and creates a backdrop for understanding the research questions I have set out to address.

1.2   Introduction to the study: empirical field, policy and research perspectives

This introduction outlines the context in which this enquiry arises and introduces the major issues and influences that have shaped the nature of the study. It identifies how medical education is conceptualised and delivered in the UK: both the acquisition of specialised professional knowledge and skills and the development of a set of behaviours and values often described as professional development or professionalism. It also explains the way in which the medical workplace is organised, providing an insight into the environmental and social context of being a junior doctor in the 21st century. It moves on to interrogate how socialisation into medical practice occurs, and when and where the process of professional formation begins. Finally it identifies the ontological perspective with which the enquiry has been approached; signposting why this study, why now, and why in this way.

1.2.1   The empirical field: an overview of medical education in the UK

Doctors in the UK undergo a long period of undergraduate education, usually lasting five or six years. All programmes follow curriculum guidance provided by the professional body, the General Medical Council (GMC). Like other vocational education programmes such as nursing or dentistry, there is a strong focus on workplace-based learning. This begins with

brief exposure to, and learning within, the workplace from the early years of the programme building up to a final year that is almost wholly workplace-based and where learning is very much focused on preparation for practice, including undertaking short periods of shared responsibility for patient care with junior doctors known as 'assistantships' or 'shadowing'.

Following successful completion of the undergraduate programme, graduates gain a provisional license to practise and begin work as a junior doctor by entering the UK Foundation Programme and completing a series of approved training posts within the National Health Service (NHS). These posts involve direct responsibility for patient care but include a strong emphasis on ongoing education and support. Half-way though the Foundation Programme, if progress is satisfactory, the junior doctor gains full registration with the GMC and enters their second postgraduate year (FY2). At the end of the Foundation Programme doctors enter the more specialist phase of their postgraduate education and continue in training posts, for between five and eleven years post-qualification depending on the chosen specialty, until they complete their specialist training and enter fully independent practice.

The postgraduate years are characterised by both formal learning, as part of defined postgraduate curricula in pursuit of specialist postgraduate qualifications, and other, less formal, workplace learning that is supported by more senior doctors acting as education supervisors. The Royal Medical Colleges, in consultation with the GMC, ensure a suitable curriculum and approved training posts for these work-based postgraduate years and, like undergraduate curricula, there is a focus on both the development of specialised professional knowledge and expertise and the development of a professional attitudes and capabilities (GMC, 2009, 2010, 2011).

1.2.2 Medical School

The historical roots of medical education with its emphasis on apprenticeship means that although undergraduate medicine programmes have long been located within university structures, the 'Medical School' stands rather apart in higher education settings; physically, culturally and in terms of programme delivery, structure and governance. In the UK, delivery of undergraduate medical education is the shared responsibility of the university and the NHS and much of the teaching is within healthcare venues, and by doctors, rather than by university faculty. Furthermore, unlike the majority of other undergraduate programmes (even those tailored to other professions such as Law), medicine is a fully

vocational course; and thus admission to medical school presupposes, indeed demands, a strong orientation towards becoming a doctor (Cavanagh et al., 2004). Students are defined, and define themselves, as *medical students*. For these reasons medical school is a powerful socialising force, not just a place of university based learning and the transformatory nature of the experience at medical school has long been of interest (Merton et al., 1957, Becker et al., 1961, Bloom, 1973 and 1989, Coombes, 1978, Sinclair, 1997). Medical school learning is seen to extend beyond the accumulation of technical knowledge and know-how to an enculturation: where norms, values and roles are also learnt (Olesen and Whittaker, 1970, Beagan, 2001). The informal curriculum (Hafferty and Franks, 1994, Hafferty, 1998), professional aggregation (Becker et al., ibid) and the exposure to role models (Merton et al., 1957, Kenny et al., 2003) are all powerful contributors to both learning and 'learning how to be'.

Workplace-based learning is the backbone of the latter years of the medical school experience; providing an authentic learning venue with the potential to learn how to become a doctor alongside learning medical knowledge and skills. One conception of the undergraduate years, encouraged by the discourse of the regulatory bodies and the dominant competency and accountability culture within medicine today, takes for granted that professional formation occurs during the undergraduate years; with graduates emerging well formed as new doctors, clearly understanding their role and able to transfer medical school competencies and learning into their work as junior doctors (*Tomorrow's Doctors*, GMC, 2009, the *New Doctor*, GMC, 2009). A competing discourse, influenced by the socio-cultural literature, is emerging however that suggests it is only once fully active in the world of work that professionals develop their practice, including their 'way of being' as a professional (Wenger, 1998, Bleakley, 2002). However, neither of these understandings adequately account for the potential impact of undergraduate medical education on professional formation. Extensive workplace learning and the powerful socialising role of the medical school experience, would suggest that undergraduate education is likely to be a partial contributor to professional formation but does not create an end product. New doctors do not emerge from medical school as fully formed professionals, but rather ready, to a greater or lesser extent, to start the next phase of development: both with regard to their knowledge and skills and their professional identity and professional expertise.

1.2.3 Work as a junior doctor

The transition between medical school and work is a managed one, via the compulsory Foundation Programme; a series of relatively brief training posts over two years that aim to provide exposure to, and experiences in, different aspects of medical practice. Although classified as highly supervised training posts, the reality is that this is a period of significant and rapidly increasing responsibility. Transition into the Foundation Programme should therefore be seen as a period of rapid and multidimensional transformation: a consequential transition (Beach, 1999).

Junior doctors are immersed in direct patient care from their very first days of work so, whilst the world of a the newly qualified doctor shares some similarities with that of other newly qualified professionals, newly qualified doctors cannot easily be compared to other neophytes: partly because of the extensive workplace exposure in the undergraduate programme and partly because doctors have significant autonomy, even at the earliest stage in their careers (Friedson, 1994), enabling them to make independent judgments and professional decisions very soon after qualification (Booth, et al., 1995).

The second post-qualification year, FY2, is a relatively new stage in the careers of junior doctors. The introduction of the compulsory Foundation Programme in 2005 (DoH, 2005) amalgamated the former Pre-Registration House Officer post (PRHO) and the first full-registration year formerly known as the first Senior House Officer post (SHO). Although categorised, organised and assessed as a single, two-year programme, in fact this second year involves a significant step up in expectation and responsibility with FY2 doctors often undertaking the same work as more experienced doctors (Armstrong et al., 2008), and undertaking roles in more specialist areas (Collins, 2010).

1.2.4 Policy perspective

Fundamental changes in the undergraduate educational focus (GMC, 1993, 2003, 2009), postgraduate training (GMC, 2009, 2011) and work patterns of junior doctors (DoH, 2008, 2009) over the last decade have transformed the medical workplace and the roles of junior doctors within it after many decades of stability. Recent undergraduate curriculum guidance (GMC, 2003 and 2009) and the Foundation Programme curriculum (DoH, 2010) both focus on two key areas of education and development: the acquisition and recording of competencies and the development of a set of behaviours and attitudes described as professional development or, more commonly, professionalism. These newly defined

requirements, together with the Foundation Programme's emphasis on patient safety (DoH, 2005, 2010), have significantly altered the nature and orientation of learning in the undergraduate and early postgraduate years and the type of activities carried out by students and very junior doctors.

The introduction of the Foundation Programme (DoH, 2005) has also shifted the emphasis of the first two postgraduate years from service delivery towards education and more formalised assessment of achievement. The concurrent implementation in 2005 of the *Modernising Medical Careers* policy which focused on the later postgraduate training years (DoH, 2005) also profoundly altered the experiences of all doctors in training and has created a world of work and learning that is characterised by: shorter attachments; a wider variety of professionals involved in once traditional junior doctor roles; a need to make career decisions earlier in one's professional life and an increased emphasis on more formal learning and assessment in the workplace rather than a more flexible apprenticeship approach. Finally, the implementation of the European Working Time Directive in 2009 (DoH, 2009) has meant less time in work (and therefore training) for junior doctors, a more fragmented workplace, less consistent supervision from immediate superiors and the introduction of shift patterns of working rather than working in established teams.

These fundamental changes to the work of junior doctors and the medical workplace make questions concerning professional formation particularly pertinent at this time. Processes and actions that supported, or indeed inhibited, professional formation in the old system may no longer apply in this new, fragmented and managed world of the junior doctor. This study provides a present-day understanding of the role of educational, social and environmental factors in professional formation and adds a contemporary element to the debates concerning how professional development can be fostered both in undergraduate education and postgraduate training.

1.2.5   Research Perspective

There has been a wealth of sociological research in medical education over the last sixty years. Much of this has concerned the socialisation of medical students. This includes the work of Merton and colleagues (1957) where professional socialisation was described as a straightforward and linear process in which students are gradually assimilated into the medical profession and, conflictingly, the work of Becker et al. (1961) and later (Sinclair,

1997), that suggested that much of this socialisation is in fact directed at being a medical student rather than at eventual professional roles.

Whilst there is a significant body of literature regarding the early years of work and professional formation for many professional groups, including nurses (*for example,* Cohen, 1981, Kelly, 1992, 1996, Philpin, 1999), teachers (*for example,* Bullough, 1992, Sachs, 2001, Beijaard et al., 2004) and other professional groups (*for example,* Eraut, 2000, Eraut, 2004), there has been a relative paucity of such theoretical work concerning doctors as they enter practice. This is surprising given the amount of public investment in medical education and training and the rapid pace of reform both the workplace and junior doctor training over the last decade (Brown, at al., 2007). Whilst we can gain some insights from the bodies of work with other professional groups into the possible mechanisms of professional formation in junior doctors, differences in working context, training patterns and career progression make such generalisations problematic (Booth et al., 1995).

The medical education literature has more recently begun to focus on some aspects of professional formation. There is a growing body of literature on what is termed 'professional development' and 'professionalism' (*see for example,* Cruess and Cruess, 1997). However this literature often focuses on a rather narrow conception of these terms; somewhat untouched by prevailing theory concerning the role of developing expertise and participation on formation and identity despite a persuasive body of sociocultural literature being available for some considerable time. There is little within this 'professionalism' literature that provides a way of theorising identity and professional formation in relation to professional development. This study therefore aims to provide a theoretical 'lens' with which to more rigorously explore the domain of professional development and identity formation in medicine.

Postgraduate medical education is intimately interwoven with service delivery (Tooke 2008) where education is consistently referred to as 'training': suggestive of a narrow focus aimed to equip the 'trainee' with the skills for service delivery (Downie and Charlton, 1992). By narrowing the boundaries and ambition of postgraduate education to 'training' and framing the early postgraduate period in this way as the pursuit of attaining measurable competencies, the transformatory potential of this period is overlooked; when the potential influences of the environment, professional others and indeed the practices in which one becomes involved, may have a significant formative influence. Some authors such as Bucher and Stelling (1977) and Bleakley (2002) who are theorising in the socio-

cultural tradition, have highlighted the formation process that does go on whilst learning through and for medical work. This formation is seen to encompass the development of professional identity, commitment and a sense of career (ibid, 1977) and positions role models as influential in these processes as *'Junior doctors do not simply learn from consultants, but learn to be like the consultants they admire and respect'* (ibid, 2002, p12).

1.2.6   Theoretical perspective

Issues of identity and professional identity have been debated and researched in a range disciplines including sociology, psychology and anthropology. My theoretical perspective on identity, informed by both the literature and my experiences as both a doctor and a medical educator, is that professional identity is a socially constructed phenomenon that develops within and through social practice (Eraut, 2004, Rubin, 2007) and is intimately intertwined with issues of developing expertise (Lave and Wenger, 1991) and professional learning (Eraut, ibid). I conceptualise identity in this study therefore as not solely located in the individual, but rather *'negotiated in social interactions that take place in cultural spaces'* (Nasir and Saxe, 2003, quoted in Rubin, 2007, p221). I am thus casting professional identity as a *process* that is continuously (re)defined, rather than as a set of essential characteristics common to all doctors.

This socio-cultural conception of identity also acknowledges the structural forces at play in identity development. As one of the purposes of medical education must be an enculturation, to enable the development of a professional identity acceptable to the profession, this study creates an opportunity to explore the extent to which one's identity as a doctor is about acting as you are expected to, the influence of others and context on identity and to what extent other key elements such as one's core values, one's history, one's self-perception as a doctor and what one finds important in everyday work, influence identity.

By adopting a socio-cultural position I am asserting identity and practice are profoundly shaped by both the learning and working environment and the roles, activities and relationships learners become involved in within the workplace learning setting. I am also suggesting, like Bleakley, that novice doctors, do more than accumulate facts, skills and competencies in their early years of work but rather come to understand their professional world and define and adopt their places within it (2002). Thus professional identity is conceptualised in this study as a complex and dynamic equilibrium between self-image and the roles one feels obliged to play and is understood as not fixed but relational and

affected by the social. Approaching the enquiry from this perspective focuses my research further towards interrogating how the contemporary model of healthcare delivery, and thus junior doctors' responsibilities, experiences and relationships, impacts on notions of self-as-doctor in an attempt to determine what factors in the workplace allow some doctors to move forward more quickly in their formation than others and whether the current arrangement of education acts as a facilitator or brake on this formation. Finally, as this positioning focuses the enquiry on the socio-cultural aspects of identity, particularly its constructed nature and within that, the effect of structure and agency on this self-concept, it raises a further important aspect of formation concerning how an individual's emerging identity may be felt to be at odds with idealised notions embodied in policy and educational rhetoric and what conflicts and compromises arise due to such incongruence.

1.3   Summary

This enquiry concerns the formation of professional identity in junior doctors. It explores how novice medical practitioners come to develop their sense of self-as-doctor and expertise, and attempts to reveal the process of professional identity formation; illuminating the structural, educational, social and personal influences on this formation.

For medical educators this work aims to provide insight into the socio-cultural dimension of the professional development of doctors, focusing on a fundamental aspect of this development, identity formation; an area currently under-theorised in the medical education literature. By exploring the personal, structural and situational factors newly qualified doctors identify as having shaped their developing sense of self and their emergent professional identity, the study opens up opportunities for theorising how and why resultant identities develop and the effects of workplace and education reform on professional identity and formation: which ultimately influences the ways in which doctors approach practice.

Becoming Doctors: the formation of professional identity in newly qualified doctors

Chapter 2:   Theoretical perspectives and literature review

The previous chapter provided the rationale for the study and an orientation to the empirical and policy field in which it was carried out. It also began to signpost the key theoretical perspectives that influenced the framing of the research question and the research approach.

This chapter explores and develops the concept of professional formation in medicine; examining how newly qualified doctors come to develop their professional identities and professional expertise, and the influences that impact on this formation. It also places the study within the relevant literatures concerning identity; both in the field of identity studies in general, and in the existing empirical and theoretical literature regarding medical identity in particular.

Starting by examining notions of professional formation and professional learning it moves on to examine how this formation is thought to occur in the medical profession. It also explores learning through apprenticeship, and how socialisation into the role of doctor and the world of medical practice is thought to occur. It identifies how the contemporary medical workplace, current conceptions of professional development and the educational endeavours that aim to influence this professional development might impact on this formation. The chapter also explores concepts of structure and agency with regard to professional development and 'professionalism' in medicine, highlighting the forces at play on what discourses are being constructed and by whom. Through this exploration it aims to highlight what might constitute an 'acceptable' professional identity, or indeed professional actions, for doctors in the modern healthcare system.

The chapter moves on to place the study within the relevant literatures concerning identity and identity formation. By looking at a number of key writers in the domains of identity and medical identity, it highlights the key theoretical positions within the field and the debates concerning conceptions of identity, identity formation and professional socialisation. Whilst acknowledging that the literatures on identity includes psychological, anthropological and social conceptions of identity, I will argue that to understand how the professional identities of junior doctors develop, one needs to conceptualise identity as dynamic, multiple and situated in social relationships and practice, and identity formation

as dialogic; that *'identity is self-in-situation, and central to this concept is the notion that self is constructed, maintained, and challenged by self and interlocutor's communicative practices'* (Eisenberg, 2001, p. 281).

Throughout the chapter a variety of fields of research are drawn upon: sociology anthropology, education and medical education. Empirical, theoretical and policy literatures are used to provide a backdrop for chapter 3 which describes the theoretical and analytical framework adopted in this study, the objectives of the study and the research questions.

2.1   Professional formation and professional learning

Professional formation and professional learning have been explored by a range of disciplines and as a consequence, different constructs, understandings and definitions are put forward depending on the perspective(s) of the field. Whilst professional formation is a conceptual term it has, in some situations, taken on an everyday meaning. Thus professional formation is variously understood as: the development of professional knowledge and know-how, the development of professional behaviours, the acquisition of professional orientations and attitudes through the process of socialisation, or a complex mixture of all of these things. The way in which professional knowing develops is also much debated with substantial bodies of work underpinned by different theories of learning. The discourses within the literature in this domain range in focus from the predominantly behavioural; (*for example* 'professional formation' in law and teaching is the name given to the formal supported period of learning immediately post qualification), to the transformatory development of moral character; (*for example*, Daaleman et al., 2011, p327, who describe professional formation as where *'lives of service are created and sustained'*). The ways in which professional expertise and professional formation are understood to develop also ranges from the purposeful to the incidental.

Conceptions of knowledge and learning in the professional occupations are extensively debated in the education literature and this debate reveals two prominent competing discourses that centre around the nature of how one moves from being a member of the lay public to a professional with expertise. One model, underpinned by notions of learning as participatory, suggests that developing as a professional occurs through practice, by immersion in the field and participation within a *community of practice* (Lave and Wenger,

1991). This model casts professional knowledge and expertise as a collaborative knowledge production: learning is not an act of acquisition, but of participation, and subsequent identity construction (Wenger, 1998). Professional learning through practice is situated; it is not an abstract or distinct action but an *'integral and inseparable aspect of social practice'* (Lave and Wenger, ibid, p31). Viewing professional learning as situated provides a persuasive model of how professionals become able to apply technical and theoretical knowledge to practice contexts (Maudsley and Strivens, 2000) and learn to carry out the practices of that profession. Viewed through this lens, professional knowledge is socially constructed and highly context-specific and thus attempts at 'teaching' professional knowing and development as a body of knowledge and behaviours would be futile:

> *Learning cannot be designed. Ultimately it belongs to the realms*
> *of experience and practice.... Learning happens. Design or no*
> *design.*   *(Wenger, 1998, p225.)*

This perspective instead suggests that meaningful exposure to the site of practice, immersion in practices and relationships with professional others are central to professional formation.

Whilst persuasive, a range of authors have found a solely participatory model of learning unsatisfactory in understanding how learning and formation occurs in the workplace. Edwards suggests that whilst the participatory model of learning provides a *'compelling account of learning as socialisation into existing beliefs, values and practices'* (2005, p 51) it does not offer an account of how new knowledge is produced. Sfard (1998) and Fuller and Unwin (in Evans et al., 2006) both raise concerns that viewing learning as a by-product of practice and purely contextual would mean nothing can be carried forward, either from formative periods or between one workplace and another. Fuller and Unwin (ibid, p 31) also suggest participatory models 'downplay' the importance of formal learning opportunities which are a substantial component of work and learning for the professions. What is also missing from participatory models of professional formation, particularly as it might be applied to the emotionally charged setting of working in medicine, is the personal, psychodynamic dimension of professional formation and the role of reflection in and on action (Schön, 1983). Dreier (2008) offers a critique of viewing learning as social practice alone and suggests the emotional dimension of people's experiences are not considered in concepts of learning through practice where the impact of reactions are limited to social ones.

There are problems therefore with how situated learning theory can be applied to key areas of learning in this study such as how formal learning fits into the picture, how learning something new might occur, how learning can be 'transferred' from one setting to another and how the personal and reflective dimensions of learning impact on professional formation as a doctor. Doctors in training spend considerable time in education activities outside the workplace and they clearly learn from this. Furthermore their work is characterised by planned, frequent movement between very different workplaces and while this 'rotation' approach makes a flawed assumption that transfer of learning between settings is completely unproblematic, some aspects of learning are carried forward; the codified knowledge, some sense of normative practices, behaviours and values, even *how to become* a junior doctor member of a community.

A competing discourse has therefore emerged that questions whether all professional knowledge can be relative or situated (Moore and Young, 2001, Young, 2007) and suggests that some aspects of professional learning consist of codified knowledge and concepts that can be acquired and used to construct meaning. Young suggests that neither an empiricist nor a relativist view of professional knowledge and formation is entirely satisfactory and proposes a social realist account of knowledge in this domain: accepting such knowledge as socially constructed and the role of human agents in its production, but acknowledging it also has context independence or realism (Young, 2007). Similarly, Standish argues that education of a professional does not merely consist of initiation into practice but also the introduction to a body of knowledge (Standish in Drummond and Standish, 2003).

Eraut's empirical work with beginning professionals also highlights the importance of acknowledging this more individual and purposeful learning, as well as learning that is situated (Eraut 2004). He suggests for all professional groups work processes with learning as a by-product account for a very high proportion of reported learning. Thus success as a workplace learner depends both on the available opportunities and on the quality of relationships in the workplace. However as well as learning in or near the workplace, his novice professionals also learnt through courses, independent study or by being coached. By drawing on both acquisition and participatory perspectives he argues that socio-cultural and cognitivist theories of learning are complementary in understanding how professional learning might occur, even if they do emerge from different theories of mind (Eraut in Hall et al., 2008).

Adopting this rather more nuanced positioning on professional development and learning that acknowledges the contribution of the individualistic and knowledge-acquiring model rather than a purely participatory model suggests there are areas of knowledge and capabilities that can, and often will, be learnt in earlier stages of development and carried forward; that purposeful professional learning goes on in classrooms and other structured settings and through the personal study and reflective practices of novices as well as in practice; that professional learning has both personal and social dimensions and that learning through and for the workplace and learning inside and outside of work (Evans et al., 2006) all contribute to professional formation.

Whilst there is an extensive literature on professional *learning* (Eraut 2004), there is often little attention paid in the literature or education policy to the interplay of this developing knowing and a developing *sense-of-self* as a professional. Often this development is assumed to happen as a taken for granted by-product of other learning. Beijaard et al.'s (2004) review of the literature concerning the professional formation of teachers found studies tended to focus on the teacher's personal, practical knowledge with very few studies explicitly exploring the relationship between this knowledge and emerging professional identity. Some authors however are clear that one must understand professional learning as not just *what we do* or *what we know*, but *who we are* (*for example*, Moore, 2004, Daly, 2008). Wenger (1998) attempts to identify the ways in which participation in communities helps to construct the identity of the learner and Evans and Kersh in their interrogation of the ways in which personal biography is relevant to learning at work, also suggest that *'working and belonging to a workplace community contributes to the developing battery of dispositions and orientations and the sense of identity of the workers themselves'* (in Evans et al., 2006, p 71).

Adopting this stance foregrounds the role of professional socialisation in professional formation rather than leaving it in the background of practice or knowing; acknowledging that professional learning, whether it take place in practice or in other settings, is likely to encourage socialisation whether purposeful or not. Merton et al. describe this professional socialisation as a:

> *process by which people acquire the values and attitudes, the*
> *interests, skills and knowledge – in short, the culture – current in*
> *the groups of which they are, or seek to become, a member.*
>
> *(Merton et al., 1957, p. 41.)*

Professional socialisation is not an uncomplicated process. It cannot be easily separated from other aspects of learning to be a professional and much of it is neither linear nor planned (Lamdin, 2010). However, by acknowledging that professional socialisation occurs as part of professional learning, the aims of professional training can be better conceptualised as not only to acquire the necessary practical and professional knowledge and skills but to enculturate individuals with the appropriate values and attitudes. Socialisation and the development of a professional identity thus becomes an important part of the development of the professional; with neophytes needing to 'think, act and feel' as members of that profession (Cavenagh et al., 2000, p. 897).

Once again, a social realist positioning on professional learning, that suggests codified knowledge is critical to the initial phase of formation but is also important in later phases as it is used in participation, helps us to create a link between learning and identity. Bernstein (quoted in Young, 2007, p 56) suggests that it is this very acquiring of profession knowledge that socialises learners into disciplinary traditions and creates the sense of 'otherness', encouraging highly specialised identities that create the inner dedication central to professional practice. Evans also suggest that re-contextualisation, the putting together of disciplinary knowledge that was learned outside the workplace with practice based and local organisational knowledge, is a process through which individuals come to *'think and feel'* in a new identity (Evans 2011).

2.2   Professional formation in medicine

Understanding where, when and how professional formation occurs and concepts of self-as-doctor are formed, are central to this study. As previously highlighted, there is a significant body of literature regarding the early years of work for many professional groups but there is a relative paucity of theoretical and empirical work concerning doctors as they enter independent practice. As medical education research has begun to recast itself as a social science rather than a branch of health sciences research (Monrouxe and Rees, 2009, Bunniss and Kelly, 2010) the medical education literature is increasingly sharing some of the thinking about the complexities of professional formation with the mainstream education literature (*for example*, Apker and Eggly, 2004, Bleakley 2006, Clandinin and Cave, 2008). However this developing understanding of professional formation remains obscured by two of medical education's most pervasive discourses; that which concerns the nature of medical knowledge and encourages a 'competency' culture, and the moral or

virtue driven conception of practice played out in the 'professionalism' discourse. I assert that these pervasive discourses have become 'common sense' unexplored assumptions in medical education research and policy that prevent meaningful progress in understanding how professional formation occurs in medicine and in doing so, distort attempts to support such development.

Understanding the professional formation of doctors therefore requires some exploration of what the term 'professional' means in the context of medicine. The very purpose of the professions has been questioned over the last half-century and medicine has not been immune to these debates. Recent high profile events such as the Alder Hay, Shipman and Francis inquiries (Redfern, 2001, Smith, 2005, Francis, 2010) have further fuelled the debate and as a consequence the professional standing and 'professionalism' of doctors has become a politicised notion and the profession's powers and privileges of self-regulation have been challenged and questioned (Abelson, et al., 1997). During this period of scrutiny, there have been numerous attempts at re-asserting contemporary medical professionalism and seminal policy documents such as *Good Medical Practice* (GMC, 1995) and *Doctors in society: medical professionalism in a changing world* (Royal College of Physicians, 2005) reflect this period of concern and subsequent reaffirmation of what contemporary medical professionalism means.

This swell of interest both within the profession and within society has created a discourse that identifies education as the principle vehicle for change (Hafferty in Cruess et al., 2009) and thus In medical education, attempts to define professionalism and crafting opportunities in which professionalism can be learnt have consequently become ubiquitous across undergraduate and postgraduate programmes. Defining contemporary medical professionalism has however remained elusive. The literature, policy documents and curricula recommendations use interrelated but non-synonymous terms in descriptions and debates and behind this inconsistent use of language, how the profession, and the educators within the profession, conceptualise professionalism remains unexamined. Is 'becoming a professional' concerned with a commitment to a set of behaviours and orientations as suggested by Cruess and Cruess, (1997)? Or does it concern the transformation of lay members of the public into someone with a commitment to a set of values (Maudsley and Strivens, 2000, Coulehan, 2005, Huddle, 2005)? An examination of the burgeoning medical education literature surrounding professional development and education for 'professionalism' reflects this divergence of ideology: whether

professionalism is conceived as 'teachable' through a series of planned activities, or whether it is believed to develops as a process of socialisation through practice, either mediated or incidental. However, whereas mainstream education has embraced sociocultural understandings of professional learning and formation, much of the medical education literature still assumes the acquisition model of learning and demands 'professionalism' must be formally taught (Cruess and Cruess, 1997, Swick, 2000, Roberts et al., 2004). These views have gained substantial purchase despite empirical evidence that suggests formal education has weak effects on professional behaviour in clinical practice (Eisenberg, 1986), and that situated learning theory appears a 'better fit' for teaching and learning professionalism (Maudsley and Strivens, 2000, Steinert in Cruess et al., 2009). Dornan et al., (2007) suggest the reason for this continued failure to embrace more contemporary pedagogical approaches is because medicine has simply not kept pace with developments elsewhere and thus work-based learning remains under-theorised. Bleakley suggests that there may be unexamined ideological reasons why medical educators fail to engage with this notion (2006, p150). Maudsley and Strivens go further to suggest this conception is favoured as the situated learning perspective *'challenges professional education by questioning the value of knowledge transmitted by instruction'* (2000, p 537).

2.2.1   Conceptions of knowing and professional knowing in medicine

In both medical practice and medical education there is a tension between the dominant biomedical model that casts medical knowledge and expertise as objective and abstract scientific knowledge, and a situated model where learners come to understand how to use their knowledge and expertise through practice and become enculturated into the norms and values of medical practitioners. Whilst most medical educators acknowledge that learning must be aimed at both technical competence and the ability to respond sensitively, and with understanding, to patients' emotional needs (Grant, 2002), throughout medical education practice this holistic model consistently takes second place to the pervasive biomedical model. For example Apker and Eggly, (2004) looked at the 'morning report' (a traditional, formal, patient-based learning activity where doctors present cases to each other) and suggested that this process, aimed at learning in and through work, has the potential to provide a powerful socialisation of junior doctors into the norms and values of the profession and have a significant effect on professional formation but that:

> *Meetings embraced a discourse...that privileged scientific*
>
> *medicine and marginalize humanistic approaches...(and where*

juniors) deviate from traditional ideology by articulating the voice

of the lifeworld, faculty physicians counter these moves by

asserting the voice of medicine. (Apker and Eggly, 2004, p411.)

Professional knowing and know-how is also side-lined by the dominant pedagogical discourse that conceptualises learning, including professional learning, as acquisition. This pervasive framing of learning as individualistic and knowledge-acquiring narrows the potential for understanding how learning might occur within the workplace and how professional formation evolves alongside this learning. Bleakley (2002) warns of the limitations of using only psychological conceptions to understand student learning and Kenny et al., (2003) highlight how attention to professional formation has persistently been overlooked in the quest for competence, adequate knowledge, safety and preparedness. They assert that whilst medical educators increasingly understand professional education to be a process of *'moral enculturation, of taking the values, attitudes, character, and identity of the chosen profession and, implicitly, of the good professional'* (ibid, p1209), frustratingly, this understanding is not being transformed into meaningful changes in policy or practice. Bleakley argues a reconceptualisation of medical learning is needed; highlighting that while an acquisition perspective that focuses on transmission of knowledge and skills from one individual to another is an important part of work-based learning, on its own it is not a sufficient explanation of how such learning occurs (Bleakley, 2002). I concur with Bleakley's assertion that both perspectives on professional learning have something to contribute to our understanding of professional learning in medicine and that, as Young suggests, a social realist conception of knowledge and knowing in this domain is the most helpful (Young, 2007). This provides a way of understanding professional expertise in medicine as socially constructed whilst acknowledging the context independence of some professional knowledge and know-how. This study, that embraces a more holistic notion of professional learning, therefore can provide important new insights into how those who embark on a medical career develop and progress as a new member of the profession in all its dimensions.

2.2.2 *Apprenticeship and learning through participation*

Whilst medical education has been slow to move beyond individualistic understandings of learning, the use of an apprenticeship as an organisational approach to learning is as old as the practice of medicine itself. Whilst the apprenticeship in medicine has been argued to begin during the undergraduate years (Bleakley, 2002), Turner, et al., (2001) challenge the

idea that the undergraduate course is truly an apprenticeship because the lack of responsibility and participation and the short multiple placements deny the medical student a sense of belonging to a particular community. However, participation in work-related areas has been shown to positively affect students' occupational identity across a wide range of careers, through the acquisition of relevant skills and attitudes, the internalisation of motives, and ideological development (Becker and Carper, 1956), and by learning in the workplace medical students are becoming part of the medical world, however peripherally, and being socialised into it whilst they learn about it; they are participants, and not recipients. Such socialisation is often seen as a taken for granted by-product of the programme and occurs haphazardly rather than as a declared aspect of planned learning opportunities. Consequently, whilst the development of a secure sense of identification with the role of doctor in students by the end of their time at medical school is an important goal of any undergraduate medical programme (Baszanger, 1985), some studies have shown that newly emerging doctors have problems in achieving appropriate role identification (Gude et al., 2003) and many reveal significant gaps in preparedness (*for example*, Wilson et al., 1998, Jones et al., 2001, Armstrong et al., 2008).

Postgraduate medical education is intimately interwoven with the day-to-day work of junior doctors and the apprenticeship model of medical education continues to be unquestionably adopted in the postgraduate arena despite fundamental changes to the workplace and the learning relationships within it in recent years as highlighted in the previous chapter. There has been some recognition of the changes needed to the existing apprenticeship model used in recent decades; mainly moving from the traditional novice-expert dyad relationship towards a more distributed apprenticeship (Nielsen and Kvale, 1997) and there is some work in the medical education literature on more contemporary notions of apprenticeship as a mode of learning from a small number of authors (*for example*, Bleakley, 2002, 2006, Swanwick, 2005, Koens et al., 2005), much of which has arisen as a counter to the pervasive creep of the rather narrow competency and 'training' culture as much as in response to the changing nature of the apprenticeship opportunities for doctors.

Situated learning theory suggests learning through participation involves not just learning *what to do* but also includes learning *how to be*. Within weeks of entering practice junior doctors take on considerable responsibility for the care of patients and this is a powerful stimulus for learning (Miller et al., 1998) and for learning to work with colleagues. However

I assert that the participation of junior doctors and the becoming a member of a community involved in patient care is somewhat different to that of other newcomers to medical teams and is always partial. Lave and Wenger's notions of communities of practice and participation cast newcomers as moving from the periphery toward a more central positioning as expertise and membership develops (Lave and Wenger, 1991). However for novice doctors, particularly in the contemporary healthcare environment, this participation is more marginal. Junior doctors are always moving on and thus dipping in and out of communities, always remaining, to a lesser or greater extent, peripheral. Their ability, and indeed their need, to become an integral part of a community of practice is limited and they are using the work they do to develop skills and abilities to carry forward to their next role (Evans and Rainbird in Evans et al., 2006). They are entering always with one eye on leaving. This persistent peripherality is likely to impact on participation and consequently both learning and learning how to be: on their professional identity formation.

Placements within the Foundation Programme are deliberately diverse. As juniors move from one job to another and from one community to another, they are developing different relationships, facing different challenges and attempting to learn different roles. They are also trying to enter multiple communities concurrently; the community of health practitioners in *this place*, the community of professional working in *this speciality* as well as the community of *medical practitioners in general*. Wenger suggest that identity is formed in this 'nexus of multi-membership' as we define who we are as we reconcile our various forms of membership (Wenger in Hall et al., 2008 p 105). It is likely that this work of reconciliation may be a significant challenge faced by novice doctors as they move continuously from one community to another.

Finally, learning through participation requires *participation*. As highlighted above, a junior doctor is a rather peripheral participant in their everyday workplace community and there is variation between individuals in the extent to which they pursue and gain membership. In medical workplaces certain personalities 'fit in' to a lesser or greater degree and differences in trainees' confidence, experiences and declared career aims can all create barriers to participation and engagement that can lead to unequal learning from similar experiences (Cornford and Carrington, 2006, Evans et al., 2006).

2.2.3 *Professional formation and socialisation*

Within vocational education that extensively utilises work-based learning, socialisation can be considered to occur across three stages: a period of anticipatory socialisation before

being accepted into the programme, a more formal socialisation during the training or education period (both planned and unplanned), and socialisation that occurs in the post training/education period (Cant and Higgs in Higgs and Edwards, 1999).

The period of anticipatory socialisation, before formal training begins may be significant in the professional formation of doctors. The literature concerning teacher identity formation (*for example,* Bess, 1978) suggests preconceived notions can have a profound effect on later values and behaviours and it has been shown that medical students, more so than students in others courses, understand, and are oriented to, the expectations of their profession (Cavanagh et al., 2000). Studies in the anticipatory period in medicine however are rare and tend to focus on attributes predictive of students' success such as academic achievements or socio-economic backgrounds rather than on their anticipatory ideas and notions of what it means to be a doctor (Lamdin, 2010).

Once students enter medical school, their learning extends beyond the accumulation of professional, technical knowledge and know-how to an enculturation (Olesen and Whittaker, 1970, Beagan, 2001). The role of medical school in the socialisation of students has long been a focus of study with the process of socialisation emerging as complex and involving cognitive, practical, symbolic, emotional, and moral components (Ryynannen, 2001). As signposted in the previous chapter, the transformatory nature of the medical school experience has been noted by sociologists and anthropologists (Becker et al., 1961, Bloom, 1973 and 1989, Coombes, 1978, Sinclair, 1997). However, medical students are not simply learning to be doctors and being socialised into the world of medical practice; they are also forming powerful *student identities* and being socialised into the occupation of being a medical student (Becker et al., 1961, Bloom, 1973 and 1989, Coombes, 1978, Sinclair, 1997). A number of authors identify the inconsistencies faced by students as making the process of socialisation problematic (Shuval, 1975, Hafferty, 1991, Rees and Monrouxe, 2011). It has been argued that in these situations medical students are not necessarily developing traits counter to their early idealism but rather that their idealism is 'side-tracked' by greater demands (Becker and Geer, 1958b, Becker et al., 1961, Testerman et al., 1996) and obedience to authority (Rees, 2003). It is likely therefore that medical school acts as a source of dual identity formation and socialisation and this socialisation is neither straightforward nor linear.

Professional socialisation often takes place within the non-formal curriculum and is just one aspect of a more general adult socialisation. In this way, experiences outside of education

are likely to impact on formation. Even authors purporting to provide a more comprehensive account of the medical student experience (Sinclair, 1997) pay limited attention to the world of students and doctors outside of the medical school or hospital. I assert that whilst the accepted culture, norms and traditions associated with socialisation into the medical profession are an important aspect of developing an identity as a doctor, medical students and novice doctors also experience a more personal sense of becoming based on their experiences, expectations, their place in their own community and their own lives, and the influence of important others. Therefore in this study professional socialisation is considered an interactive, personal and social process and the effect of *all* experiences felt to be important by the junior doctor to their developing sense of self-as-doctor are considered a part of this formation.

Both Bleakley (2002) and Bucher and Stelling (1977) identify the early postgraduate years as an important period of formation beyond the mastery of skills and the development of expertise. By focusing this study in the immediate postgraduate years it provides an opportunity to interrogate when and how socialisation into the profession occurs and the extent to which novices enter work with a well formed sense of identity, the extent to which they (re)develop this identity through the early years of work and whether this socialisation process is straightforward and linear.

2.2.4 *Professional formation and transitions*

Transitions are seen as important influences on professional formation. Medical education and work in the early years is characterised by almost relentless changes in specialty, role, location and status and medicine is cogniscent of the potential consequences of these frequent transitions, mainly because those making transitions do not perform at expected levels of competence immediately (LaPointe and Jollis 2003, Armstrong et al., 2008). Doctors are often thought 'under-prepared' for transitions, especially the move from medical student to beginning clinical practitioner (Lempp and Searle 2004, Illing et al., 2008). The problem with this literature is that it again focuses on a competence model of preparedness based on a simplistic notion of knowledge transfer (Roberts 2004) and does not concern itself with the impact on professional formation of these frequent transitions. Beach's work (1999) identifies broader impacts of transitions. Conceptualising transitions and transfer along socio-cultural lines, he identifies that far from being uncomplicated periods of transfer of learning from one role to another, transitions are transformative, what he terms 'consequential transitions', where the individual 'becomes something new'

and there is a substantial developmental change in the relation between an individual and one or more social activities (ibid, p102). He asserts such transitions are a conscious, reflective struggle to reconstruct knowledge, skills, and identity in ways that are consequential to the individual's identity; creating change in both one's sense of self and one's social positioning (ibid, p114). Evans et al., have recently extended these ideas to medicine and identify transitions not as simple transfer but as a multifaceted re-contextualisation of learning within one context to be used in another (2010). Transitions when considered along socio-cultural lines therefore become significant episodes of professional formation and identity development. For junior doctors, because of their frequency, these transitions are likely to be major contributors, both positive and inhibitory, to a developing sense of self-as-doctor.

2.3   Identity and identity formation

Having explored professional formation this section moves on to place the study within the relevant literatures concerning identity and identity formation. Conceptions of identity, identity formation and socialisation are intertwined and have emerged from the psychological, anthropological, and sociological traditions. Definitions of 'self' and 'identity' vary depending on the academic tradition of the author or researcher and the literature is somewhat difficult to explore as many studies in the domain do not clarify the perspective taken on identity. In general, whereas psychologists have traditionally used individual notions of self, sociologists have adopted more constructivist understandings. A range of discourses of self and identity emerge from this diverse literature. These can be loosely categorised as psychosocial, social-constructionist, and socio-cultural models and they are briefly outlining here to signpost why a particular conception of identity has been adopted in this study; one where identity is not seen as a distinct concept but a *process*, that takes into account the reality of ever-changing social experiences that impact upon identity (Hall et al., 2008).

Psychosocial models (for example, Erikson, 1964, 1968) define identity as *"a subjective sense of sameness felt by individuals within themselves, an experience of continuity oriented towards a self-chosen future"* (Erikson quoted in Ryynänen 2001). Here the emphasis is on the individual aspects of identity, but there is an acknowledgment that identity is also constructed through a constant comparison of self-image and the image

perceived by others through a process of self-reflection, and self-judgement. It remains conceptually a predominantly internal project, with an assumed linear process towards a final product and thus this model provides insufficient focus on the social world and the working practice, during which individuals struggle to create and maintain their identities.

Social constructionist notions of identity move on from this view of identity as located in the individual and cast both 'self' and 'other' as concepts created through dialogue and relationships (Berger and Luckmann, 1966, Shotter and Gergen, 1989). In this way identity is a process: constructed, reconstructed and maintained by the stories we tell about ourselves and others and thus identities are linked to the contexts and practices in which they are created and recreated. Other authors adopting this social construction notion of identity extend this thinking to argue that identities therefore need to be examined in action (*for example*, Penuel and Wertsch, 1995), particularly in contexts where identity is contested or under significant transformations as it is in these contexts that individuals and groups struggle to co-construct a new way of speaking about themselves and to develop new forms of action and identity.

Socio-cultural perspectives on identity foreground the role of both context and personal agency on identity and additionally highlight the collective or social dimension to understanding identity formation: *'it is in cultural practices -- as people "do" life -- that identities are shaped, constructed, and negotiated'* (Nasir, 2003, p15). Holland et al., (1998) suggest identity formation should be viewed as not just as situated or examined within the institutions and communities in which those identities are put to use (what they term the *figurative identity*) but also that identity should also be understood from the perspective of *positionality*: that identity is relational and thus shaped by one's position relative to others: *'ones sense of social place and entitlement'* (ibid, p125). Building on anthropological understanding of these positional identities, they suggest the way in which one is positioned influences the way in which one views and expresses self and that positional identity , *'a person's apprehension of her social position in a lived world' is influenced by everyday relations of power, deference, and affiliation'* (ibid, p127-128).

Whilst social constructionist and socio-cultural notions of identity encourage a more holistic understanding of identity, as something that you *do* rather than *are*, a number of authors in the field of identity studies suggest more attention should be given to *personal* identities, particularly as they relate to social and role identities. Stets and Burke argue that examining all three bases of identities: person, role, and social leads to a more integrated

and a stronger theory of identity (in Leary and Tangney, 2003). Deaux (in Blackwell, 1992) suggests acknowledging both socio-cultural and more personal aspect of self and identity also opens up opportunities to understand the multiple influences on and by the self and others in forming identities. Recognising the social nature of identity, including the influence of culturally sanctioned and collective shared identities on identify formation, and how identity, like professional learning, is an aspect of social practice and is situated, I assert that to gain purchase on how doctors develop a sense of identity, identity formation needs to be considered in the terms of what people *do* and who people *are*. Thus exploring person, role and the social and their inter-relatedness are important, as is viewing professional identity as a discourse that is continuously (re)defined, rather than a set of essential characteristics common to all doctors.

2.3.1 *Professional identity*

Schein (1978) defines professional identity as one aspect of social identity that concerns group interactions in the workplace and relates to how people compare and differentiate themselves from other professional groups. Professional identity is conceived as dynamic and developing over time and involves gaining insight into professional practices and the development of the talents and the values of the profession (Schein, 1978, Ibarra, 2000). In this way it is likely that professional identity is more adaptable and mutable early in one's career. The social aspects of this definition of professional identity, and the way in which it is seen to develop over time from exposure to practice, suggests socialisation into a profession, and emersion in practice both have a significant part to play in professional identity formation. Jenkins (1996) understands the processes of professional socialisation and development of professional identity as being in dialectical relationship with each other. Cohen (1981) similarly suggests that professional identity is acquired through processes of professional socialisation and is also concerned with the acquisition of the knowledge and skills of the relevant profession. Ryynänen's empirical work in the field (2001) supports this understanding and suggests professional identity is formed in situations involving interaction, learning, and practical, professional activity.

2.3.2 *Medical professional identity*

Professional identity, when conceived as an aspect of social identity, is an important element of how individuals approach practice: if it is how we think of ourselves in our professional role, it affects how we perform at work amongst fellow members of the profession and professional others, shapes practice and influences behaviour (Wenger,

1998, Apker and Eggly, 2004). This understanding, like many theoretical conceptions of the processes and outcomes of work-based learning, has only been patchily accepted in medicine. Eisenberg argues that to understand how the professional identities of junior doctors develop, we need to conceptualise identity as *'dynamic, multiple and situated in social relationships and practice'* (2001, p. 281). It may simply be that a nuanced understanding of identity is absent from the medical education community (Monrouxe, 2010): certainly studies in medical education tend to interchange the terms and processes of professional socialisation and professional identity formation without exploration of either term. Most studies in the domain of formation and identity in medicine focus only on socialisation (Ryynänen, 2001) despite the causal links between this medical socialisation and subsequent medical identity formation being unclear (Apker and Eggly, 2004).

Within the literature a range of factors have been put forward as potentially shaping the development of medical identity in undergraduates and early years practitioners including: personal factors (Adams et al., 2006); environmental factors such as time pressures (Becker et al., 1961, Niemi, 1997); communication with other doctors (Hafferty, 1991, Apker and Eggly, 2004); the use of language (Lingard et al., 2002, Apker and Eggly, ibid); role models (Merton et al., 1957, Becker et al., ibid, Kenny et al., 2003); legitimate participation (Niemi, ibid; Wenger, 1998): educational experiences, including reflection (Niemi, ibid); interprofessional education experiences (Adams et al., ibid) and teaching practices (Bleakley, 2006).

The professionalism discourse in medicine, as described earlier in the chapter, has foregrounded a rather nostalgic and virtue-oriented professional identity as the only culturally sanctioned way of 'doing' medicine and being as a doctor (Gee, 1999). However there are likely to be differences between the idealised version of the profession and acceptable professional identity as portrayed to newcomers to the profession, and the real work practised by the existing members of the profession (Melia, 1987). Therefore, part of the development of identity is about individuals developing an understanding of what it actually means to be a professional (Cohen 1981), figuring out what and who they are and are expected to be, and hence moving beyond the idealised version presented to them in formal settings.

Wenger, building on his work that suggests we form professional identity through practice, suggests a helpful way to understand the development of professional identity is to

conceptualise identity as a trajectory; that provides coherence by connecting past and future to the negotiation of the present (in Hall et al., 2008). He identifies a number of trajectories that help to conceptualise the ways in which doctors form their identities. Wenger's *peripheral trajectories* never lead to full participation but are still significant enough to contribute to one's identity. This notion of a peripheral trajectory resonates with the medical school years; with medical students present within, but never truly belonging to, communities of practice. I suggest that these peripheral trajectories are also very much part of the junior doctor experience; with belonging always a partial process because the junior doctor is never a full member of the community of practice but, to a lesser or greater extent, an outsider just passing through. *Inbound trajectories* involve newcomers joining with the prospect of becoming full members: their identities are invested in future participation even though their present participation is peripheral. I propose that the junior doctor's place within a community of practice is not inbound in the way one might expect with newcomers to other professions. The earliest years of practice do not see the formative influence of *insider trajectories*: instead this trajectory is very much delayed until the more stable specialist training element of a doctor's postgraduate experience and this has important implications for learning and for identity, particularly aspects of identity that are related to one's sense of position, in the early years; where the positioning of the junior doctor as a permanent outsider on a peripheral trajectory inhibits anticipated socialisation and professional identity formation. I also suggest this may be overlooked by those supporting learning in the early years. Instead identity is likely to be forming in *boundary trajectories* that involve sustaining an identity across boundaries, a challenging identity demand but one that is a very real experience as junior doctor move from one post and the next, and in o*utbound trajectories* that lead out of a community and involve making new relationships and seeing oneself in new ways.

Wenger (in Hall et al., 2008) suggests that we form identity by reconciling our multiple memberships and our varied trajectories within these communities. Whilst this is a helpful in understanding professional identity formation in medicine, I would argue that the contemporary world of junior doctors presents a complication that requires further consideration. As previously identified, some elements of a Foundation Programme rotation may not be within a community or role of choice but part of a predetermined rotation: in these instances the role may not be a stepping stone onto a different and more valued trajectory but is to some extent a cul-de-sac. If doctors develop their identity through reconciling serial memberships (and partial membership) within different

communities; some of which he or she feels more or less a part of and that are more or less aligned to their personal trajectory, what do they make of these communities to which they never feel they belong (or want to belong)? What impact do these reluctant memberships have on identity? And what do consequent interstitial or informal communities formed in these situations contribute to developing identities?

Whilst the social is clearly important in shaping professional identity, I would argue this casting of professional formation as created by trajectories of membership somewhat underplays the influence of the personal trajectory on professional formation. As highlighted earlier in the chapter, individuals tend to enter the profession with a robust orientation (Cavanagh et al., 2000) and medical school is a powerful socialising force. Low attrition rates, both at medical school and in the early post qualification period suggest doctors have an enduring sense of self-as-doctor. As Identity theorist begin to grapple with the importance of incorporating influencing aspects of the personal in identity formation, so to we need to acknowledge the influence the personal, the enduring values and orientations, on the overall process of professional formation. This is likely to produce a personal trajectory in novice doctors which, whilst possibly still underdeveloped in a practical sense, is a powerful influence and, like other trajectories, based on the constant (re)negotiation of professional identity.

2.4   Summary

This chapter explored the existing literatures and theories in the fields of identity and professional formation in an attempt to identify how the identities of newly qualified doctors might be formed and how professional expertise begins to develop. It has used the literature in the fields of professional learning and formation to provide a background to the conception of professional learning in this study as going beyond the acquisition of a professional knowledge base and knowing how to utilise this knowledge, and indeed beyond conceptions of all professional learning as situated, towards a model that concerns individuals *becoming* doctors through an iterative process linked to their participation in practice, their use of knowledge and know-how and their developing sense of self-as-doctor. I have also argued that a broad conception of identity, acknowledging the social and the personal and the interplay between the two is important to understand and unpick the influences on individuals as they work out who they are in the world of doctoring. This chapter thus provides a backdrop for the next chapter, which demonstrates how the

literature and theoretical perspectives in the field have influenced the theoretical and analytical framework with which this study has been approached.

Becoming Doctors: the formation of professional identity in
newly qualified doctors

Chapter 3: Theoretical and analytical framework

In Chapter 2 the existing literatures and theory were used, together with my own experience, to present professional learning and identity formation in novice doctors as interlinked, situated and socio-cultural. This thinking is further developed in this chapter and used as a basis to define the theoretical and analytical framework used in this enquiry: the thinking and positioning that underpin the research question, the research approach, the methodological choices and the interpretation of the findings.

This chapter begins with an account of the epistemological stance that shapes my research approach and, ultimately, what sort of contribution the research findings might make towards disciplinary knowledge. It identifies the key theorists that have influenced this stance and the 'lens' adopted to focus the research with the aim of coming to understand the field, and the specific object of inquiry. It goes on to outline how adopting a socio-cultural perspective on identity and professional formation not only allows a multifaceted exploration of how identity and expertise develops, but helps provide purchase on key influencing factors in the lived experiences of young doctors that encourage or inhibit such formation. Finally, it outlines the aims of the study and the research questions, clearly identifying how my theoretical positioning has led me to frame these particular questions in this particular way.

3.1   Theoretical perspectives

As identified in previous chapters, I approach this study with a particular stance with regard to the key concepts of learning, formation and identity that form the basis of this enquiry. I have adopted a socio-cultural interpretation of professional learning, and professional development. By socio-cultural I am using this term to refer to a group of theories that share the premise that learners and social organisations exist in 'recursive relation to one another' (Beach 1999). I maintain a predominantly situated perspective on this tacit element of learning medicine and medical practice and suggest that learning to be a doctor is an aspect of social practice and is thus shaped by the learning and practice environment, relationships with others in that workplace and the activities individuals become involved

in within that workplace. My theoretical perspective of identity and identity formation is that identity can be understood as a socially constructed phenomenon that develops within and through social practice (Rubin 2007) and that identity is not solely located in the individual, but rather *'negotiated in social interactions that take place in cultural spaces'* (Nasir and Saxe 2003, quoted in Rubin 2007). I suggest that identity as a junior doctor is dynamic, situated and reflexive and that a professional identity develops, and novices *become* doctors, through participation in practice:

> *...because learning transforms who we are and what we can do, it*
> *is an experience of identity. It is not just an accumulation of skills*
> *and information, but a process of becoming.*
>
> *(Wenger, 1998, p.215.)*

Adopting these perspectives has a fundamental influence on the research approach and therefore the potential research outcomes of this study. Firstly, the research is focused on providing a detailed understanding of what is clearly a complex phenomenon therefore a qualitative methodology has been adopted. Secondly, in common with most research on workplace learning and professional development, and a small, but growing, volume of medical education research, I have used a socio-cultural approach in this study of identity formation: the overall approach adopted is a constructionist one, which can be broadly characterised as interpretivism. Thirdly, by searching for the meaning individuals create from their experience rather than aiming to uncover a simple or common trajectory, this study aims to access multiple and diverse interpretations of reality rather than seeking to reveal an overarching phenomenon (Berger and Luckmann quoted in Bunniss and Kelly, 2010). Finally, in an attempt to access personal experiences and understandings and the participation in practice in which identities are being formed, the richest data sources are the stories and the meaning making that goes on as these stories are told, and an insight into the world of doctoring in which this learning and formation is taking place.

In adopting an interpretivist approach this study anticipates the co-construction of meaning; acknowledging the influences of the researcher at the point of data collection, and an approach to data interpretation where the researcher's perspective is acknowledged and accepted as intimately woven into the findings of a study. Whilst broadly within the interpretivist paradigm however, this study aims not simply to illuminate the issues in a neutral or abstract way, but, in the tradition of Bourdieu and others, to politicise them: to critique the discourses and practices identified (Webb et al., 2002).

It is also important to highlight at this point that my positioning is clearly theorised within the socio-cultural literature and that this is in considerable contrast to the medical perspective. Indeed making a theoretical framework explicit at all in medical education research is a relatively infrequent occurrence when compared to the mainstream education literatures. Recent critiques of medical education research (*for example*, Monrouxe and Rees, 2009, Bunkiss and Kelly, 2010) highlight that the positivist paradigm, dominant in medicine and medical research, extends into medical *education* research, despite its clear limitations for studying complex social phenomena. Along with other authors, I have argued that these limitations have not only hindered the discipline's progress and impact but limit the ability of the medical education community to develop a meaningful understanding of some of the pressing issues in the field (Monrouxe and Rees, 2009, Gill and Griffin, 2010).

Furthermore, my experience as a medical educator is that the existing literature, limited in both quantity and quality, is often used as a rather faulty basis for action; creating an illusion of understanding of complex issues and leading to 'evidence-based' solutions from decision and policy makers. I assert that this can be problematic in many areas but it is of particular importance in the issues at the heart of this study. The 'medical perspective' sees formation of professional identity as an automatic and mainly problem-free process, established as part of developing expertise and knowledge, and does not tend to interrogate how it might develop operationally in professional settings (let alone how development might relate to peers and others). Where the understanding of this phenomenon is overlooked and under-theorised there is the potential for those charged with supervision of junior doctors, and indeed the policy makers that influence and direct their supervisory practices, to fail to support this critical developmental stage as a doctor, creating problems further in the career with underperformance and a failure to fully engage in practice. This is what makes this research, approached in this way, a compelling undertaking for me as a practitioner, and for the medical education community as a whole. As it is unlikely that medicine is alone in taking for granted that 'becoming' is an automatic rather than mediated phenomenon, this study has the potential to inform across the field of education for the professions and create a more substantial foundation for the consideration of further action to support professional formation.

3.2 Theoretical Framework

My positioning, that uses social practice to theorise professional learning and identity formation, draws on the thinking of a number of key theorists whose empirical and theoretical work has profoundly influenced the interlinked fields of identity studies, work-based learning, practice and expertise. Starting with Bourdieu, in particular his notions of *cultural field,* and *habitus*, I use his work to understand the social interactions and conditions that influence both practice and a sense of identity (1977, 1990). As I conceptualise learning and formation in medicine as interlinked, I also bring in the thinking of Lave and Wenger on *situated learning* and *participation* to provide a clearer focus on learning as part of social practice and formation (1991). This understanding of practice, learning and participation is further developed to include aspects of Holland et al.'s theory of self and identity that concerns *figured worlds* and *positionality:* to better conceptualise the multiple aspects of, and influences on, identity, the sense of agency and position that emerges through engagement with the social and how language is used in the creation of self (1998). In the following section I show how these areas of theory have influenced my understanding of the field that constitutes the particular focus of this study, and how I have used these concepts to interrogate how individuals *become* doctors.

3.2.1 Bourdieu: cultural field and habitus

Bourdieu's work in understanding the relationship between people's practices and the context in which those practices arise, is a central foundation of my understanding of the development of professional expertise and identity in novice doctors. Bourdieu describes these contexts or sites of cultural practice using the metaphor of a 'field'. For Bourdieu, 'cultural fields' are:

> ... *a series of institutions rules, rituals conventions, categories,*
> *designations, appointments and titles which constitute an*
> *objective hierarchy, and which produce and authorise certain*
> *discourses and activities.*   *(Webb et al., 2002, p21.)*

He suggests a cultural field is dynamic; created by the interactions between institutions, rules and practices as individuals and groups within the field attempt to determine what counts as capital within that field and how such capital should be distributed. He suggests power within a field is determined by both position and possession of relevant capital. These cultural fields are therefore sites of cultural (re)production. Linked to this notion of

cultural fields are ideas of: *cultural literacy*; a self-reflective ability to understand the rules and values of the field, *discourses*; accepted forms of language within the field; *cultural capital*; culturally authorised possessions, behaviours, attributes, skills and values, and *orthodoxy and heterodoxy*; the beliefs and values that constitute the received wisdom of a field that create a status quo, or challenge that status quo, respectively. This notion of the field casts professional formation and one's sense of identity as a doctor as intimately linked to the workplace and the people and practices within that workplace, the gaining of culturally specific capital, a sense of the tacit and explicit rules of the game and a sense of belonging to the field.

Using the notion of the field when conceptualising a profession such as medicine, suggests there is an acceptable behaviour for newcomers that constitutes an expectation of the profession's members and that this is communicated both intentionally and unintentionally, in both education and in practice. The need to gain purchase on 'the field' in this study suggests an approach that encourages novices to articulate descriptions of everyday life in practice, education experiences in their broadest sense, and what it is to be a junior doctor in this place at this time in the 'storying' of professional identity formation (Winslade 2002). It also suggests that an interrogation of actual practice, both as observed and as described, will give purchase on the field itself.

Bourdieu's field theory also attempts to make sense of the structure and agency debate as it applies to practice by providing the notion of *habitus* as a way of thinking beyond this subjectivist-objectivist split (Webb et al., 2002). He suggests the habitus is a partly unconscious taking in of the rules, values and dispositions of the field: *'the durably installed generative principle of regulated improvisations (which produces) practices.'* (Bourdieu in Webb et al., 2002, p36). Bourdieu suggests that as agents are socialised in a cultural field they learn about, and accommodate to, their roles and relationships in the context of their position in the field, and internalise the relationships and expectations for operating in that domain: sometimes referred to as developing 'a feel for the game'. These internalised relationships, roles and expectations form, over time, the habitus. Bourdieu suggests this habitus is both durable and oriented to the practical and, as it is constituted at the point of practice and is used as a way of reacting to a particular problem, choice or situation, it has a profound effect on practice.

An important feature of the habitus is that it said to naturalises itself; that is these rules, norms and practices become devoid of their conditions of construction and are perceived

as 'common sense' by members of the field, but are in fact arbitrary (Webb et al., 2002). Bourdieu suggests we internalise these so profoundly that they become part of who we are and we reproduce them spontaneously and unconsciously and that, by perceiving these rules and practices as 'natural', we limit possibilities for alternatives. Bourdieu does however suggests that because habitus is constituted at the point of practice, it is always modifiable and this modification tends to occur when the habitus becomes conscious; because it has stopped making sense as a way of addressing a situation, or when the agent perceives modification as a means of gaining improved position or capital in the field.

Perhaps the most important features of the habitus in the context of this study are: that the habitus is created through practical experience or gaining a 'feel for the game' (May 1996); that cultural trajectories, the movement between fields through an individual's history, shapes the habitus (Mahar et al., 1990); and that the habitus is internalised and becomes part of who we are, thus knowledge, including how we understand our world, is constructed through the habitus. Using these understandings of identity as formed through practice suggests a research approach that encourages participants to make explicit the process of gaining (or failing to gain) a 'feel for the game' as they start to feel their way into their working lives. This will help me to gain some purchase on the habitus. By selecting as participants those who have recently undergone a consequential transition, the becoming of something new (Beach 1999), this process may be a little closer to the surface and thus more accessible. Whilst the habitus is largely internalised, Bourdieu suggests it can be partially described through interrogation of the field and the perceived actions of agent on field and field on agent. Although an 'insider' in this study because I am a doctor, I am a very different sort of doctor to the doctors in this study (in seniority, in specialty and even location of practice) and so the rules, dispositions and practices within the field of the modern junior doctor are not normalised within my own habitus; allowing me to more clearly see these practices and discourses as not necessarily 'common sense' and to legitimately question and explore these with participants.

Importantly, the relationship between field and habitus is cast as dialogic; as external structures and practices are internalised into the habitus and the actions of the agent externalise interactions between actors into the social relationships in the field. An exploration of how the field has been perceived to shape participants' emerging identities, both as a facilitator and as a brake, is an important part of understanding the dialogic nature of professional identity formation. Using Bourdieu's lens therefore allows

professional identity formation to be viewed as a process of resolving construction of the self (*habitus*) in relation to wider influence (*the field*) (Brosnan and Turner, 2009).

Whilst the notions of field and habitus in this study of identity are clearly helpful, Bourdieu provides a rather deterministic notion of the habitus arising from the field (Jenkins, 1996) and, in my view, this neglects, or down plays, two important issues: reflection on practice and resistance to the habitus. Firstly issues of reflection, in the Schönian sense of the term (Schön, 1983); the human quality that supports our own lines of enquiry and allows us to bring past experience to bear on current problems and to interrogate and make sense of what goes on around us are missing from this conception. Secondly, Bourdieu suggest habitus only becomes conscious when it stops making common sense or when the individual can make a gain, either positional or capital, from change. I will challenge this over deterministic account and suggest that junior doctors today are mindful of, and indeed some would argue politicised about, a number of the assumptions, norms and practices within their 'field'. Furthermore, this mindfulness of the field and the game being played allows them to select which elements of the identity they chose to adopt and reject and these choices are as much about pragmatism and resolving tensions as they are about gain.

Bourdieu's theory of field and habitus thus creates one important element of the theoretical framework of this study; providing a lens through which practice as relevant to identity can be understood. However, this study also concerns *professional learning* as a fundamental element of professional formation and, as Lave points out, whilst Bourdieu offers a robust theory of practice, his theories operates without a strong theory of learning:

> *Bourdieu takes cognition in its conventional sense as an*
> *unexamined primitive element of this conception of disposition...*
> *these views continue to relegate culture, acquisition of knowledge*
> *and memory to an internalised past, closing it to the investigator*
> *except as it surfaces in action.*   *(Lave, 1988, p18.)*

As my positioning understands professional identity to include the development of professional knowing and know-how, it is to Lave and Wenger that I turn for a theory of practice that has a more emergent, generative, future-shaping character and that extends Bourdieu's theory to one that more clearly addresses *learning* and formation in practice.

3.2.2 Lave and Wenger: situated learning and legitimate peripheral participation

Lave and Wenger propose an understanding of learning as an integral and inseparable aspect of social practice (Lave and Wenger, 1991, p31). Through their work on providing a more nuanced understanding of apprenticeship, participation, and the relationship between learning and practice, their theories support a conception of professional learning as an interwoven aspect of practice rather than as a separate activity. They consider learning as *situated*. In using this term they are not simply suggesting that learning occurs in-situ or that individuals learn by doing, but that learning concerns activity in, and with, the world (ibid, p33). By casting learning as situated they suggest this refocuses conceptions of learning away from solely concentrating on the internalisation and assimilation of knowledge by the learner, and allows a more complete understanding of learning that includes the nature of the learner, their world and their relationship with that world (ibid, p47). It also moves understanding of learning away from a view that it is a primary activity in and of itself towards one where *'social practice is the primary generative phenomenon and learning is one of its characteristics'* (ibid, p34).

Legitimate peripheral participation is their term for the engagement in social practice of which learning is an integral part. When used as a way of understanding learning, it can be seen as an evolving form of belonging and a way of gaining access to communities of practice by growing involvement in their practices. They suggest learning through legitimate peripheral participation takes place whether there is intentional instruction or not. In contrast with notions of learning as acquisition and internalisation, learning is *'increasing participation in communities of practice* (that) *concerns the whole person acting in the world'* (ibid, p49). This refocusing on the learner, away from the person in isolation as a receiver of information toward the person-in-the-world, casts learning through practice as *becoming a kind of person* and thus includes the construction of identity: that *'identity, knowing and social membership entail one another'* (ibid, p53). In this way they cast identity and professional learning as intimately interwoven and interdependent and that identities and motivations develop as newcomers move towards full participation.

Lave and Wenger also propose that their concept of legitimate peripheral participation provides a framework for bringing together theories of situated activity and theories about the production and reproduction of social order through the evolving relationships between newcomers and old timers. This nuanced understanding of apprenticeship is

important in this study in the field of medicine where the apprenticeship model has been employed for centuries but where understanding how learning happens within apprenticeship relationships and situations is under theorised. It suggests examining experiences of practice is central to understanding professional learning and its contribution to formation.

Two further aspects of situated learning and participation theory important to my theoretical framework are the consequences of restricted participation, where the doctor's trajectory and the workplace community are rather temporary bed fellows, and the role of language and discourse, within and about practice, in identity formation.

Legitimate peripheral participation as a model of apprenticeship learning takes into account the social environment of the learner (Lave and Wenger, 1991) and their relationships within that world. Learning, or failure to learn, in apprenticeship may therefore be related to the success or otherwise of participation. However, as signposted in chapter 2, whilst Lave and Wenger's notions of communities of practice and participation cast newcomers as moving from periphery to centre as expertise and membership develops, for novice doctors, particularly in the contemporary training and education world, this participation often remains peripheral. I propose more complex bypass routes to belonging and becoming are undertaken by novice doctors and this study aims to interrogate how this more de-centred belonging supports, or inhibits, learning and formation.

Lave and Wenger (1991) highlight the consequences of being in a workplace that does not allow the exercise of agency or the development of a sense of belonging:

> *Conditions that place newcomers in deeply adversarial relations*
> *with masters, bosses, or managers; in exhausting over*
> *involvement in work or in involuntary servitude rather than*
> *participation, distort, partially or completely, the prospects for*
> *learning in practice.* *(ibid, p64.)*

In these situations they suggest that communities of practice may well develop 'interstitially and informally' (ibid) and what is learnt will be the socio-cultural practices of the informal communities of practice. This provides a way to interrogate whether and how junior doctors bypass the communities in which they are 'posted' and what might be the consequences for learning and identity formation.

Wenger, as an extension of this work in the area of identity and belonging, redefines identities as they form in relation to communities and participation as *trajectories* (in Hall et al., 2008); noting the effect of an individual's trajectory on possibilities for participation and consequent identity formation. Junior doctors pass through multiple posts and a range of factors are likely to affect their sense of belonging, their participation, their relationships to 'old timers' and their opportunities for learning and development. These factors will each impact on their sense of positionality and agency regarding the behaviours and identities they may be allowed to exhibit or reject.

The role of discourse is captured to some extent in situated learning theory: with *'discourse production as part of that social practice and not a second order representation of practice'* (Lave and Wenger, 1991, p22) however this aspect is relatively underdeveloped as it applies to identity. As my positioning considers professional identity as *'self-in-situation, and central to this concept is the notion that self is constructed, maintained, and challenged by self and interlocutor's communicative practices'* (Eisenberg, 2001, p281), the final facet of my theoretical framework accesses the work of Holland et al., (1998) to extend this framework of sociocultural theories of formation to utilise theory that has language and 'talk of self' as a more central aspect of identity formation and maintenance. Holland et al.'s work also foregrounds the relational nature of identity and the role of agency and active choice in selecting and rejecting aspects of identity which appear useful in understanding the active crafting and re-crafting of identity as a junior doctor's roles and relationships constantly change.

3.2.3   *Holland et al.: Figured worlds and positionality*

Holland and her colleagues (Holland et al., 1998) offer a theory of self and identity that draws on a range of schools of thought, including cultural, anthropological and constructivist understandings of identity. Their theory builds (inter alia) on Bourdieu's notion of cultural field and habitus. They describe identities as 'self-understandings' and suggests people come to understand themselves, to *figure* who they are, through the worlds in which they participate and by how they relate to others both within and outside of these worlds. Their theory extends the work of Bourdieu both in understanding identity as a more reflective 'storying' of self and in moving on from the deterministic notion of the habitus highlighted previously, in recognising the potential to create opportunities to change this narrative of identity, particularly as an individual moves through different contexts.

They also emphasise, like Giddens (1991), the role of language in the construction and maintenance of an on-going 'story' of self:

> *What people tell others and themselves about who they are and*
> *the way they act as though they are who they say they are.*
>
> (ibid, 1998, p3.)

Perhaps the most important aspect of their work that allows me to extend my thinking about how doctors develop a sense of self-as-doctor is the concept of *figured worlds* which they define as:

> *Socially and culturally constructed realm[s] of interpretation in*
> *which particular characters and actors are recognized,*
> *significance is assigned to certain acts, and particular outcomes*
> *are valued over others.*   *(ibid, p52.)*

These figured worlds are conceived as *cultural* phenomena into which people enter and that develop through the activities of their participants and which function as contexts of meaning. They are social encounters in which participants' positions matter and importantly *relate actors to landscapes of action* creating identifiable social types and persons. Thus:

> *Identities form in these figured worlds through the day to day*
> *activities undertaken in their name, and are historical*
> *developments, grown through continued participation in the*
> *positions defined by the social organisation of these figured*
> *worlds.*   *(ibid, p41.)*

These figured worlds help to create *figured identities* and are places where people come to conceptually and materially produce self-understandings and thus identities.

Two further concepts developed in this theory are also important in understanding identity formation in new doctors: *positionality* and *space for authoring*. Positionality suggests figured worlds create not just figured identities but also *positional* or *relational identities*. These positional identities shape affordances within figured worlds and suggest when people are positioned they are not so much engaged in self-making, but rather are *'varying the degrees of accepting, rejecting, or negotiating the identities being offered to them'*

(Urrieta, 2007, p111). Space for authoring captures the reflexive, agentic, narrative creation of self through multiple internal dialogues and new talk of self.

Within figured worlds *'discourses, practices and interactions provide important tools for identity formation'* (Horn in Rubin, 2006, p. 6), thus figured worlds provide a useful framework to interpret meanings of actions, cultural productions, performances and disputes, and the understandings people come to make of these and themselves (Holland et al., 1998). The notion of figured worlds is also useful for conceptualising the way that meaning systems take on coherence in particular settings (Rubin 2007): to identify what is valued as 'being a good doctor' in the workplace; both personally and by others.

Adopting this perspective places narratives or stories as central to understanding identity. When Identity is seen as created by self-narrative (Bruner, 1991, Giddens, 1991) it must continually integrate events which occur in the external world to create an on-going story about the self. These personal stories are thus not only acts of telling someone about one's life and life-world but also a means by which identities can be fashioned (Holland et al., 1998): the self is inseparable from the narrative or life-story it constructs for itself. Narratives are also an important aspect of positionality: how people talk of self, and indeed the conversations and relationships they are afforded, are affected by how they see themselves positioned in relation to others. Using the lens of positionality, what participants say, both to me within the context of interviews, and to others, as witnessed during observations, provides important insights into the relationships between how the doctors are positioned (or perceive themselves to be positioned) and professional formation and learning.

Notions of figured worlds and space for authoring also help me gain purchase on what it means personally to participants to be a doctor and whether these doctors accept or reject idealised notions of a 'good' or 'professional' doctor (both in their fashioning of self as doctor in general and in particular within individual posts) and whether the figured worlds of novice doctors, dominated by artefacts such as the current discourse of competency, shifts and consequent 'handover' and GMC rhetoric, is perceived by them as too narrow and restricting. The notion that figured worlds are not static will also allow me to explore what happens when they run up against the limitations of this figured world, the resistance they exhibit or are permitted to exhibit in relation to the positionality they see as imposed on them, and whether they engage in new world-making from restrictive figured worlds.

As figured worlds can represent multiple, and even contesting identities for each individual, this understanding will allow me to explore any duality of 'being a good doctor': whether the outward-facing, risk adverse, compliance version of 'professionalism' as created through policy and within the contemporary competency driven world of medicine and the inwards-facing, personal meaning and patient focused professionalism are part of the same world or occupy different spaces.

In summary, this study uses social practice to theorise professional learning and identity formation and draws on a number of key theorists whose empirical and theoretical work has strongly influenced the interlinked fields of identity studies, professional formation, work based learning and practice. I have used as a foundation Bourdieu's work on practice to understand social interactions and the conditions that influence practice and a sense of identity. However this theoretical model has some limitations when learning and expertise are considered central to identity and where a more reflective, self-understanding conception of identity is put forward and therefore I have extended my theoretical framework beyond that put forward by Bourdieu by incorporating Lave and Wenger's work on situated learning theory to better understand learning as part of this social practice and Holland et al.'s work to further theorise how aspects of the habitus might be taken up or rejected in creating figured identities and how language is used in the creation of self. In this way I have constructed a framework in which to investigate the multiple influences on junior doctors as they develop a sense of self and as they *become* doctors. This leads to a particular framing of the study focus and research questions as outlined below.

3.3 Aims of the study and research questions

The aim of this study is to explore how professional identities are formed in newly qualified doctors: how they *become* doctors, and the influences that affect this identity formation. It is clear from the complex nature of formation, identity and expertise identified in previous chapters and my sociocultural framing of this process, that the object of inquiry in this study is not immediately accessible. I am not measuring an observable phenomenon; instead my object of inquiry, the *becoming* a doctor, the type of learning and socialisation that this implies, the events and experiences that affect formation and the kind of self-understanding this involves, are tacit, dynamic and subjective. In attempting to understand and make sense of this I need to ensure that any reification does not reduce *becoming* to an object-like or oversimplified conception of what is being studied (Säljö, 2002).

Furthermore, it is also clear that the isolated individual is not a sufficient unit of analysis in this study: the actor, the activity and the environment in which that activity takes place must all be incorporated. To gain purchase on the complex and tacit object of this study the units of analysis are the complex and multidimensional *figured worlds* and experiences of junior doctors as described and as enacted (Holland et al., 1998) and the points of access to these worlds are life history, narrative-style interviews and naturalistic observations.

As participants narrate their experiences and perceptions, I am interested in *what is the nature of the experience described by the participant?* and *how has she/he come to understand it, and talk about it in this way?* In conceptualising a 'storying' of professional identity, I do not expect participants, nor ask them, to construct a self-contained notion of identity, one that is owned within the individual and independent of the world around them or the practices they take part in. Instead, I am interested in a more constructionist understanding of identity (*for example*, Shotter and Gergen, 1989): in identities that are constantly formed in practice, in relationships and through reflection. By using observations in addition to this storying of self I am attempting to gain purchase on actor-in-world, not as a way of triangulating data but as a means of conceptualising and enriching the interview data.

The objectives of this study are:

- To identify how the professional identities of newly qualified doctors are formed
- To understand the influences, both major and minor, both personal and social, that have affected this identity formation
- To explore the effects of this emerging identity on their practice as a junior doctor

My specific research questions and focus that arise from these objectives are:

1. How do junior doctors describe their development as doctors?
2. What are the perceived significant influences on this self-concept?
3. What are the manifestations of these influences in the identity/identities produced?
4. How far have these influences helped or hindered their development as a doctor? And what compromises have they had to make?
5. To what extent are these professional identities and the processes of identity formation common amongst this group?
6. To what extent are these identities at odds with idealised notions of novice members of the profession?

3.4 Potential of the study

This study aims to determine how identity and professional expertise are formed in and by practice and how this identity formation is fundamental to becoming a doctor and participating in the social world of doctoring. For medical educators this work provides insights into the socio-cultural dimension of professional formation and, by exploring identity as a fundamental aspect of professional development, it extends understanding in an important area currently under theorised in the literature. By highlighting the what, when, how and why of factors that support or inhibit this formation it provides a theoretical and empirical foundation upon which to consider how supportive cultures can be developed, meaningful relationships fostered and professional learning mediated in both the undergraduate and early postgraduate years. With the preparedness for practice of new doctors and the clinical risks associated with transitions frequently questioned in the medical education literature (Brennan et al., 2010, Wilson et al., 1998), this stage in training has become a current focus for education and policy reform (GMC, 2009 and 2011 and DoH, 2005 and 2010). By interrogating these early years as a key developmental period and consequential transition (Beach, 1999) the study has a place in informing debates, pedagogy and policy.

It is also clear that studying *this particular group of doctors* at *this particular time* provides exciting new understandings. The junior doctors in this study represent a unique cohort; who are emerging as products of a reformed education into a dramatically altered world of work and into a rapidly changing society in which notions of the very purpose of the medical profession and the nature of the social and fiduciary contract are questioned and challenged.

Finally, in relation to my own professional work as a curriculum lead in undergraduate medicine, this study provides an opportunity for me to explore questions about identity formation as a fundamental aspect of professional development. With professional development within the current competency culture often reduced to a set of learnable competencies and still largely framed in the positivist paradigm in the medical education literature, this study provides an opportunity for me to offer a different account of professional formation, influencing both my own practice and acting as a persuasive resource to influence policy and practice within the medical education community.

Becoming Doctors: the formation of professional identity in newly qualified doctors

Chapter 4:   Methodology

Chapter 3 identified the epistemological stance that underpins the approach to this study, outlined the theoretical and analytic framework that has been applied to attempt to understand the object of inquiry and outlined the aims of the study and research questions.

This chapter begins with an overview of the methodological approach to the study; highlighting the consistency of this approach with my theoretical perspectives. It moves on to a detailed description of the research design; outlining the selection and recruitment of participants, the methods used to generate data and how data were generated, managed and stored. It details how analysis, rather than an isolated stage, permeated the data generation process; with the analysis and interpretation taking place in an iterative way as data were generated.

The chapter moves on to describe the approach to further analysis and interpretation of the research data, identifying the ways in which the analytical framework was put to work to find meaning from the detailed and complex stories and observations.

Having outlined the research approach and research design, the chapter moves on to identify methodological and ethical issues that arise from the choices made and how these affected the nature and quality of the data generated.

4.1   Methodological Approach

As outlined in previous chapters, I have adopted a socio-cultural conception of identity, learning and professional formation as an organising framework and this provides not just a steer to the research question I am interested in pursuing but also to the approach I have taken to address it; the methodological decisions about what data, how, and from whom will best enable me to gain purchase on professional identity formation as a socially constructed phenomenon. This socio-cultural positioning also has a fundamental influence the interpretation of findings and, ultimately, the research outcomes and claims.

The study aims to provide insight into a complex phenomenon as understood by those who have personal experience of it and therefore a qualitative methodology has been used. This socio-cultural framing casts experiences in practice as fundamental to the development of both professional identity and the professional learning that shapes that identity and so relatively novice doctors are the participants in this study. Existing research in the field tends to focus on students anticipating practice (*for example,* Niemi, 1997, Monrouxe, 2009a), or on doctors already well into the specialist practice phase of their careers (*for example,* Pratt et al., 2006, Clandinin and Cave, 2008). I assert that more junior doctors, will have particularly rich, almost daily stories and experiences of 'becoming'. They will be entering new fields and communities, be forming new relationships, be re-contextualising existing knowledge and rapidly developing practical, professional knowledge and know how, be learning the 'rules of the game' and their positions within the field and, importantly, will be undergoing frequent and demanding transitions.

It is also clear that within this theoretical framework the isolated individual is not a sufficient unit of analysis in this study: the actor, the activity and the environment in which that activity takes place must all be addressed in the methodological approach. To gain purchase the social experiences and personal understandings of junior doctors I have chosen to use life-history, narrative-style interviews and naturalistic observations of research participants as they go about their day-to-day work.

Where identity is conceptualised as dynamic, social and created by narrative, both with self and with others, the capture of personal stories and sense-making of these doctors become central to addressing the research question. My understanding of these narratives are that they are about who one claims to be, include explanations of behaviour, are sense-making, and involve the management of social impressions; all central to my notions of identity as *constructed* and *dynamic*.

Framing Identity as a lived experience; with novices *becoming* doctors, through participation in particular practices (Wenger 1998) means gaining some purchase on the learning and practice environment, the relationships with others in that workplace and the activities individuals become involved in through practice, are also central to addressing the research question. Observations of everyday practice and the social contexts in which participants go about their practice are used as additional points of access providing contextual insights into how professional identity is created; both in how what participants

do corresponds to or contradicts their perceptions portrayed in their narratives and in giving purchase on the complexities of self-in-world.

4.2   The study population and the research sites

Doctors in their second foundation year (FY2) can be considered 'telling cases' for this research. They have begun their work as doctors and have moved from their highly supervised pre-registration year and are beginning to establish themselves in more independent practice. They have been through a number of posts and thus have experienced 'finding their feet', fitting in and moving on a number of times. They are also looking forwards to the specialist training part of their careers. FY2s can be considered a 'population' because of a number of consistencies between them: they have all been subject to the influencing effect of medical school; they have successfully graduated and been granted the title 'doctor', have completed the pre-registration year and gained full registration with the GMC and they will all have experienced 'rotating' through a range of posts.

 The site of the study was the North Central Thames Foundation School (NCTFS) one of the 18 'Foundation Schools' in England: the educational and organisational structures responsible for providing, coordinated and supervising foundation posts within a geographical area. The NCTFS area covers a wide and densely populated area of north and east London and provides over 330 foundation posts across a diverse range of workplaces (NCTFS, 2012).

Four NHS Trusts, associated with NCTFS were identified as research sites as they incorporate the typical range of placements experienced by FY2 doctors. The doctors were recruited into the study by e-mail invitation sent by the Foundation Programme Directors at the participating Trusts to the whole FY2 population based at that site (see appendix 1). Initial expressions of interest were followed up with a more detailed description of the study and detailed participant information sheets (see appendix 2). To ensure the most comprehensive sample was utilised within the constraints of the study, purposive sampling of those expressing an interest in participating was used. Participants were selected from those working in all four Trusts, including those undertaking placements outside of the Trusts in associated mental health Trusts or general practices, and from a variety of

specialties[1], including academic positions. The sample also selected: men and women; those who entered medicine as an undergraduate and as a postgraduate; and those who trained at medical schools associated with the NCTFS and those who trained elsewhere. Twelve FY2 doctors were recruited to the study, the sample size chosen to be sufficient to include doctors with the range of demographic, educational and occupational characteristics outlined above. Table 1 provides an overview of the demographic and biographic details of the participants and their current posts. The purpose of the detail provided is: to demonstrate a 'typology' of junior doctors, revealing the range of participants included in the study; to give some insight into the 'field' in which each participant is learning and working; and to provide some indication of what the individual is bringing to their identity from their personal life. Thus it provides a heuristic framework that will allow me to draw on some of the ideas developed in previous chapters as I analyse the data.

---

[1] In the FY2 year, doctors have not yet embarked on training towards a specialty. Instead they complete a rotation of short attachments in a variety of areas of medical practice.

Table 1: Demographical/biographical details of participants

Name[2]	Demographic details	Biographic details	Details of current post
Clematis	In her late 20's she is marrying later this year	Studied medicine as an undergraduate at a medical school not associated with NCTFS	Clematis has completed two, 4-month FY2 posts and has been in her current post for 1 week. All three FY2 posts were in teaching hospitals; this final post is in a specialist hospital with few other foundation doctors on site
Lavender	In her early 30s she is married and expecting her first baby	Studied medicine as a post doc in the United States then came to the UK for her foundation posts	Lavender has completed one, 4-month FY2 post at a central London hospital and is in her final week of her second post in the busy emergency department (ED) of the same Trust with many other doctors in training on site
Oak	In his mid 20's he is in a long-term relationship	Studied medicine as an undergraduate at the medical school associated most closely with NCTFS	Oak has completed one, 4-month FY2 post at a central London hospital and is in his final week of his second FY 2 post in adult mental health in a small hospital with few other foundation doctors on site
Thistle	A single man in his mid 20's	Studied medicine as an undergraduate at the medical school associated most closely with the NCTFS	Thistle has completed one FY2 post in a central London hospital. He was completing his last day of his second post in General Practice during his observation and first interview where there was one other FY2 doctor working. He had just started a new job in the ED of a central London hospital with many other doctors in training on site at the time of a second, follow- up interview
Tulip	A single woman in her mid 20's	Studied medicine as an undergraduate at the medical school associated most closely with NCTFS	Tulip has completed two, 4-month FY2 posts and is in her second week of a post in orthopaedics. All three FY2 posts were undertaken in a hospital Trust recently reconfigured as an Integrated Care Organisation
Aster	Recently married and in her late 30s	Entered medicine as a mature student having worked in the City. She studied at the medical school associated most closely with NCTFS	Aster has completed two, 4-month FY2 posts in a central London hospital and is in the third week of her final post. This is an academic post in a laboratory with minimal patient contact and no other FY doctors in the laboratory setting

[2] The names used are pseudonyms.

Name	Demographic details	Biographic details	Details of current post
Jasmine	A single woman in her mid 20's	Studied medicine as an undergraduate at a medical school not associated with NCTFS	Jasmine has completed two, 4-month FY2 posts and is one month into her final FY 2 post in the medical admissions unit (MAU) of a central London hospital with many other doctors in training on site
Saffron	A single woman in her mid 20's	Studied medicine as an undergraduate at the medical school associated most closely with NCTFS	Saffron has completed two, 4-month FY2 post and is in her third week of her final FY 2 post in the ED of a central London hospital with many other doctors in training on site
Daisy	A single woman in her mid 20's	Studied medicine as an undergraduate at the medical school associated most closely with NCTFS	Daisy has completed two of her FY2 posts at a District General Hospital (DGH). She was interviewed during the last few weeks of her final FY2 post in General Practice. There were no other FY doctors at the GP surgery
Aspen	A single man in his early 20's	Studied medicine as an undergraduate at the medical school associated most closely with NCTFS	Aspen completed all three FY2 posts at a DGH and is in the last month of his final post in general medicine. He plans to leave medicine to return to study immediately after completing his FY 2 posts
Rowan	A single man in his late 20's	Studied medicine as an undergraduate at a medical school not associated with NCTFS	Rowan completed all three FY2 posts at a single DGH. At the time of interview he was in the last month of his final post in a short stay medical ward
Rose	A divorced woman in her late 30 with three school-aged children	After a career outside of medicine she studied in her 30s at a medical school in London not associated with NCTFS	Rose completed all three FY2 posts at a DGH. She is in the last month of her final post in cardiology

Participating doctors were asked to take part in an in-depth interview and be 'shadowed' by me during a routine working shift. They were advised about the general purpose of the interview, the sorts of questions posed and the likely length of the interview. The aim of the observation period was also described (see appendix 2). However consent for participation allowed them to vary this arrangement based on their personal preference, the permissions they received from education and service supervisors and the complexities of their rotas. At recruitment I also asked for permission to return for a second interview if necessary. Table 2 shows the activities undertaken with each participant.

Table 2:   Data generation activities

Participant	Data generating activities	Comments
Clematis	Interview only	Clematis did not consent to an observation
Lavender	Observation of the first few hours of a night shift in the ED plus interview two weeks later	Lavender 's interview was arranged after a run of night shifts were completed
Oak	Interview followed by an observation the next day during a day shift on an adult mental health ward. A brief follow –up interview was conducted four weeks later	
Thistle	Observation during an evening GP surgery and initial interview followed by a second interview three weeks later	The interview and observation took place on Thistle's last day in his post. The interview was curtailed before coming to its natural end due to the start of evening surgery. Thistle agreed to meet again to continue the interview once settled in his new post
Tulip	Observation during the first four hours of a day shift on the orthopaedics wards followed by an interview on the same day	
Aster	Brief observation of work in a laboratory followed by an interview on the same day	Aster had difficulty in arranging a standard observation given the non-typical nature of her work. Instead we met in her workplace, she showed me her workstation and her roles and tasks and introduced me to co-workers
Jasmine	Interview followed by an observation of the first few hours of a late shift with the medical admissions team	
Saffron	Interview followed by an observation of a weekday late shift in the ED	
Daisy	Interview only	Daisy did not consent to an observation
Aspen	Interview only	Aspen did not consent to an observation
Rowan	Interview only	Rowan was recruited towards the end of his time as an FY2 doctor. Shift work and holiday meant it was organisationally difficult for an observation to be arranged with his clinical supervisors
Rose	Observation of a weekday shift of ward work followed by an interview the following week	

4.3   Generating data

This study used two tools for the generation of data: interviews and observations. The use of interviews and observations is often portrayed in the methodological literature as a form of triangulation; a way of strengthening claims or corroborating evidence about what has been seen or said. My conceptual framework encouraged me to use them in a different way with the two methods providing complementary insights and a multidimensional view of same phenomenon.

4.3.1   The Interviews

Much of the data in this study is interview data so it is important to clarify what kind of event the interviews were and to what extent something can be made of what was said during them. The interviews used a narrative-style, life-history approach and were conducted in a relatively informal way, described by Burgess (1984) as *'conversations with a purpose';* to allow the exploration of aspects of formation and identity that are tacit and rarely articulated. The interviews were conducted in the spirit of Kvale's concept of *InterViews*: exchanges of views and joint construction of knowledge (1996). The interviewer contributed to a shared understanding of the issues being explored and stories were thus not simply witnessed or heard, but co-created.

Interviewees were encouraged to tell stories about any aspects of their work, lives, experiences and challenges they were interested in sharing. This was very much in keeping with my understanding of identity as formed through narrative and that:

> *...the stories we tell to others (and ourselves): as we try to make*
> *sense of events our identities emerge as we story our individual*
> *experiences, positioning ourselves to cultural and social*
> *expectations.*   *(Schiffrin, 1996.)*

As social aspects of identity form my area of interest, the focus of the interviews was very much on *self-in-world* rather than simply *self* and, in this way, the interviews acted as a means to facilitate refection on both figurative and relational identities. I recognised that these were not stories waiting to be told but were partly crafted during the telling: they should be seen as not simply acts of telling someone about one's life but also means by which identities were fashioned (Holland et al., 1998).

There is no doubt that the nature of the questions posed influenced the narrative and the presentation of self, with the interviewee performing a preferred self or identity (Langellier, 2001) and choosing to tell their story in a particular way to take account of the anticipated audience and based on judgements made about me as the interviewer and how we were relatively positioned.

The interviews were semi-structured in that they used an interview guide intending to cover my 'orienting concepts' (Layder, 1998) drawn from my theoretical framework. These questions aimed to trigger stories that related to notions such as: learning through work, participation, the rules of game, self-in-world and positionality (see appendix 3 for the interview schedule). The interviews also ensured space was given for the interviewee's understandings and perspectives; encouraging participants to formulate in the dialogue their own conceptions of their lived world (Kvale, 1996). Some of my questions cast the interviewee as informant and others as respondent. Throughout the interview I took opportunities to ask participants to expand on descriptions, to explore comments and stories for meanings and to check and correct my understanding and interpretation of what was being said.

Acknowledging both the performance nature of the interviews and the construction of meaning during the interview process, means that each interview should be viewed as a unique event. Furthermore, whilst both piloting of the interview and my relatively clear theoretical positioning before conducting the interviews guided the interview schedule, my understanding became more nuanced as I became immersed in the empirical setting and unanticipated themes emerged during interviews and observations and thus the interviews became refocused with later participants. In anticipation of this I asked early participants to allow me to return for a second interview if new areas or themes arose that should to be explored with all participants. I re-interviewed two participants for this reason.

The interviews took place in the latter part of the participants' second year as a doctor. They were conducted away from the workplace in a venue chosen by the participant and tape-recorded and fully transcribed to allow detailed analysis of the conversation. Extensive field notes created during and after the interviews and generated whilst listening to the tape recording of the interview also formed part of the interview data set. The interviews ranged in length from 53 minutes to 189 minutes.

4.3.2 The observations

Holland et al. note that not only do individuals 'talk the talk', but they also 'walk the walk' of identity: *'the way they act as though they are who they say they are'* (1998, p3) and so interviews can provide only part of the picture in exploring identity formation. For this reason I also 'shadowed' most of the participants through a normal working shift, preferably on the day of the interview. These observations were conducted as a non-participant observer but I did not attempt to remain fully unobtrusive. The purpose of the observations was made clear to participants and their fellow practitioners (see appendix 8) and, by being explicit about purpose, these observations incorporated questions and clarifications throughout, included face-to-face 'in the moment' discussions and, at times, encouraged participants to provide snippets of reflective commentary. The use of this observation or 'performance period' (Eraut, 1994) had an important purpose in data generation. They aimed to capture real, everyday events as a focus for discussion, either in the observation or at later interview and to capture incidents or manifestations of 'in the moment' identity, that cropped up when the doctor did not have the space or capacity to rationalise the behaviour, that were either consistent with or at odds with the identity being constructed within their interview narrative. The observations also create the opportunity to capture the fleeting conversations that enrich the more considered narrative of the interview:

> *...narratives that instantiate identities are not just found in the*
> *'big stories' we tell of our lives, but can be seen in fleeting*
> *moments of ordinary conversational contexts.*
>
> *(Monrouxe, 2010, p 44.)*

The observations were semi-structured; conducted using a framework based on a typology of workplace based learning developed by Eraut and colleagues (2004) (see appendix 4), but like the interviews, each observation should be viewed as a unique event. At times the observation checklist was either too obtrusive or not suitable for capturing the activity being observed. For this reason detailed notes were taken during and after each observation, capturing what was going on, with whom and, where possible, why. These included comments and descriptions of activity made by participants, answers to questions posed by me, reflections made by me during the observations and my reflections immediately after the observation.

Despite sharing the same profession, job title, and grade and working within the same geographical area, the doctors were each working in unique situations: with different roles and levels of responsibility, supported and surrounded by different professional others, looking after different patients, and performing different task. The doctors were invited to choose a typical activity on a typical day and they ranged from a night shift in a busy central London ED to an office based day away from patient contact. The observations ranged in length from 2 hours to 10.5 hours.

4.4   Data Management

Data in this study took the form of audio recordings of interviews and their transcription into written texts, extensive field notes from both interviews and observations and, in some cases, completed observation schedules. Where possible identifiers were obscured at the time data were generated and, where not possible, data was anonymised immediately after production. Computer files were stored on a password protected computer and paper documents kept in a locked cabinet.

The transcription process for all interviews was undertaken by the same experienced professional transcriber. Acknowledging that the transcription process in itself is an act of interpretation, the transcriber was given a clear briefing of the context and purpose of the interviews and what constituted a useful transcription of these interviews (Kvale, 1996); in this case a verbatim reproduction of the conversation with all its oddities, asides, repetitions and convolutions. The explicit aim was to create transcripts to be used alongside the listening to the actual audio recordings and a re-reading of the accompanying field notes.

Interview data were transcribed into Microsoft Word documents. Observation checklists were managed in a Microsoft Excel spreadsheet and observation field notes typed into Microsoft Word documents with a separation into columns of contemporaneous notes and subsequent comments and reflections. The data management package NVivo 8 was used to aid the process of managing and analysing the large data set.

4.5 Data Analysis

My approach to analysis was shaped by my theoretical and analytical framework described in chapter 3. Theory was used from the outset to shape the research questions and methodological approach; influenced by what I wanted my empirical data to *do*. Employing an interpretivist approach and a clear theoretical framework created two important consequences that shaped data analysis. Firstly, this approach meant that initial steps towards analysis were undertaken at the time of data generation. Questioning during the interview, and therefore which issues were expanded upon, was focused by my orienting concepts and during the interviews the meaning of what was being said was interrogated and the interpretations reflected to the participant for clarification, confirmation or disconfirmation (Kvale, 1996). During the observations I asked participants to identify what was happening and the meaning or purpose of the activity. I occasionally articulated what I had observed and invited the participant to add their observations or understandings. I also wrote a substantial amount of reflective commentary alongside the descriptive field notes; both during the observation and immediately after. Secondly, my position as an interpretivist researcher meant that whilst I aimed to understand the everyday interpretations of stories and events I was also attempting to see beyond the presented and observed to use this to create an explanation of the phenomenon (Mason, 1996).

My overall approach to analysis can be broadly described as a thematic analysis utilising a framework described by Kvale adopting three levels of analysis; moving from self-understanding (re-phrased and condensed meaning as described), to critical common sense understanding (a wider frame of understanding than that expressed by the subject) and then theoretical understanding (linking to an analytical framework) (Kvale 1998). Transcripts and field notes were approached using methods outlined by Ritchie and Spencer (in Burgess, 1984) involving a set of stages beginning with a process of familiarisation with the data; reading through the texts and re-listening to the tapes a number of times to begin to identify initial patterns, themes and clusters of ideas, then beginning to draw out broader, more conceptual themes and indexing the data in an iterative process (see appendix 5 for an example of this analytical work). Although my overall approach was broadly thematic analysis, this was not confined to content themes. I was interested not only in what participants said and did but also how they talked about this (Monrouxe, 2010).

This approach appears at first glance to be structured and hierarchical with ever increasing depth being applied to understanding the data. However it should be signposted here that my theoretical perspectives were pervasive throughout the study; these theoretical tools were used to interrogate the data at the 'top' level of my analytical approach (Kvale, 1998) but this was not a distinct phase in analysis but an enduring feature of this study. They oriented my research questions, the questions used in the interview and the framework used in observations. They also impacted on every part of the analysis. Employing these theoretical tools therefore meant that it was impossible to consider the first listening to the tapes or reading of the interview transcripts or observation notes as a 'literal reading' (Kvale, 1996).

With the above proviso, the identification of themes was both inductive, with meaning flowing from the data, as well as deductive, to answer the questions posed by the research (Miles and Huberman, 2002). Initial themes for coding were generated both from literal and common sense understandings of the stories being told and from my theoretical framework. Further interpretation and generation of themes and constructs were produced iteratively. Throughout the process I maintained a reflexive approach; examining whose interpretation of events I was prioritising and why and how the data generated supported or conflicted with my developing theoretical understandings.

I acknowledged that throughout data generation the topics of discussion in the interview and the nature of the observations created a powered relationship between interviewer and interviewee. This meant that the conversations that occurred and the activity observed were likely to be the result of significant management of social impressions: what was said and done could not always be taken at face-value. Therefore emerging themes included not just what was talked about or done but my interpretation of the meaning of this talk and action. I recognised that by collecting stories a layer of further interpretation was being applied to the phenomenon under investigation at the point of data generation. This was wholly consistent with my social construction approach to the research and this complexity also extends into my approach to interpretation of the data: I acknowledge that I was not trying to interpret from raw data but to re-interpret already multi-layered data.

As the data were analysed there was a dialogical relationship between theory testing with the data and theory generating/extending from the data. If viewed using Miles and Huberman's spectrum from open reading of the data with no presupposition through to

tighter reading using an existing framework (2002), in is clear that my analysis was closer to the latter.

4.6   Research Timeline

Below is a table that provides a timeline of the study, identifying key milestones during the design, conduct and write up phases.

Date	Events
December 2009	Thesis proposal submission to supervisor
January 2010-March 2010	1. Redrafting of thesis proposal submission and submission for IOE approval 2. Drafting of interview schedule and observation checklists 3. Application for ethics approval at the Institute of Education, London and the National NHS Research Ethics Committee
March 2010-November 2011	1. Redrafting of ethics approval documents 2. Resubmissions the NHS National Research Ethics Committee 3. Production of further ethics committee documentation 4. Redrafting of interview schedule and observation checklists 5. Full ethics approval from NHS National Research Ethics Committee received
November 2011-February 2012	1. Local ethics approval from participating NHS Trusts secured 2. Recruitment of participants 3. Pilot interviews conducted 4. Minor redrafting of interview and observation schedule
March 2012-July 2012	1. Interviews and observations conducted 2. Initial analysis of interviews and observation data 3. First drafts of early chapters and initial findings to supervisor
July 2012	Follow up interviews arranged and conducted where necessary
August 2012 – October 2012	1. Further analysis of data 2. Further drafts of chapters to supervisor
November 2012	Final version of thesis to supervisor

4.7   Methodological and Ethical considerations

Many of the consequences and intentions of my methodological approach have been highlighted in previous sections. In this section I focus on the potential to generalise from this research, the impact of my position on the study and the ethical considerations that shaped the conduct of the study.

I have already signposted some of the issues associated with working in the interpretivist tradition and judgements concerning notions of reliability, validity and generalisability of this research also need to be considered in the context of a study of a complex phenomenon, with a moderate sized sample, adopting an interpretivist approach. Clearly this study does not aspire to provide a straightforward observation the world to describe what it happening, but instead involves the drawing up of concepts to interpret what seems to be going on. Moreover, this is the study of individual human beings; the interviews aim to capture the voice, the lived experience and the identity as crafted through a storying of the self and the observation aim to access and understand the contexts in which this is taking place. For these reasons notions of reliability, validity and generalisability are of a different order than would be considered in research carried out in the positivist paradigm.

Questions of validity concern whether this study is measuring what it claims to be measuring: does it gain purchase on professional identity? I assert that by ensuring ontological and conceptual clarity I have used these to create a meaningful epistemology and study of the phenomenon. Having identified a wide range of understandings of identity and formation I have focused on a socio-cultural understanding that suggests identity, expertise and learning are interwoven and so all need to be explored in the understanding of professional identity formation. Validity claims also extent to the validity of the data generated. Again, my positioning with regards to professional identity has shaped the choice of methods; accessing self-understandings and self-constructions of identity (Holland et al., 1998) in an attempt to capture *'What people tell others and themselves about who they are'* (ibid) through interviews, and *'the way they act as though they are who they say they are'* (ibid) through naturalistic observation. Validity of sampling was ensured by careful purposive sampling, ensuring I had the widest possible range of FY2 doctors in the study. Finally validity of interpretation is of course influenced by my theoretical stance and my research question. Whilst all interviews were transcribed verbatim and all data collected during observations were considered for inclusion, only a

small fraction of the data generated can be presented here. Appendix 6 provides an excerpt of a typical interview and appendix 7 an excerpt from a typical observation. Appendix 5 shows a sequence of notes concerning theming and interpretation that provide an insight into the way in which I approached the interpretation of the data, identified important themes from this data and remained reflexive throughout the analytic process. One way in which I attempted to ensure interpretative validity was to ask two colleagues familiar with researching work-based learning to read some of the interview transcripts and observation field notes with only the research question available to them and to suggest their own themes. There was a strong correlation between my overarching themes and their interpretations of the data and this process helped to shape and emphasise some of the themes in the data, for example the importance of transitions in identity formation.

Reliability is often described in relation to the consistent way in which a research tool was applied. Consistently applying the same tools to all participants was not the aim in this study: the interviews and observations were an exercise in data generation and not data collection. Indeed the interview schedule was used only as a general guide and the observation framework devised turned out to be less useful than the detailed field notes taken during the observations. Reliability in this study was instead ensured by undertaking data analysis appropriate to the clearly defined and delineated research questions and careful, honest and accurate representation of that data, including interpretation and use of data that was not representative of the commonly held views or not consistent with anticipated findings (Mason, 1996).

Generalisability of the findings in this study concerns both empirical and theoretical generalisability. The purpose of this study was to provide an in-depth and nuanced account of the experiences of a small group of subjects in a limited number of contexts. By focusing on narratives, which represent *constructions* about who one claims to be and which contain layers of explanation of behaviour, sense-making, and the management of social impressions, this study uses very personal interpretations of this identity-forming process and this therefore limits what can be generalised from the data. The management of social impressions; saying and doing the 'right thing' may be a particular limitation in the emotive and moral world of 'being a good doctor' in medicine. Whilst these factors create limitations to the claims that can be made about junior doctors' identity and identity formation in general, there is some empirical generalisability. Through careful, purposive sampling, the use of a range of sites across the geographical location, and the deliberate

choice of subjects across a range of work situations, I would assert that despite the relatively modest sample size, many of the experiences, perceptions and beliefs of these doctors are likely to be common to other junior doctors working and learning in the NHS elsewhere in the UK at this time. Issues of theoretical generalisability such as *can the theoretical insights gained in this study be plausibly carried over into another study setting?* And do *the findings 'fit' into or pull together existing theoretical understandings and literature in the field or build new theory?* are further explored in the final chapters as I present and analyse the study findings in relation to the empirical and theoretical field.

4.7.1   *My position*

This study represents 'insider research' even though it gathers data from outside my own place of work and from doctors with whom I have no professional or educational relationship. My identity, as a senior doctor interested in notions of identity and formation was not, and could not, be blinded to the participants. This demanded constant reflexivity during this study; and an overt stance that does not attempt to erase me from the research site, but inserts me as a recognisable actor in the figured worlds of these doctors.

Furthermore, this study interrogates the effect of positionality on formation and therefore my own personal positionality, both theoretical (as it affects my choice of the research area, choice of research literature within the area and consequent methodology), and actual (as it affects the research process in terms of power relationships), needed to be acknowledged throughout. I was aware that things said to me (or that remained unsaid), and behaviours enacted (or not enacted) may have been differently said or enacted if the research had been conducted by a research assistant or a less identifiable individual. However, conducting these interviews personally and creating *InterViews*; sites for the shared construction of understanding between two individuals with a shared interest (Kvale, 1996, p42), was an active choice that has been acknowledged in the interpretations and claims I make about what I have seen and heard.

4.7.2   *Ethical issues*

Throughout this study I was mindful of what I was asking these junior doctors to do. The life-history approach, and thus intensely personal nature of the interviews, presented challenges. Discussing what it means to be a 'good doctor' in any setting creates challenges for doctors: particularly with new practitioners for whom this is a rapidly evolving issue with new demands being encountered on an almost daily basis. I also recognised that

discussing medical practice and experiences may uncover challenges to *my own professionalism* as a doctor: discussions about practice and experiences often focus on observed breaches of professionalism, support and supervision and therefore some discussion between the research participants and myself about how to manage such issues preceded all data collection episodes. The consent process needed to clearly outline what they were consenting for and so a range of verbal and written approaches to providing information and gaining consent were used (see appendix 8).

The observation element of this study generated further ethical problems which led to a complex arrangement of written and verbal consent and safeguarding and detailed negotiation with the NHS Ethics Committee before consent to undertake the study was granted. During these observations I was a more senior doctor than the research participant but not an employee of the Trust and although present as a non-participant observer, I needed to maintain my own professional responsibility as a doctor; to *'make the care of the patient your first concern'* (GMC, 2006) and which could theoretically 'trump' the boundaries of the agreed role of non-participant observer. Incidents, both anticipated and unanticipated, needed to be considered where this role might necessarily change and this needed complex documentation well in advance of any planned observation and detailed discussion with the participant and their colleagues on the day of the observation (see appendix 8). On more than one occasion the participant or those supervising them decided that an observation was not appropriate given these constraints. Consent was therefore a complex issue in this study and was further complicated by the understanding that data from the study could form part of a paper for publication in the future. Therefore consent was obtained on multiple occasions, both verbally and in writing, allowing opportunities for participants to ask further questions and clarification and to withdraw from the study at any time.

Ethics Approval
The British Education Research Association regulatory framework (BERA 2004) was used as a guide to the research design and conduct and, as this study took place in clinical settings, formal ethical approval was applied for and granted by the National NHS Research Ethics Committee.

4.8 Summary

This chapter provided a detailed description of the methodological approach adopted in this study. It highlighted how my conception of identity, learning and professional formation provided a steer to the research question, the approach taken to generate the data to address this question, and how I attempted to create a meaningful understanding of the data generated. In acknowledging that these methodological decisions created just one 'lens' through which to research, and make statements about, the professional identity of junior doctors, I have identified both methodological and ethical issues that arose from the choices made and how these affected the nature and quality of the data.

In this way I have set the scene for the next chapter in which I present my research data and show how I have used my analytical framework to attempt to find meaning from the detailed and complex stories and observations.

Chapter 5:   Results and Analysis

This chapter begins by outlining how I have used my data to address my research questions and the decisions that have shaped what 'slices' of data I have chosen to present and for what purpose (Mason, 1996). I identify how I have used data both cross-sectionally; to explore themes common to junior doctors and providing an explanatory account of how expertise and identity seems to develop, and developmentally; using individual narratives to trace this perceived development in personal accounts. It moves on to make use of the stories and observations of these junior doctors' participation and experiences in the world of doctoring to suggest that identity develops in relation to the interwoven experiences of *learning, belonging* and *becoming* and identifies how I have come to make these claims. Throughout the chapter I identify how these findings relate to existing theory and identify where existing theory and empirical data are at odds with the experiences of these doctors.

5.1   Use of data

I have suggested in previous chapters that identity and formation are not tangible or measurable things. For this reason the data generated in this study do not stand up on their own and require a level of interpretation to create meaning. As described in the previous chapter, analysis in this study began at the data generating phase as I became attuned to the emerging stories and the themes within them. Furthermore, although I utilised Kvale's three levels of analysis in exploring my data (1996), this was not confined to using the levels in a hierarchical way and theory was very much in the foreground as I analysed data: with an orientation to, and heightened awareness of, my theoretical framework impacting on what elements of the data were chosen for more detailed focus. Thus some of cross-sectional themes that arose from the data were, in many respects, consistent with, or related to, anticipated themes: and the data have been used to understand this phenomenon in this particular field and examples and direct quotations are used illustratively. Of course, new insights and themes arose from the data and I have attempted to make sense of them in extending theoretical understandings of how people *become* doctors. In these instances the quotations and examples are used constitutively.

The data generated in this study consisted of personal narratives and observations of individual experiences. Therefore as well as showing commonalities across participants' experiences and stories, the data are also used to illuminate these highly individual stories of who people are and how they have come to be; including their personal understandings of self-as-doctor. In this way I will show that although ostensibly the subjects of the study are all at the same point in their postgraduate training and have many similarities in their past educational experiences, these individuals have come to this stage in their careers with different perspectives and different experiences, having made different uses of their times at medical school and perceiving their initial experiences at work as having contributed differently to their personal trajectories. I suggest this personal story and personal trajectory is important in shaping their interpretations of themselves and their lives and is thus a vital element of the interpretation of the data.

5.2 The research questions and the findings

A reminder here of the research questions, as an orientation to what is presented in the following sections: *How are the identities of newly qualified doctors formed? What are the influences that have affected this formation? What are the effects of this emerging identity on their practice as a junior doctor?*

The data, and my interpretations of that data, are presented around the following three interwoven themes which each appear to impact on identity, professional formation and practice of novice doctors. They can be broadly described as:

- *Activities focused on learning*: situated learning; including developing the professional capabilities to do the job, learning from the job, and learning focused towards the future; the influence of prior learning experiences on identity and learning outside of the workplace.
- *Perceptions of belonging*: to teams and communities of practice, and trajectories; both the trajectory common to junior doctors and personal trajectories, and effects of belonging, or not belonging, on these trajectories in terms of both learning and identity.

- ***Becoming a 'good' junior doctor***: developing and reflecting on conceptions of self-as-doctor, developing (or resisting) the 'habitus', and the impacts of role, positionality, agency, and life histories on these self-conceptions of identity.

Throughout each of the following three sections I highlight the pervasive effects of transitions, change and the fragmented nature of the journey through the novice years on this sense of learning, belonging and becoming.

5.3 Developing professional capabilities

Participants identified the work they do as important in shaping them as a novice doctor. As might be expected, one of these doctors' main preoccupations was how to develop the capability to do the job. This thinking led them to try to identify how prior learning in medical school, their formal learning away from the workplace and their learning from doing the job contributed in different ways to the development of this capability. The onset of responsibility, whether it began as they started work or in limited ways in the medical school years, was felt to be a powerful trigger for developing the capabilities to carry out their job and for 'feeling like' a doctor. Transitions and change were felt to be inhibitors rather than facilitators of professional learning.

5.3.1 *Engaging with work roles and opportunities*

There were three significant elements to this theme; working out what to do, learning *from* work and learning *for* work. Each of these elements were talked about extensively as these doctors explored and verbalised influences on their developing sense of identity.

Working out 'how to do the job'

This was a significant focus of the first few weeks of all posts. This working out of what to do, how to do it, when to do it and for whom was seen as problematic and time consuming by most; inhibiting more meaningful work and learning. Whether it was due to a lack of clear explanation of the role, poor induction, inappropriate levels of senior supervision, or benign neglect it was frustrating and, because of frequent movements between posts with very different demands and expectations, did not seem to improve with growing experience. During observations participants spent considerable time and effort in working out 'how to do things round here'. For example, during her observation Rose needed to arrange a procedure for a patient. She spoke to four different individuals on the telephone

and three people in person before working out exactly how that job was done in this hospital. She commented on the differences in arranging such a procedure in her last place of work: *"it's so different here, in my last job it was all more formal"* suggesting this whilst this sort of learning was key to doing the job, it was highly context specific and therefore not necessarily transferable.

Part of getting to know how to do the job seemed to be getting 'a feel for the game': getting to know the field and one's place within it. Talk of working out the rules of the game appeared in many of the interviews. Some used a common sense understanding of this term, describing how they learnt the tacit knowledge of what the job was and how you were supposed to perform it. For others this was also about the unspoken understandings of doing *this* job in *this* place and talking about what counts as capital *here* with *these* people: the unwritten rules of engagement. Although there was an understanding that this was to some extent only learnable 'on the job', time and again participants highlighted that no one communicated even the basic of this 'know-how' to them. This ranged from simple tasks such as how the computer programme worked to complex and fundamental issues such as Clematis faced; what one is actually expected to *do* on a day-to-day basis or Tulip; who was not even sure who were her patients. Although all posts in theory had some induction, this tended to either not happen, particularly after the first ever four-month post had been completed, or was not helpful. Clematis described how she had turned up on the first day of her current post and there was no induction and no seniors present. Oak's experience below was also a fairly common one:

> I   *How long did it take to get a sense of 'This is my job, this is what I do'?*
>
> R   *I'd say a good ... probably by the end of the first month I was a feeling a bit more confident and understanding what needed to be done really for the patients.*
>
> I   *Nobody told you what the job was?*
>
> R   *Not really. I mean I had a vague idea when ... when you come onto the ward someone obviously always inducts you by saying 'Consultant does the ward round on this day, make sure you have this ready and this ready for them' – and that's kind of all they tell you ...*   *Oak*

Participants all struggled to a greater or lesser extent with the lack of attention to this central dimension of their work. The language used to describe these experiences was more of benign neglect than wilful unhelpfulness or obstruction. However participants seemed unsettled by the experience. Aster, who was a mature junior doctor having worked in the City for many years before studying medicine, found it hard to understand this neglect; suggesting this feeling of not knowing what to do and of no one helping you to work it out is related to a real experience particular to doctors rather than simply a more general 'starting work' phenomenon common to all novices:

> It was bizarre to me that we arrived and as a really big gesture we were given a presentation on rotas, handovers, whatever. But it made no sense to us all … you know 'movers', 'AMU', you know 'on call',… I mean what are all these words? And we all sat there … I mean I certainly had no idea what was going on. But I thought well presumably if we need to know someone will tell us … and then we were all just let go, and we worked it out as we went along.   Aster

She went on to compare the situation to the finance sector:

> My standard was what I saw in investment banking where, you know, the stakes are high …. where there is no way that some junior person who has never done the job before would be just let loose on a presentation and then everybody turns up the next day and says 'Okay it's worked out brilliant' – it just wouldn't happen.
>   Aster

For some this lack of understanding of their role extended to their positionality in the workplace. Tulip described her first day in her current post:

> And I saw the FY1 writing things down, and I heard the senior saying something, and I was thinking to myself: is that something that I should be organising or is that for the physios to organise? I think in my first week or so I just asked directly 'Is that something you want to me organise?' They said 'Of course not, it's the nursing staff organising that'.   Tulip

Oak, who was working in a speciality he would not have chosen but was part of his rotation reflected:

> *I'd say perhaps my responsibility and role isn't so clear in my*
> *identity as the doctor in this setting. I find it quite hard to*
> *understand what I'm really doing here. Sometimes I feel quite*
> *supernumerary, which is understandable – perhaps I am. And in*
> *terms of the psychiatric decisions that need to be made, they*
> *often ... I don't blame them ... they take the opinion of the nursing*
> *staff perhaps more over mine.* Oak

Like working out how to do the job, this learning about the rules of engagement and one's place in the order of things was constantly fragmented by frequent rotation through posts:

> *I don't really know what it achieves to move every 4 months ...*
> *because you really just start to know what you're doing, and then*
> *they throw you into a new environment. And that's fine if it was*
> *they throw you into a new area and you learn something about*
> *medicine that's new ... but that isn't what's so disruptive. What's*
> *so disruptive is you have to learn a new team, you have to learn all*
> *the new personalities, a new environment often – because people*
> *move from one hospital to another hospital every 4 months ... and*
> *that takes about 3 months. And then you spend about a month*
> *learning the medicine of the speciality that you're doing. And then*
> *you ... then you know what you're doing and then you move. And*
> *it's ... it's horrible.* Lavender

To further compound these problems of getting to know the work and the workplace, these doctors' posts were very variable; not just in the nature of the patients or the jobs to do, but in more fundamental ways such as who are my co-workers, how things are done round here, the language used in daily practice and the amount of responsibility and flexibility afforded to juniors. As Clematis explains, this important information is so context specific it cannot be carried forward to the next post and, with posts lasting for a maximum of four months, a significant proportion of time and energy is spent in learning and then re-learning this:

Well the trouble is...you're ready to take the step up at the job

*you're at., ... but then when you change jobs **and** change hospital*

***and** take a step up, you're just like 'Oh my goodness me!'*

<div align="right">*Clematis*</div>

It seems very little could be carried forward between post about the 'rules of the game' other than a growing understanding of how to go about trying to find this out and the ability to cope with not knowing.

Although this perceived absence of help to learn how to do the job was a common experience, it was not uniformly problematic. Saffron, Rowan, Aspen, Daisy, and Clematis had all experienced at least one post where this process was well managed:

We were incredibly well supported in that department, so I think a

lot of people ... get thrown in the deep end. Whereas I think we

were ... we sort of waded slowly in from the shallows, which is

nice I think.   *Saffron*

Rose, a mature graduate with a background of working in short term posts in hastily assembled teams had a different outlook to other participants about finding your feet and had worked out that relationships were central to this process:

I don't think it's difficult to learn how to do the job, you know, I

think that's fairly ... it's fairly straight forward...and just making

relationships with people....particularly if you've done a job like

(mine) where you had to keep learning new jobs.

<div align="right">*Rose*</div>

Learning from work and learning for work

All participants were asked: *'Is this a good job for learning?'* The answers were varied. Oak, Thistle, Saffron, Clematis, Aspen and Tulip, whose interviews and observations suggested that they did not particularly enjoy their current post for a variety of reasons, all said *'No'*. Those working in the ED talked about formal teaching opportunities they could not access due to their rotas but not particularly about the learning opportunities whilst working. The observations of those individuals that took place in the ED however revealed a fair amount of work-based learning: presenting cases to others, discussing patients with others, booking tests and being told how to do tasks etc. but none of them talked of this as

learning at interview. Those who said their post (either past or present) was good for learning described lots of opportunities to do supervised tasks (Oak), opportunities to ask questions (Rose and Daisy) or just good exposure to others through supervision (Saffron):

Yeah so GP ... again it wasn't great, I didn't really enjoy it, but I'm really glad I did it. I feel like I learned a lot during that time. I had a huge amount of time with seniors so ... the way that the practice I was at they did it....I did my own consultations and then I would review ... every patient that I saw would be reviewed with a senior ... at the end of the day we'd just sit down and go through all the patients that I'd seen that day. So a wonderful learning experience. Yeah, really, really good. And so I really kind of came out of that job feeling like I knew what I was doing, and also there was great support there during the day, so if I saw a patient and didn't quite know what to do with them, there were people there I could go and ask.   *Saffron*

Some participants identified a job as good for learning because it provided enough flexibility or free time for preparing for postgraduate exams. All but two of these doctors were building in personal study for postgraduate exams into their work and free time. This sort of learning tended to be described as a separate phenomenon to work-based learning, usually using 'acquisition' language and calling it learning 'medicine'. It was seen as a relatively unproblematic sort of learning: both in its acquisition and utility and rarely talked about in the context of doing their daily work. Daisy described her role as not really requiring this 'medicine', Saffron talked of being relieved about finding she did not need to know much 'medicine' to do her job. Clematis said learning the 'medicine' was the easy bit or her role.

The modernising medical careers agenda (DoH 2005) focuses junior doctors on making career choices very early in their careers and, as a result, had forced these doctors to reflect on anticipated personal trajectories and ideals about the doctor they wanted to become relatively early in their careers. Some participants talked of the easy and straightforward decisions about starting on a particular career pathway; for example Rose, Aster, Oak and Clematis had all begun studying for a physician pathway being quite clear of the direction they would be following. Others identified difficulty in making that decision or keeping their options open. Daisy had wavered in her anticipated general practice

trajectory when she unexpectedly enjoyed hospital medicine. Lavender, Aspen and Clematis remained unable to make clear postgraduate study decisions because of impending changes in their personal life and in interviews with all three this interrupted trajectory, and the hiatus in formal learning after so many years of studying for the future, significantly impacted on their 'storying' of themselves as doctors; with no clear story of who they would become available to them.

5.3.2 Taking on responsibility

The link between the onset of responsibility and rapidly developing professional capabilities was consistent across these doctors' experiences. Whilst for some the final year of medical school, particularly if the medical school arranged assistantships or 'shadowing' opportunities, gave some idea of what the job of junior doctor entailed, others felt they left medical school with little notion of the job other than some theoretical understanding of the tasks to be performed. Taking on responsibility, for the work being done and for patients, created an important shift towards learning how to do the job and how to 'be' a junior doctor. Participants concurred that one does not learn how to be a doctor at medical school; rather that such learning *'belongs to the realms of experience and practice'* (Wenger, 1998 p225). The amount of responsibility within that practice shaped how much one learns and how well one learns it:

> R *...until you actually spend time on a ward and you know you*
> *have responsibility for patients, that's the key thing for me where*
> *you can ...*

> I *So responsibility makes the difference?*

> R *Yes, definitely. And I think that's the biggest difference ...*
> *clearly the biggest difference with being a student. No matter*
> *how involved you are as a student, you know deep down inside*
> *you don't have ownership and responsibility of those patients.*
>
> *Oak*

This taking on of responsibility happened variably for these doctors: some felt they had taken on considerable responsibility in the final year at medical school, others in their FY1

year. Some described a much more significant step up in responsibility as they began their FY2 posts:

> *But there is a big step up from being ... cos F1 you are the most*
> *junior person basically in the whole hospital – everybody knows*
> *that, and you sort of know that so you can always say 'Oh I don't*
> *know what I'm doing, because I'm an F1'. By F2 you should know*
> *a little bit what you're doing, so there isn't that to hide behind.*
>
> *Lavender*

The level of responsibility afforded by a post was influenced by a number of structural factors: the NHS Trust in which the post was being completed (for example Aspen, who was based in a District General Hospital, talked of the 'mummy-ed' doctors at the teaching hospitals); the type of post (all who had done an ED post talked of a significant shift up in levels of autonomy and responsibility); and the configuration of the post (Rose for example had an FY1 doctor working immediately beneath her, Tulip and Jasmine described a structure in their current post where FY1s and FY2 did the same job on the same rota whereas Lavender and Aspen were working on a shift system alongside a range of junior doctors including some two or three years more senior and were expected to undertake the same sort of role):

> *At X, F2s are on the general SHO rota, so you would have the*
> *same level of responsibility as the core medical trainees ... and*
> *that makes a big difference. And so it might ... if you're doing*
> *acute medicine you're covering the whole tower and so that is*
> *very different than being just the kind of 'extra' on the take. But*
> *that feels good actually because you think well I can do this and I*
> *can have a bit more responsibility and make some decisions.*
>
> *Lavender*

The level of responsibility undertaken was only rarely ascribed to, or influenced by, the individual. For example While Aspen explained away the reason for him doing some quite advanced procedures on patients as structural: *'it's different out here'* (meaning at a District Hospital there is more work to do and less supervision that in a teaching hospital), he also admitted that he liked procedures, was good at them and was happy to take on relatively unsupervised tasks.

5.3.3 The medical school years

Medical school was seen as variably contributing to being able to do the job and a sense of self-as-doctor. Clematis, Jasmine and Saffron all gave a clear description of the difference between knowing the body of knowledge of medicine and knowing how to practice medicine. Jasmine explained how the theory/practice gap was never fully addressed at medical school which limited the usefulness of undergraduate learning:

> *it was pretty much the kind of traditional medical British*
> *experience, kind of you know – you've learnt the theory, now we*
> *expect you to be able to translate directly into practical, despite*
> *not having really told you how. (laughs) Go and do it!*
>
> *Jasmine*

Now they were in work, most participants found it difficult to articulate how their experiences at medical school had prepared them for practice. They did not describe the powerful socialising force identified in the work of Becker et al. (1961) or Sinclair (1997), instead they focused on the formal learning and how this could be used now they were in work. Oak, Daisy and Clematis identified that while much of the codified professional knowledge learnt at medical school did not seeming useful at the time, calling it *'stuff'*, they realised this *'stuff'* was useful in some ways in starting work. Both Oak and Daisy described it as a *'script'* for *'how to do it'*: of particular importance in task-based activities and creating, for Oak, and important sense of feeling like he knew what he was doing. Shadowing, either as part of the undergraduate course or arranged by the Foundation School in which they were about to begin work, or other opportunities in the final year as a student to be fully immersed in practice, had the most impact on learning how to be, and feeling like, a doctor:

> R   So I think ... and also in the last few weeks of that rotation
> actually as a student....nurses ... people will say to you, people will
> call you 'Doctor'
>
> I   Yep.
>
> R   ... and I think the first 2 ½ years of clinical I was obsessive
> about pointing out that I wasn't.
>
> I   Right.

R   And I think in the last few weeks of that rotation I was sort of

slightly aware that I was letting it go a bit. I certainly wasn't ... I

certainly wasn't doing anything I wasn't supposed to do, but like if

they were saying 'Doctor, there's somebody on the phone' I didn't

quite so obsessively say 'Thank you, I'll take that phone call, but

I'm not a doctor'.....I mean I was really acting as an F1 in that, so I

think I did feel very ready, because it was a very pleasing

experience.   *Clematis*

5.3.4   Managing transitions

A feature of the work of some professionals as they enter practice is being expected to rotate through a number of learning placements and activities and make transitions between contexts, and ways of working to get a complete picture of their new professional career. This is the case for junior doctors and these doctors described the impact of such movement; how they felt they had just learnt how to 'be' and to 'do' in one job before moving on to the next. This was compounded by shift systems that impacted on the consistency of the role and team even within the typical four-month post and by moves not just of specialty, but of venue at the same time. This preoccupied these doctors with a recurring need for very context specific learning *'how to do it here'*-type competencies at the expense of learning that could be carried forward into the next post.

All participants saw disadvantages in changing posts every four months during their first two years of work. While many participants could identify potential learning benefits of exposure to different specialties with the aim of developing a wide range of skills and an understanding of a range of disciplines before making their next career choice, they felt the disadvantages outweighed the benefits. Daisy described how this movement was unsettling to her performance:

Because actually it's funny when you're used to someone, you're

used to a place, and you're comfortable with your environment, I

think your medicine's better as well. And when you change,

suddenly ... I was on call as an F2, so I was a medical SHO on call

for medicine on my first day as an F2, and actually I felt more

nervous about my medicine ... I don't know why ... but my

medicine being in a new place than I was in (as an) F1 – I just

wasn't as comfortable with the environment, and actually ended

up asking more kind of questions than I would normally, just

rather than getting on with it.   *Daisy*

Lavender identified how this movement impacted not just on learning but on belonging:

I don't really know what it achieves to move every four months ...

...you feel like a spare part cos you feel I'm coming to do this job

that's important, and I know the hospital couldn't do it if I wasn't

here, but it doesn't have anything to do with me as a person at all

– we're interchangeable.   *Lavender*

Those who by design or by chance had stayed in one hospital for a whole year felt this was beneficial to their learning and belonging: particularly in that they could carry learning and relationships forward to the next post:

I did the whole of house jobs in one hospital, which was really

nice, cos you get to know everyone, your juniors as well as the

seniors and how everyone works.   *Daisy*

I think if you did your F1 and F2 jobs in the same hospital it would

be best, because you would have sorted out who people were and

all of that extraneous, you know, how do I order an x-ray? blah,

blah, blah ... and you'd have a much better clinical base.

Rowan

Whilst the transition from medical school to the first days at work is expected to be difficult and some induction was provided for all newly arriving FY1 doctors, this first transition was seen as relatively straightforward for some. Previous shadowing experience and induction helped. Other felt the low expectation of what one should be able to do protected them in this transition:

F1s, you still have a blanket, you know people don't expect much

of you, they really don't.   *Thistle*

This however was not a uniform experience and Oak provided a worrying account of his very first day:

My first day was quite a horrific experience. I was on a care of the

elderly ward. The registrar called in sick, the F2s were on

91

induction, so they weren't there in the morning. So I had to do a
ward round on my own of I think about 20, 25 patients. And I
asked for some help and there was another registrar who was
kind of coming across from the other wards trying to help out
sometimes, but for the vast majority of it I was assessing all the
patients on my own for the first time really. Oak

Often the problems arose further down the line with subsequent changes in role; to the next FY1 post or, more commonly, at the transition from FY1 to FY2 where there was a significant step up in responsibility and expectation. Whilst this new onset of responsibility was seen as having a positive effect on learning by Lavender, Clematis and Oak were not so sure:

R   I found F2 infinitely more stressful than F1

I   Why's that?

R   I think because you're an SHO potentially. If people want you
to be an SHO they can declare you to be an SHO. And actually
your first week into F2, you really are really only a week out of F1
... and suddenly being promoted to the level of SHO, which
encompasses CT2s (a grade 2 years above FY2) , is really quite ...
it's a very broad ... there's a lot of difference between beginning of
F2 and end of CT2.   Clematis

Based on the above analytical commentary about the ways these doctors saw their capabilities developing, we can see that professional learning and in particular getting the work done was a major pre-occupation for them. They linked the development of professional capability to the onset of responsibly and found the relentless experience of being the newcomer inhibited meaningful and transferable learning. Rather than *consequential transitions* (Beach 1999), these changes were so disruptive they led to stagnation in learning and prolonged newcomer identity in the early years rather than encouraging ever increasing understanding of what is means to be a doctor and how to do the job.

These junior doctors maintained a somewhat acquisition-focused understanding of learning even when they are participating in practice, often devaluing situated learning in favour of

formal learning. The roots of this perspective seem to begin in medical school. Taking on responsibility seemed to be the most important aspect of fledgling feelings about becoming a doctor. Reconceptualisation of medical school learning into useful professional knowledge was articulated as an important part of becoming a doctor by relatively few participants.

Issues of learning in all its forms and perceived purposes were therefore central to how doctors develop their professional identity.

5.4 Developing a sense of belonging

The following three themes are interwoven aspects of being, or feeling, part of these doctors' communities of co-workers. They each seem to affect both the potential for learning from and through the role and one's sense of being part of a group of practitioners with a common goal; a key aspect of socialisation and formation (Merton et al., 1957, Bucher and Stelling, 1977, Cavenagh et al., 2000). The trajectory of the individual, their personal view on where they were heading, and what they were aiming to learn and achieve impacted on the level to which these doctors found themselves to, or indeed desired to, belong to the practitioners with whom they were working and learning.

5.4.1 Belonging

A sense of belonging was an important contributor to learning, practice and for a developing sense of identity, but was often absent. Participants tried hard to belong by learning about people, about rules and expectations and how to do the job well:

> *I make an effort when I ... when I start a new job ... it's been a bit*
> *different in A&E because I felt so unsure of myself, but all through*
> *kind of last year...when starting a new job I like to go and*
> *introduce myself to the sisters on the ward 'I'm your new house*
> *office' or 'Your new F2' whatever. And I also like to go into the*
> *kitchen and say hello to the cleaning staff, and say 'Hello, I'm one*
> *of the new doctors on the ward'*   Saffron

There were stories of feeling that they had belonged more, and consequently learnt and developed more from, previous jobs:

> *The care of the elderly job here I really enjoyed, I really, really liked it. It wasn't so much the medicine, it was more the team. It was a really, really nice team to work in. …..it it was … much flatter – you felt like you could give your opinion, give your input, and at the same time I just felt very kind of well supported by the registrars and the consultant. … you felt like a valued member of the team I suppose, and you didn't really feel like you were at the bottom of the pile, because you didn't really feel like there was a bottom of the pile.* Saffron

Oak felt he might have scuppered his chances of belonging in his current post because of declaring this post was not part of his personal trajectory. This affected both his sense of belonging and the potential for development, his sense of the benefit of his investment in trying to belong and, he felt, the team's sense of investment in him:

> *R I probably told them I wasn't so interested in psychiatry as a career, more interested in general medicine and gastroenterology, so I think they almost perhaps wanted me to take that role. Perhaps if I told them I was more interested in psychiatry they would have given me more responsibility in that sense.*

> *I And do you think perhaps in other jobs where you've been more keen for that to be your pathway, you've done different things?*

> *R Absolutely. I think the post before this was in gastroenterology at XXX… because I'd told the consultants and the registrars I was very interested in this and they knew I'd done some reading, they were always happy to accommodate perhaps me presenting at research meetings or the internal meetings. I think it made a big difference, compared to the other trainees who weren't so interested, just wanted to get their head down and get through the day.* Oak

This feeling of being an outsider in a current post was also noted during Thistle's observation. He had a problem with managing a patient and rather than walking out of his room to the GP next door to ask for advice he telephoned the medical on-call doctors at his previous hospital. When questioned about this he said *'This lot will just tell me 'do what I think is best'; that's not really helpful'.*

For Clematis, Aspen and Rowan a sense of belonging was created by talking to, and learning from, others in the same boat. They identified strongly with other FY doctors. Clematis described how she and her peers developed their way of coping with a lack of belonging and support through the formation of an 'interstitial' community of practice (Lave and Wenger, 1991) that, while supportive of its members, excluded relationships developing with old timers in the community:

> *We'd done induction together and then we'd split up. So we*
> *turned up on that first day and there was a single office….and we*
> *just sort of took it over, the ten of us, and it was really nice*
> *because it was very, very supported amongst ourselves. I'm not*
> *saying it was terribly supported from the seniors, cos surgeons are*
> *surgeons, but it was very … it was really nice amongst the ten of*
> *us, … it was a rota just the ten of us, … and one of you was always*
> *on lates, and the others were on your firms but it was really, really*
> *supportive. I don't think I've actually seen that in anything else,*
> *the way we managed to get that ten of us as a team sort of*
> *against the rest of them.   Clematis*

When a sense of belonging did occur, it was transformatory in the way a post was perceived and in contributing to developing professional identity. Daisy, who dreaded her hospital posts because of her past feelings of not belonging when in hospital settings as a medical student, was surprised by how this belonging altered her certainty that hospital medicine was not part of her trajectory:

> *Yes, I didn't expect to like hospital, cos I think it all stemmed from*
> *what my experience was as a medical student. So I think I really*
> *didn't expect to enjoy hospital medicine so much, but once I*
> *became an F1 I suppose … your confidence just does naturally*
> *grow. As I said, once you feel a part of something, that someone*

actually appreciates you for being there and you work well as a
team and people include you as an important member of the
team, then like you start enjoying what you do. And actually I
realised I really enjoy the medicine in hospital, because I've never
not liked the medicine it was just everything that went with it.
And once I realised that actually I really enjoyed this medicine, and
I really like working with all these people ... and actually there's a
bit of a buzz in hospital as well ... that I think I don't want to leave.

<div align="right">*Daisy*</div>

Discussions of belonging moved on from their current or recent jobs to the wider picture and generated personal stories of a sense of identity and feelings of professional adherence. The three doctors who entered medicine later in their lives had a strong sense of belonging to the wider community of doctors. Aster became quite emotional at the mention of ever leaving medicine:

Yeah. It's funny though because in my wedding speeches my dad
did not allude to the big transformation I've made. And
interestingly, my husband ... His speech wasn't ... he hadn't made
as many notes as he wanted, and there were a few things he
forgot to say. And ... it's interesting, because ... I felt a bit upset
about my wedding speeches because they didn't really ... it was
almost like they were representing the person I was before I
became a doctor, and it's almost like ..I almost feel like people
don't really perhaps know that you know ... how different I feel
now.

<div align="right">*Aster*</div>

Others also had a strong sense of belonging to the profession; for some this was developed initially during medical school, for others it developed once in work. Thistle said even if he could not work as a doctor he would *'always be a physician at heart'*. Tulip claimed she could not understand all these junior doctors saying they wanted to leave: *'I think you are, or at least I am, a doctor for life'*. This sense of belonging to the profession was not straightforward for all however. Daisy, Thistle and Aspen each described 'wobbles' about being a doctor in their journey through medical school. Interestingly, now that these doctors were established in work, two of these three could still see themselves as possibly *not* being a doctor in the future: Daisy suggested that if she had to choose, then family

would take precedence over medicine. Aspen has already resigned himself to one day leaving medicine. He had not been offered a job he wanted immediately after his foundation posts and had taken the opportunity to re-consider his future. His adherence to the profession, his reasons for studying medicine and his sense of self-as-doctor seemed less emotionally bound than the others. His comments suggesting he entered medicine with a different perspective than most:

> *I wanted to do kind of research into kind of bio ... biochem,*
>
> *biotech, but I realised that to actually do most research you need*
>
> *to have a medical background first....*   *Aspen*

However his experiences around feeling unsupported following a patient complaint in his first few months of work seemed to have also coloured his views:

> *I was doing renal medicine first there, that was my first job. That*
>
> *was good, I got along well with my registrars and they're a happy*
>
> *family there. Then I did orthopaedics. ....and I've learnt the hard*
>
> *way that it doesn't matter what happens, doctors are not one nice*
>
> *big family, they don't help each other.*   *Aspen*

Although the remaining participants could not imagine themselves *not* being doctors, they were all able to tell tales of others who were talking of leaving or who had left; usually because the job was not what they wanted or had envisaged. Lavender reflected on her own feelings about the work she was expected to do and how this might lead younger doctors to consider leaving:

> *it's not what you imagine being a doctor is going to be....the*
>
> *majority of your job is admin...It's not what you imagine being a*
>
> *doctor to be like, and I think for a lot of people it also comes at a*
>
> *time in their life where they're either in their early or mid-twenties*
>
> *and so they question.*   *Lavender*

5.4.2   *Being part of a team:*

The contemporary world of junior doctors is one of constantly reforming teams and fleeting relationships. This happens not just because of frequent changes in jobs as already described, but also on a daily basis as doctors work shifts and come together to form 'on-call' teams and structures. During observations I saw only three doctors working as part of

relatively 'fixed' teams; Oak in mental health and Thistle and Daisy in general practice. This situation compounded the issues of not understanding roles and responsibilities highlighted in the previous section. It also limited possibilities for understanding positional relationships and developing co-working relationships in which learning and belonging could happen. A good example was Tulip. She was three weeks into a post at the time of her observation and interview and she was still not confident which consultants she worked for or whether the other junior doctor on the ward worked above her (because he was a specialist trainee therefore more experienced), beside her (because she thought he might 'own' half the patients and she might 'own' the others), or indeed whether he would be in work on a regular basis. During all observations I usually asked who other people were in relation to the doctor. Complex answers and explanations ensued revealing an almost daily reconfiguration of who is my senior/junior/co-worker.

The only stable relationships within most posts were with those who were not part of the teams of doctors: the nurses, the ward clerks, and other professionals. It was often to these others that these doctors turned to find out how to do things:

> *I probably rely on them quite heavily, particularly in orthopaedics.*
> *The nursing staff have the best overall view as to ... what's going*
> *on with the patient; when they might be going home, what their*
> *current needs are. When my seniors come and see them they give*
> *the orthopaedic input, but for the rest of it it's more ... I need to*
> *find out from the physios and the OTs what their current level of*
> *function is ... and the pharmacist ... though I've met him only a*
> *couple of times he seems brilliant and he's very knowledgeable*
> *about what he's doing and it's actually a good opportunity for me*
> *to learn off him as well.*   Tulip

However for some, these well-established communities were difficult to penetrate:

> *I think because as the (FY2) you move around, and the nursing*
> *staff are permanent, and so they know each other very well and*
> *you kind of rotate into their territory so to speak. And so it can*
> *feel a bit off-putting that you're joining this very well established*
> *team and they know that you're not there for very long, so it's*

> *really... the onus is on kind of the doctors to make the effort.*
>
> *Lavender*

For Lavender, this 'passing through' status seemed to affect her sense of self and postitionality as a doctor:

> *There's something about the way that our training is in 4 month*
> *blocks, that you never really feel a part of a team. And the people*
> *who are permanent, whether they're the consultant's secretaries*
> *or the senior nurses ... there's not really that much incentive for*
> *them to get to know you, because you are just passing through.*
> *And I don't know, there's this perception that it used to be better*
> *in the like good old days when you had longer in each post. I don't*
> *know, because I've only known this system, but especially in A&E*
> *you .. ..there's this feeling that you're providing a service and*
> *you're filling a spot on the rota – and that's your job ... which is*
> *not very satisfying.*   *Lavender*

5.4.3   Trajectories

Wenger suggests identity is best understood as a trajectory (in Hall et al., 2008) and for these doctors feelings of belonging, a sense of self and a sense of developing and learning were all linked to trajectories; both the trajectory of the junior doctor in general, someone always passing through an existing community, and their own personal trajectory, and how much this resonated with the post in which they were working.

The position of 'outsider' entering an established team who is soon to move on and be replaced by another outsider was felt to affect the investment teams were willing to make in creating a sense of belonging for the novice doctor. Oak discovered how this feeling of being an outsider can be improved by expressing an interest in the work of the team or the specialty, or indeed worsened by suggesting their world is not one you want:

> *.. when I told people I wasn't so interested in psychiatry they kind*
> *of assumed I wasn't ... I mean they thought that was probably*
> *synonymous with my saying I don't want to get involved. But it's*
> *not true, I mean I think as time's gone on I have got a bit more*
> *involved. But often I find for example the opinions of the nursing*

staff or the beliefs is that I'm just a kind of a junior that's going to

move on in a few months, there's no point discussing complex

issues (about) the patients, it's better to talk with the more senior

core trainees.   *Oak*

For all participants the length of the posts meant that they, as the new junior doctor, were always on a very peripheral trajectory. Some who had experienced a very specialist post or and ED rotation also highlighted that some posts were just not suitable for a very junior doctor to undertake[3]. By undertaking these posts they felt they were losing opportunities to develop core skills and expertise required for more mainstream practice and were almost pre-destined to not belong:

I think the specialisation is a problem. I mean I just think having

an O&G rotation ... I mean it isn't the right place to have an O&G

rotation... cos I mean if you want to do O&G you want to be a

surgeon. I would love to do O&G but I wouldn't be a good

surgeon so I'm not going to do O&G. The right place to do an

O&G rotation is in core surgical training. A&E was also fantastic,

but I really needed another medical rotation. Aster

Personal trajectories also affected the level to which individuals engaged in their work. For some this was about their intended specialty: Aster and Tulip said they were not surgeons and therefore didn't feel a particular affinity for their surgical posts and colleagues, Oak was clearly not a career psychiatrist, Thistle was not a GP. For others it was about the type of service; Clematis felt out of kilter in a very specialist tertiary referral service, Aspen was not happy working in a DGH where poor supervision affected his learning and his perceived ability to provide good care.

The current arrangement of 'bundling' of posts together in the first two years of practice meant that when this study was conducted two thirds of the participants were completing a post they did not enjoy or would not have chosen if given the choice. This lack of

---

[3] Junior doctors chose foundation posts as a grouping of approximately six posts. They rank their choices of these 'rotations' and are 'matched' based on their academic performance and application form to a given foundation rotation. One doctor in this study was working in his almost last choice of rotation, another was in her first. As the jobs are bundled into rotations, doctors may be allocated to at least one 4-month post they would not have chosen. Often this post is in a specialty with recruitment problems such as primary care or mental health.

congruence between role and sense of where they were heading impacted on both learning, what were considered useful things to do and what could be made of experiences as learning, and on a sense of belonging. During Tulip's observation her consultant said *'see you in theatre when you have finished up'* meaning she should join the team in theatre once the post-ward round work was completed. Whilst she recognised this would place her alongside other members of her team and please her consultant, she really did not enjoy the experience or feel she got any learning from it and instead found ways to 'string out' the jobs on the ward until the theatre session was over.

5.4.4   Fragmented journeys and belonging

Concerns over the impact on learning opportunities of new working and postgraduate training patterns have been much debated in medicine but the impact of these changes on a sense of *belonging* and on professional formation are rather overlooked. These doctors were clear that transitions, the frequency of these transitions and the consequent fragmented journeys had a profound effect on not just their learning, but on their belonging and sense of becoming.

One of the issues that crops up regularly in studies of development of professional identity is the challenge posed by 'boundary trajectories' that is, sustaining an identity across boundaries (Wenger in Hall et al., 2008). For these doctors this challenging identity demand was a very real experience; all participants had made at least five changes of role by the time they participated this study. Whilst some aspects of formation and learning were enduring and were being carried forward from one job to next, others were more difficult to sustain. This moving on was particularly problematic for maintaining the social aspects of developing as a junior doctor: working out and maintaining the kinds of relationships to be established with workplace colleagues and with patients. Being the doctor you wanted to be was found to be difficult to maintain when one was always the newcomer and trying to establish relationships and an understanding of 'how things work around here'. This was particularly problematic for those working in ED; partly due to permanent shift work, partly because of the nature of the work as a 'clearing station' (getting patient through as quickly as possible) but also because of the perceived lack of belonging to the established, permanent team.

Always being the newcomer and not knowing how to do the job each time they moved on, had an effect not just on the potential for learning from the job as described in section 5.3 but also on positional identity and behaviour. Feelings of being 'interchangeable' and a

perceived disregarding of a newcomer by the old timers seemed to obstruct potential relationships and the anticipated links between these new practitioners and the communities of practice they were entering. Instead of engaging in legitimate peripheral, and increasingly central, participation and the habitus of doctor-in-practice naturalising itself, the mindful response to this decentred positioning and being the perpetual newcomer was deference; even from the more confident or the older participants. These doctors suspended their need to belong, and indeed their potential to be identified, or identify themselves, as a valuable member of the team, and chose to adopt a set of behaviours designed to allow them to 'get by'. During her observation Rose was extremely polite to the staff in theatres as she attempted to work out how she arranged a procedure for a patient, even when she was repeatedly passed on to another staff member. Tulip walked down five flights of stairs to ask a plaster technician in person to carry out a procedure on one of her patients. Some explained this was how they had figured out how to be able to fit in and get their work done:

> *I've always found going to seniors and saying 'I don't know what*
> *I'm doing. I'm going to be asking a lot in the first couple of weeks,*
> *just bear with me'.*   *Jasmine*

Aster suggested in work she is deliberately deferential as she had worked out this was the way to get help and to get things done;

> *I'll be obsequious to an extent but I would never be in my normal*
> *life.*   *Rose*

Others also described having learnt that this behaviour and positionality was expected of them and had stories of those who did not do this (or times they themselves had appeared not to have done this) and the consequent problems. Both Aspen and Thistle, who seemed the most unsettled in their role of all participants, described episodes when they had not 'played this particular game' and how they had felt ostracised for this.

Belonging, or a lack of belonging, is a powerful influence on developing identity. These doctors remained peripheral in the workplace and within teams as a consequence of their 'passing through' rather than becoming increasingly central. This affected investment in belonging from both the community and the doctors themselves and impacted on the potential identity to be crafted from coming to understand self-in-world. Personal trajectories affected the perceived learning potential of the post and the extent to which

doctors attempted to belong. What also emerged is that in the case of junior doctors, boundary trajectories take on a different form and raise a different set of issues than those proposed by Wenger (1998).

5.5   Becoming a good junior doctor

These doctors understood that there are 'expected' ways of acting in the field: both as a junior doctor in general and as a junior doctor in a given post. Sections 5.3 and 5.4 described the participants' struggle to get 'a feel for the game' as they settled into the role of junior doctors. As they became sensitised to, and socialised within, the field, and began to adopt its practices and acceptable persona and to understand what was expected of them, they described their work in terms of being a 'good junior doctor'. For all of these participants the notion of being a good junior doctor had both outward-facing and inward-facing, personal dimensions. Within the outward-facing descriptions of self as 'good junior doctor' were the behaviours that equated to being seen to be good at the job: being deferential and humble, getting on with people, getting the work done, and most importantly, maintaining a good 'list' (see section 5.5.1). Agency and 'space for authoring' within this dimension was limited. Patients were rarely mentioned in this description of their work, other than as they featured as 'tasks' to be completed. The more personal dimension concerned being the kind of doctor they felt they wanted to be: that in the uninspected space, particularly in their relationship with patients, they were expressing *their* values and beliefs and sticking to *their* principles about what it meant to be a good doctor *to them,* whatever the expected behaviours and whatever the pressures of doing the job. For all, these were not entirely overlapping concepts and some described their efforts to become a good junior doctor as resisting some aspects of what was expected of them. Their sense of positional identity was an important aspect of how they saw themselves, how they acted in their current roles, the resistance they felt able to exhibit and in their overall sense of themselves as doctors.

5.5.1   Being a good junior doctor: developing the outward facing dimensions

Some aspects of 'being a good junior doctor' have been analysed in previous sections. An unanticipated but pervasive theme arising from the data was the importance of the 'jobs list'. This was the word-processed and annotated list of patients together with tasks completed or to be completed that was used to check work had been done, to

communicate within the team and to communicate with other teams in handing on the care of these patients. This list appeared to have a dual purpose. Firstly it created the right impression to others; maintaining a good list was seen as a measure of your ability to do the job well and the responsibility you took in your work. Additionally it appeared to be an important way of learning and transmitting information about the otherwise unexplained rules of the game; helping doctors to understand what they were supposed to do when this is not overt. When participants described posts where getting a sense of the expected role was easiest, they often included details of how the list was maintained.

During observations I saw endless reference to lists. Tulip took out and put away her list over 15 times in a half-day observation period, sometimes touching her bag to make sure it was there even though she had just put it there. During a ward round with Rose, normal practice consisted of going through the patients on the list before going to see them. Rose got to work early to perfect and update the list and was grilled on all manner of details about patients and their care by her seniors. She was pleased to be able to show these details were on the list. The FY1 on the team had a panic half-way through the ward round when she thought she had lost her list. Daisy said one of the reasons she was an effective junior doctor was because she was *'good with her list'*. Lavender described how it is an expression of responsibility and captured its almost totemic nature:

> R   ….*the majority of your job is admin, so it's kind of keeping lists.*

> I   *I notice the list is a really important tool of being a junior doctor.*

> R   *Yeah. It's the only thing you're in charge of. You're not clinically responsible for really any patients.*

> I   *I have seen many doctors in my observations constantly checking it…*

> R   *And if people praise you on the list, you know your list is really good, or you're clearly on top of – that's massive praise.*

> I   *What happens if you lose your list?*

> R   *Oh it's a disaster – it's an absolute disaster.*

I   Worse than losing your stethoscope I imagine.

R   Oh much worse, much worse than losing your stethoscope.

I   (laughs)

R   It depends, but I ... if you have like a busy take and you haven't
updated the list on the computer and you only have your written
copy of the list, I have spent 40 minutes looking for a list on a
ward without even ... you know without thinking this is ridiculous
I'll just go, try to reproduce it. Because it's all your jobs, it's all
your responsibility is on that piece of paper ... which is crazy.

<div align="right">Lavender</div>

She linked the list to the responsibility related to being a junior doctor and how it was one aspect of one's role that could be controlled:

If something clinically goes wrong with your patients it's not your
fault as a foundation doctor – somebody's supposed to be looking
out for that. So it's either the SHO's fault or the registrar's fault.
If something goes wrong in a clinic that's definitely not your fault,
that's the admin fault ... if something ... if a patient gets missed,
that is your fault.

<div align="right">Lavender</div>

Interestingly, in a study of identity, I heard few of the participants call themselves 'doctor', either in work or socially. This was particularly the case with the younger participants;

I remember being hugely embarrassed when I went to get my
name changed at the bank, and just thinking 'This is a bit silly, do I
want to get my name changed?' I'd gone in to sort something
else out and said 'Oh by the way, my title has changed, I'm Dr
now'.

<div align="right">Saffron</div>

The practice of using the phrase 'one of the junior doctors' came up in many interviews and observations and, having been sensitised to the phrase, I explored this with some of the later interviewees. Rowan's comments relate this partly to issues of not belonging to teams, as highlighted in section 5.4:

(we say it) because we're interchangeable and people don't need

to know who we are really. We are just one of the junior doctors.

It will be someone else tomorrow.   Rowan

Daisy talked this through a little more and through this narrative came to a conclusion that this phrase was a manifestation of peripheral positioning in patient care and the work of the team:

R   it was always like 'Hi I'm Daisy, I'm one of the junior doctors'.

I   What's this 'one of the junior doctors' thing? I'm puzzled by it cos lots of people say it.

R   No, do you know what, I've never … I think cos other people say it, you just … you just copy it, but … I've never given it any thought…..No one says 'I'm your junior doctor' or 'I'm your doctor' people seem to say 'I am one of the junior doctors'. It's the shift change, and it's the fact that you're on call one day and you're on nights one day, and then you're on your ward another day … but actually you're not nec- … you know as I said, continuation of care is not there anymore because of shift work, and they'll see a different doctor maybe….so I think rather than saying 'I'm your junior doctor' and then the patient suddenly thinks 'Well where's my junior doctor?' … you've gone off, you've changed shift and you've handed over to someone, and actually someone else is picking up the results and then going back to the patient to review them, and suddenly it's someone very different.

Daisy

5.5.2   The personal dimension

Wanting to be a 'good' doctor was talked about in interviews and also observed and talked about in relation to the more uninspected spaces of work as a doctor. The interview schedule asked specifically about the impact of patients on identity (see appendix 3). Interestingly, during the interviews the ways in which patients were described as having an impact on these doctors' sense of self-as-doctor were rather abstract and brief. Very few stories were told about patients. This however did not correspond with the observations:

where patients, and patient interactions, were central to learning experiences, opportunities to undertake meaningful team roles and developing a way of 'being' as a doctor. The observations also provided opportunities to see both external and more internal facing aspects of being a good doctor as it applied to patients being expressed. Tulip had an almost split persona depending on who else was about. When with the team on the ward round she stood away from the patient, had her nose in the notes and charts and simply listened to instruction. When the team had left she went back to a number of the patients, almost starting again: sitting, listening to patients' concerns and accounts of their illness, discussing the ability of one patient to cope at home with the physiotherapists. When this duality was brought up by me at interview she acknowledged:

> *Yes, yeah. When I'm doing my own ward round I can get a bit of*
> *an overall picture as to how the patient is. I think I'm quite*
> *medically minded so I sort of take an overall view ... look at um ...*
> *anything else that might be going on, but when the orthopaedic*
> *seniors are there ... I don't know anything about orthopaedics so I*
> *let them tell me what they want done.   Tulip*

Saffron and Lavender also behaved in very patient-centred ways when alone with patients. They both suggested the pressure of work and the accepted ways of behaving in ED went contrary to this aspect of what they felt was being a good doctor:

> *R   I hope to always be compassionate. And I think a lot of people*
> *possibly lose a bit of that in A&E. I worry that at times maybe I'm*
> *not being as empathetic as I could be.... Time pressure doesn't*
> *help, and also the idea that a lot of people that you see shouldn't*
> *really be in A&E, they've gone to the wrong place. You want to*
> *redirect them, at the same time we want to give them a good*
> *service and treat the reason they came in.*
>
> *I   Is it allowed to be compassionate and helpful?*
>
> *R   As long as you don't take too long doing it.*
> *I   ... what would happen if you did take too long? Would*
> *someone actually say to you 'No actually that's not what we do*
> *round here'?*

> *R   Yes some of the people have done that a few times when*
> *they're like 'You're doing too much for this patient. You need to*
> *get on and see the next one'.*   Saffron

Personal agency and perceived ability to maintain a sense of self in the face of challenge was seen differently by different individuals. Willingness to challenge depended on how much they felt enabled by their positionality and relationships and how far they were willing to 'rock the boat'. Thistle, who described himself as unorthodox and challenging, talked of behaving in one post as he felt was most appropriate and getting *'his fingers burned'* and being reluctant to repeat this. Aster, older and more experienced, felt confident to continue to challenge and not conform even if this made her unpopular:

> *I mean in terms of with patients I do it all the time, I'll push*
> *boundaries in terms of what I think is fair or appropriate for the*
> *patient, or whether I want the consultant to come and see the*
> *patient ... or the registrar ... or you know whether I feel I'm out of*
> *my depth ... I will tend to be much more demanding in terms of*
> *the support I need ... with the patient in mind.*
>
>   Aster

Aspen and Lavender, each in their own way unhappy in their current posts and feeling unconnected to their colleagues, were more resigned and described how they worked around the problem:

> *I   Do you remember any times when perhaps you weren't*
> *allowed to be the doctor you wanted to be?*

> *R   Yeah. So I think ... I think that's probably why I found the job*
> *so exhausting is cos I would quite often have to stay afterwards to*
> *either write to the GPs or to write to the consultant to say I've*
> *seen such and such a patient in A&E who's under your care, I just*
> *wanted to let you know.*   Lavender

Oak suggested the demands of work stopped him from being the doctor he felt he was or should be: one that was thoughtful and used evidence in daily practice. He acknowledged however that to some extent this notion of the kind of doctor he is was idealised:

and I think always appreciating that there's always a conflict that

goes on from me sitting in a room now telling you what kind of

doctor I see myself, and then actually on the ward with sometimes

the pressure you're under, the workload ... it's almost sometimes

impossible to keep ... be the doctor I want to be.

Oak

5.5.3 Identity as a doctor: formative experiences

When describing the journey to becoming a doctor, a range of events and life experiences were perceived as contributors to this. Most happened before joining the medical community. Fewer occurred at medical school. As might be expected in a purposive sample, there were a diverse range of stories of when and how they had become interested in a career in medicine. Some had drifted into it; being influenced by family or teachers, usually as a result of being extremely gifted at science:

And I was kind of getting some mixed signals from the doctors in

the family saying you know it is a good career, it's fulfilling, but

there are lots of downsides to it, and just think carefully before

you want to do it...but I made my own mind up because I just

found that the science and the contact with people was the most

important thing ... and I think that's held for true for me even now

in my practice. *Oak*

For Rose and Aster who came to medicine later, it had been a growing realisation that nothing else would make them fulfilled. For Saffron it had been stimulated by a key moment of clarity (which interestingly represented an idealised of junior as team member that was not borne out by experience):

And I got half way through my A-Levels and ended up going into a

hospital with a friend of mine, who was unwell. I went down to

the canteen one day and saw a group of ... well I now realise must

have been kind of junior surgeons or something ... a group of

people in scrubs sitting round a table eating their lunch and I

thought 'I want to be you'..... it was literally in that moment

saying 'Actually no I've made a mistake, I do want to be a doctor'.

Saffron

For most there were the familiar doctor narratives of wanting to help others and being fulfilled by being of some use to society (Monrouxe, 2009b). Aspen was the only doctor who did not describe any idealistic notions related to helping people or being fulfilled:

> *Cos I never went in ... a lot of people go in cos oh, the patient*
> *this, the patient that ... I was like well that's great, but I'd*
> *rather care about the disease first and then if the patient gets*
> *better, good stuff.* Aspen

Interestingly, despite what the existing literature might suggest, and despite trying to tease this out purposefully with all participants, medical school was not described by these participants as a powerful influence on identity other than the impact of activities involving responsibility already described. Some, but not all, participants were able to identify role models they met at medical school who helped them to identify *how* they wanted to be (or how not to be) once a doctor themselves. Usually this involved social aspects (with patient, relatives or teams) rather than medical ability:

> *There were a couple doctors who were just really, really good*
> *doctors, and you think 'I want to be as good as you are one day, I*
> *want to know as much as you know, I want to have that beautiful*
> *rapport you have with your patients. And I want to be as kind as*
> *you are ... I want to be ... yeah, this is the kind of doctor I want to*
> *be'.* Saffron

There was a widely held feeling that they left medical school knowing 'medicine' and not *medical practice* and with a title rather than a clear notion of themselves as a doctor. Some of this was due to not actually knowing what the job actually was, and some because they had not yet taken on responsibility:

> *I don't think I ever really felt like a doctor (at medical school). I*
> *mean even when it came to finals ... and that was the peak of*
> *when you know you could do your examinations and you could*
> *take the history.* Daisy

Tulip suggested learning 'medicine' took priority over learning to be doctor at medical school and that perhaps, while learning to be a doctor was really the function of the Foundation Programme, some small changes could be made to the undergraduate

programme to make the transition easier and to minimise the impact of the need to learn 'how' at the expense of other learning:

> *I   So learning medicine sounds like it took priority over learning to be a doctor?*
>
> *R   Yes, absolutely. I had no idea how to be a doctor when I started.*
>
> *I   And when did you start to feel like I'm going to be being a doctor soon?*
>
> *R   I felt a lot that the focus was very much on academic achievement and understanding ... and I can see why it is now, because it's great, my knowledge of medical conditions is (good)...and I sort of feel that's partly what the foundation years are for is to learn how to be a doctor. But I think there could have been a bit more of a 'This is what you're going to be doing on the wards, this is actually what you're doing as a doctor'. You know and not an awful lot, it doesn't take long to learn how to do a TTA, but ... it's those sorts of things would have taken ... definitely would have taken the fear out of first year and it might have helped me be able to get those jobs done so that I could then learn in my first year.   Tulip*

5.5.4   Identify formation outside of practice

There were aspects of self and identity as a junior doctor that participants described as features of their personality. They described these as both strengths and weaknesses, and acknowledged that these traits pervaded their work. However, at times a characteristic seen as beneficial in their personal belief about what a good doctor should be, was detrimental to doing the work of a 'good junior doctor', for example: going slowly and carefully through tasks (Clematis), being thorough (Oak), being prepared to challenge practice (Thistle, Aspen), being the patient's advocate (Saffron and Aster) or being attached to patients (Tulip). Many of these beliefs and values were described as being present from before entering medical school. However, for many it was through practice, and the

experience of the limitations of that expected practice, that these values, beliefs and subsequent behaviours fully emerged.

Although some themes concerning identity and professional formation arose across participants' stories, other threads of these stories of becoming were entirely personal to the individual. Each personal story gave insight into the unique contribution of influencing life events, influencing others, personality and self-understandings that created the doctor they described as sitting in front of me. Some compelling stories included: Thistle's tale of 'not being like the others', his feelings of outsider-ness that arose from who he was in life in general and not from the job; Aster's emotional story of the central importance of medicine to her sense of self-in-world; Oak's desire, that he described as an almost essential need, to keep learning every day of his life; Aspen's detachment from the emotional need to be fulfilled by medicine and how this affected his adherence to the profession: Rose's complex family history and personal circumstances that shaped her decisions and sense of perspective.

As the third strand of influences on professional formation, it can be seen that the weaving together of adopting the behaviours and characteristics of a good junior doctor and one's personal biography and values in a process I have called **becoming** is also central to developing a professional identity as a novice doctor.

5.6 Summary

In this chapter I have shown that novice doctors understand their professional identity as developing in relation to aspects of learning, belonging and becoming. It appears that this learning is not just a process of coming to understand the world of medical practice and their place within it through taking on responsibility and developing professional capabilities, but also involves learning outside of practice. I have also suggested that belonging is a central element in developing identity and that trajectories, transitions and fragmented journeys all impact on both learning and belonging. Taking on the mantle of 'good junior doctor' is a process of reaching a balance between expectation and personal values. I have also identified that the current organisation of the Foundation Programme seems to be impacting negatively on the potential of the early years of practice to provide a milieu in which novices can effectively become doctors.

The final chapter aims to piece together and make sense of these findings and align my findings with the work of others in an attempt to find meaning from this study; both for me as an education professional and to advance understanding in the field.

Becoming Doctors: the formation of professional identity in newly qualified doctors

Chapter 6: Doctors' professional formation: questions and issues

This chapter begins by summarising the experiences and stories of these novice doctors as they reflected upon and came to understand their *becoming doctors*. It then moves onto conceptual reflections; identifying how the existing theoretical concepts concerning professional learning, professional formation and identity development can be used to interpret and understand these doctors' experiences and where theory needs to be extended or reinterpreted to better understand this particular phenomenon. Through this conceptual framing of the findings this work aims to interrogate beyond the customary boundaries of the existing medical education literature; rather than simply looking at and describing a phenomenon, exposing what appears to be happening, criticising or applauding what is going on and suggesting what should be done about it, it aims to provide a nuanced understanding of the process of becoming doctors in the contemporary world of doctoring, thus adding to the theoretical as well as the empirical field. The chapter then builds on the methodological issues signposted in chapter 4 to further explore how methodological choices in this study have contributed both to what can be said about the process of professional formation in novice doctors and the use that can be made of these insights. The chapter then moves on to outline the policy implications of the findings and makes suggestions both about how policy, policy articulation and pedagogical approaches might need to be revisited as a consequence of these finding and the implications for my own professional work. The chapter, and thesis, concludes by identifying remaining issues that present opportunities for further research and a brief personal reflection on the research process as a whole.

6.1   The formation of professional identity: reflections of doctors' experiences

These doctors understand and describe their professional identity as developing in relation to learning, belonging and bringing together the perceived behaviours of a good junior doctor with their beliefs and values. These processes of *learning, belonging,* and *becoming*

are interlinked, socially mediated and each contribute in different but overlapping ways to an emerging sense of self-as-doctor in the social world of doctoring.

Activities and experiences categorised as *learning* included those concerned with coming to understand the world of medical practice and their place within it, developing professional capabilities through taking part in work, and an acquisition of further propositional knowledge and professional know-how aimed at their future ambitions through activities outside of the workplace. Whilst some workplace learning is focused on becoming a better doctor, this sort of learning was not the main focus of development in the early years of work for these doctors: instead learning was very much focused on the here and now and the need to learn 'how to do things round here'. While this might be expected to be the focus of any new job initially, for these novice doctors this learning spilled across the whole two years of the Foundation Programme as it filled the first few weeks or months of every post. This was recognised as problematic because it obstructed other learning opportunities by becoming the main objective and was so contextual that very little could be carried forward to subsequent posts other than how to be a bit quicker at the shortcuts to 'how to do things round here'. This fragmented the perceived learning potential of the initial years of practice limiting the potential for work-based professional learning to support the 'figuring' of a professional identity and the ability *'to keep a sustained narrative going'* (Giddens 1991). Much professional learning that did occur in the novice period, including this highly contextual learning, was stimulated by a sense of responsibility; which for some began in the latter part of training whilst for others only began once in work. Levels of responsibility however were neither uniform nor linear.

A sense of *belonging* also appeared be an important contributor to both professional formation and to being able to take part in work-based learning or indeed see work experiences *as* learning. When present, a sense of belonging not only supported learning but created the conditions for making meaning and finding value in everyday work. These doctors found belonging difficult; partly as a consequence of the 'passing through' nature of the junior doctor role but also, more importantly, because of the short rotations, shift patterns and the 'bundling' of posts in the current organisation of the Foundation Programme. The lack of connectedness with existing teams, the temporary nature of many teams that these doctors were joining to provide modern healthcare, and the frequency with which they changed posts, often finding themselves in posts that they did not see as important in their personal trajectory, inhibited a sense of belonging both *by* these doctors

and extended *to* these doctors from practice communities. Consequently movement from the periphery toward a more central position in the workplace and team was not a straightforward, or even desired, process for these novices.

Taking on the mantle of 'good junior doctor' occurred through a combination of learning 'how to be' and an incorporation of personal understandings of what it means to be good at this job into their practice; a 'figuring' of who they are and what they are supposed to do. This was an iterative process of finding a balance between expectation and personal values. Acceptance of the expected 'habitus' of a good doctor was not automatic or unquestioned: instead held in equipoise by each of these doctors with their growing understanding of how they might exhibit and uphold their own personally held beliefs about what being a doctor means whilst conforming to expectation.

The work, the workplace and the people within it were therefore central to the process of figuring a professional identity and developing professional expertise for these doctors and there is no doubt that the world and role of the 21st century junior doctor had a profound effect on how these newly qualified doctors were developing their professional identities and learning to become doctors. The policy implications of the impact of the organisation of the modern workplace on professional formation are further explored in section 6.3.

However, whilst the world of contemporary work and the way it is organised had profound and multiple impacts on the formation of a professional identity and how it develops in the novice years as a doctor, so too did the personal trajectories of the individual: their backstory, their formal and informal career plans and their personal understanding of what being a good doctor means to them. Whilst the emerging identities overlapped with idealised identities identified at medical school through GMC guidance (GMC, 2006) and the 'on the ground' meaning of what it means to be a good junior doctor in the modern NHS, identity was personal to each individual and shaped their interpretation of experiences, what they valued at work, their practice and the extent to which they were prepared to work around expectations to do the 'right thing'.

6.2 The formation of professional identity: conceptual and methodological reflections

Chapters 2 and 3 identified some of the current thinking in the interlinked fields of professional learning, professional formation and professional identity. This body of work is revisited here to identify the ways in which these theories can be put to use in understanding the experiences of 'becoming' of the doctors in this study, identifying where elements of these theories resonate with the findings of this study and where further theory building is needed to provide a more nuanced account of becoming a new doctor in the UK in the 21st century.

The impact of the methodological choices made and the use of a socio-cultural theoretical frame on what can be made of the findings is also explored; identifying the affordances and limitation of the approach taken in understanding issues of professional identity formation.

6.2.1 Conceptual reflections

Field, habitus and identity as a junior doctor

Bourdieuian notions of the relationship between people's practices and the context in which those practices arise foreground the importance of the cultural field in explaining how social interactions and conditions in the workplace influence behaviours, values, practices and one's sense of identity; the habitus that arises from immersion in a cultural field. In doing so it intimately links the workplace, the work or practices undertaken within that workplace, the possession of culturally specific capital and an understanding of the rules of the game with the development of a sense of belonging and identity. Whilst this theory is helpful in understanding the reproduction of communities it has limitations when looking at the process of formation and although many aspects of field theory are helpful in understanding the experiences of these doctors, I assert that the link between the field and the almost unconscious development of the habitus is not a straightforward concept for very junior doctors nor are field and habitus so intimately or temporally linked. I outline the reasons for this assertion below.

Certainly a significant preoccupation of these doctors was gaining an understanding of the field and their position within it. The metaphor of 'the game' as a way of understanding how cultural literacy develops also resonates with why these doctors spent so much effort in trying to uncover the rules of the game and gain cultural literacy in the field of doctoring. They needed to know this so that they could engage with the work and in doing so, become

a 'good doctor': both within their own terms and within the established rules of the game. But they also recognised that they needed to understand the field and the game to create the conditions where learning and belonging that was meaningful to them could occur in these posts.

Bourdieu's notion of the field is also helpful for understanding what counts as capital in the modern world of medical practice. The 'jobs-list' was a good example of this new capital. As these doctors quickly learnt, possession of medical knowledge and skills had little effect on positionality and as such, knowledge capital was seen as somewhat separate from what could be learnt in the workplace and was pursued in other setting and for purposes other than in pursuit of being a good *junior* doctor. Many aspects of their roles, once worked out, were not terribly demanding and seemed to consist of mainly 'administrative' tasks. Unlike their co-workers, they did not seem to value the development of these particular professional competencies in their understanding of what being a good doctor meant.

Field theory suggests capital has value only in relation to specific fields and whilst all posts required some similar behaviours and accomplishments, these early years posts were so varied in the demands made on the doctors and the experiences were so varied from post to post that one might question the notion of the 'field of the new doctor' and suggest novice doctors are in fact moving between fields with every job change. This variation in the field is important for two important reasons. Firstly, if using field theory to understand how habitus develops and is enacted, one must be mindful of the myriad ways in which the practices, experiences, affordances and positioning of each of these junior doctors was variable. It makes generalisation of the experiences of *these* doctors to *all* junior doctors more problematic as the field is not predictable even in seemingly similar roles or posts. Secondly, and most importantly, it goes some way to explaining the difficulty in directly relating field and habitus in the development of a professional identity of junior doctors. In Bourdieuian terms, coming to understanding the field creates the habitus, however something different seems to be occurring with these doctors. The deterministic nature of the habitus that implies no active becoming, an unconscious adoption of the habitus, no varying participation in the field or acceptance of the habitus did not seem to happen with these doctors. They were active in interrogating and make sense (or nonsense) of what was going on around them and what was expected of them. They were reflective in their ability to manage the lack of guidance by bringing past experience to bear on this recurrent problem. As with Hodkinson and Hodkinson's novice teachers (2004), they showed

significant insight into this being a 'game' and they made active and conscious decisions about which elements of the habitus they would accept and which they would resist. Where it was felt important or possible, resistance was exhibited; even to the extent of being unpopular or not being a 'good' junior doctor. These 'adopted' elements of the habitus together with their past and present personal understanding of what being a good doctor means became a 'mantle', using the functional emphasis of the word. This mantle allowed them to act as a 'good junior doctor' but also allowed them to exhibit some agency in that behaviour.

Moreover, it would appear that for these doctors much of the work to understand the rules of the game was focused on the *here and now* of the world of the *junior* doctor rather than shaping directly their eventual identity as doctor. For very junior doctors there is an element of separation between their being a doctor on the Foundation Programme and their planned eventual role pursuing a particular career path as doctor. The first years of practice seem rather like a staging post where prior learning is re-contextualised and basic work skills are learnt and where an active and conscious consideration of the habitus of 'junior doctor' takes place. In this way the first two years in practice are likely to be a stage in itself when a 'fledgling' identity develops before moving onto a further stage of identity formation as work increasingly involves activities targeted towards their career choice, placing the doctor in a more central position in the field and providing an incremental experience of responsibility and activities.

Situated learning, communities of practice, legitimate peripheral participation and identity:
Viewing learning as part of social practice and thus learners and social organisations in recursive relation to one another is helpful in understanding some of the learning, belonging and becoming experiences of these doctors and their perceived contribution to identity formation. But there are limitations in 'overstretching' these notions of situated learning, communities of practice and legitimate peripheral participation (Evans et al., 2006) in attempting to making sense of these doctors' stories and experiences of learning, belonging and becoming in their professional formation.

Firstly, there are issues that concern the complexity of professional learning as a novice doctor and its effect on formation above and beyond that proposed by Lave and Wenger (1991). Whilst learning *how* to do the job, and learning *from* the job were an important part of these stories, not all learning was within the realms of practice and many learning experiences that these doctors associated with developing their identity had a more

individualistic nature. There was a contribution from both existing knowledge and know-how, their personal biography (Evans et al., 2006) and learning outside of practice to their sense of self as doctors: even if this learning did not seems to contribute to their functioning day-to-day as a junior doctor. Deliberate learning outside of work and the workplace was an important part of these doctors' lives and they learnt much of this independently as they prepared for examinations and through formal teaching sessions. As Bernstein suggests (in Young, 2007) this learning was in itself formative in nature. Furthermore, they brought with them from their formative years and from medical school a profound ability and interest in medicine. They were therefore newcomers with knowledge capital (Evans and Kersh, 2003) and were further developing this capital without the support of their workplace colleagues and for purposes other than being judged good at their current job by these colleagues. This created some considerable differences in their newcomer status than that seen in Lave and Wenger's empirical examples (1991). They were clear about what they could learn through work and what was considered outside the realms of workplace learning. The casting of 'the medicine' as somehow separate to practice was in itself suggestive that these doctors saw these two sources of learning as quite different aspects of learning to be a doctor. This conception of learning held by junior doctors, together with their membership in the workplace having relatively little personal significance for many, in at least some of their posts, means the role of the workplace in learning, belonging and becoming is more complex to understand than in the theoretical frame suggested in situated learning theory.

The notion of re-contextualisation perhaps provides a more comprehensive understanding of how these novices combined these different strands of learning to 'put knowledge to work' (Evans et al., 2010). This putting together of disciplinary knowledge learned outside the workplace with practice-based and local organisational knowledge, seems to be one of the processes through which these doctors came to 'think and feel' their new identities (Evans, 2011). It also provides a better explanation of how these doctors both carry learning forward during this period and how they learn to vary the techniques of learning and belonging as they move from post to post.

Secondly, whilst belonging is an important facilitator of situated learning for these doctors (Wenger 1998), there are limitations of casting these newcomers as moving from the periphery to the centre of communities of practice as expertise and membership develops in a straightforward inbound novice-to-expert trajectory. Whilst communities of practice is

a helpful concept in clear-cut communities where the aim of membership is moving to increasingly central participation, when, as in the case of these doctors, the community is less clearly defined, the novice is a novice only in relation to the community rather than in terms of knowledge capital and the time spent in that community is so short, the influencing effect of that community is less obvious. For these novice doctors, participation was, therefore, a more decentred notion. Their ability, and indeed their need or desire, to become an integral part of a community was limited by the fact they are always 'passing through' rather than moving towards the centre of a community.

Wenger's later work on situated learning and identity formed through practice (Wenger in Hall et al., 2008) offers a 'peripheral trajectory' as a way in to understand how learning and identity formation can occur in and through practice, even in situations of limited participation and belonging. For these novice doctors whilst much of their learning was social and through participation, what they were learning was not experienced by them as part of a journey towards central participation; it was learning to get by and get on in this post until the next unrelated post came along. The desired end-point of this learning was not full membership; these individuals would never become old timers in these communities and this was clear to them and tempered their sense of what belonging and what work-based learning was possible. Whilst these doctors will become expert eventually, their current preoccupation was with managing a series of transitions. They were always peripheral to a lesser or greater extent and rather than aiming to become central in order to learn and become, their goal was to maintain a legitimately peripheral position in these communities and to attempt to make meaning from, and learn from, this position.

Turner et al. (2001) argue the undergraduate course is not truly an apprenticeship because the lack of responsibility, participation and short multiple placements all deny the medical student a sense of belonging to a particular community. I would argue that, to some extent, the same might be said of the Foundation Programme. Authors like Becker et al., (1961) and Sinclair (1997) found that medical students were being socialised into the medical school rather than the profession and it seems many aspects of the process of identity formation for these doctors are focused on their *identity as a foundation doctor* and socialisation into the Foundation Programme and not into the medical profession at this stage. With insider trajectories delayed until the more stable, specialist training element of their careers, these doctors are learning how to be good foundation doctors and, as such,

do not yet value the work, experiences, relationships and transmitted norms in the way they may later do as they embark on the period of the lives more aligned to their own personal trajectory as a doctor.

Figured worlds and figurative and positional identities

The notions of *figured worlds* and *positionality* (Holland et al., 1998) are useful in conceptualising the dynamic relationship between identity and participating in the social world and to move beyond understanding the relationship between field and practice toward a clearer relationship between field and identity. They provide a framework for understanding these novices as reflective of the ways in which their world shapes what they do and as active and mindful in the acceptance or challenge of aspects of expected norms using this to improvise and thus 'author' an identity as a new doctor. Like Holland et al's own empirical example of undergraduates navigating the world of romance (ibid), the interviews with these novice doctors revealed a discourse that reflected their beliefs, values, and social practices, conveyed their degree of expertise in being a junior doctor, the ways they dealt with new challenges when they arose, and what it meant to them to participate in the world of doctoring (Holland et al., 1998).

Figured worlds and figured and positional identities also provides a way of understanding how and why these doctors did not simply unconsciously develop a habitus that naturalised itself but instead seemed to engage in a more selective, conscious, and reactive process, that I have described as developing a mantle: a figured identity that allows them to survive and get along as just one of the 'interchangable' junior doctors in the work they are undertaking. The obstruction of belonging and central participation by old timers; partly due to the frequency in which new doctors find themselves in jobs they neither want nor value and partly because of the increasingly 'nomadic' role of the foundation doctor in teams, means a pragmatic identity needed to be adopted which did not fully resonant with the internal notions of self–as–doctor.

The concept of positional identities is also useful in understanding these doctor's experiences and perceptions. For these doctors positionality, and the agency afforded by this positionality, was only partly related to the general position of 'foundation doctor' in a hierarchy of practitioners. Instead it was perceived as more tightly bound to the doctor's personal trajectory, their efforts to belong to communities and the culture of the individual post. Positionality was very fluid for these doctors, perhaps more so than even Holland et al. suggest (ibid). For example on a single day Tulip was being a 'clerk' on the ward round, a

not very engaged surgeon in her avoidance of attending theatre, a developing physician in her hours of personal study after lunch and 'the doctor' in the personal and unexpected space of patient contact following the ward round. The affordances and restrictions of each of these positional identities were each impacting on her sense of who she was in the world of doctoring.

The notion of figured worlds is helpful in understanding how these formative experiences in the fragmented and constantly changing world of the newcomer to doctoring might be valuable. If the figured world is constantly changing what one learns is how to vary performance, how to fit in, how to re-contextualise professional knowing to make it useful and how to keep a narrative of identity going over a constantly changing terrain. Thus rather than viewing this period simply as 'the waiting room' before meaningful formation can begin, I suggest this period can be viewed as preparing them for the challenges of developing and maintaining an identity as a doctor across their professional lives.

The casting of identity as dynamic and a work in progress and the key role of narratives, both internal and articulated, in creating and recreating this identity (ibid) also enables a view of these fledgling identities as a step towards further identity formation as practice and experience develops. Each doctor's narrative included: the exhibiting of agency in the face of expectations of their current work that they find unpalatable; the story that the rules of the game were being obscured, tales of being an outsider to a lesser or greater extent and of learning as something individuals do. This discourse of resisting the habitus was crafted in the relative safety of the interview or enacted in uninspected spaces. The tales of not belonging, not understanding and not needing to use any 'medicine' to be a junior doctor were told as if this was not the end of the story; that their world as more senior doctors would not be so. There is clearly an anticipated period of further identity formation in the next stage of their careers.

6.2.2 Methodological reflections

In undertaking this study of a complex phenomenon I adopted an approach steeped in the socio-cultural tradition. The methodological decisions made and the consequent limitations to the study at the design stage were outlined in chapter 4. These methodological choices also impact what can be made of the findings and the interpretation of these findings.

In approaching this study I did not use an existing overarching theory or model to conceptualise the aspects of learning, formation and identity I wished to pursue in this

study. Whilst activity theory (Engeström 1987, 1999) or the expansive-restrictive continuum (Fuller and Unwin, 2003) might have been relatively good fits, and have been used by others to explore identity and formation in relation to activity and articulation of activities within systems of power and privilege (*for example* Engeström in Chalklin and Lave, 1996, Boor et al., 2008, Bleakley, 2010, Bleakley et al., 2011) they seem better suited to interrogating and making claims about the larger structures, the NHS Trusts in which these individuals worked or the Foundation Programme as a whole, rather than the focus of this study; how individuals figure out who they are as they become doctors. As I did not find a wholly satisfactory existing model that could be put to work in this study, I Instead used three overlapping theories to gain purchase on the relationship between learner, place of learning and identity. Whilst I made this theoretical framework and how this influenced my collection and interpretation of the data explicit, by choosing to use a combination of theories, this approach makes theoretical generalisation from this study more difficult.

This approach has however previously been used by Rubin in her study of student identities in urban schools (Rubin 2007). Rubin viewed the setting, like the setting in this study, as profoundly shaping the learning that was possible, the approach to learning and the identities that the practices in the school afforded. She argued that viewing learner, learning and setting as intimately linked through the notion of the figured world allowed her to provide a more nuanced understanding of identity and the factors impacting on this identity. Despite this study of novice doctors working in a NHS hospital being a very different empirical setting to Rubin's urban US High School, I would argue that there were many elements of her justification, and indeed findings, that resonate with the perceived effects of setting, practices and affordances on these doctors' emerging identities.

By collecting a significant amount of data on a small number of individuals, choices needed to be made about which 'slices' of this huge data set to use to provide an account of the process of formation. Whilst being clear about the influence of my positioning on the notions of formation and identity and reflexive about how and when I was using my data to describe or explain, there is no doubt that my theoretical stance influenced the aspects of identity formation I foregrounded. Of course using a different theoretical 'lens' to interrogate the data would have resulted in some different emphases emerging.

There were also a number of features of the research approach chosen that limit what can be said about the phenomenon under investigation. Despite my framing of identity as a

'work in progress', the limitations of the scope of this study meant that data were generated over one, two, or occasionally three, contact periods and thus it could be argued that I merely captured a 'snapshot' of identity. Alternative approaches might include a series of interviews and observations to explore identity over the whole period of the initial years of practice or a follow-up study of these doctors a year or two down the line to provide an understanding of the role of this initial period of identity formation and the ongoing 'figuring' of identity as these doctors continued to develop professional capabilities and experienced more stable periods of practice.

I also aimed to capture stories of becoming as narratives based on my understanding of identity being crafted as the story is told. However whilst identifying narrative themes, I did not use a narrative approach to data analysis. The choice to foreground the commonalities of experiences rather that the ways in which stories of identity are told gives a different flavour to the interpretation of the data generated in this study than what might have emerged from a narrative analysis.

6.3   The formation of professional identity: policy implications

The introductory chapter highlighted the context in which this study took place: a time of significant change in medical education and practice. It is important therefore to identity what this study brings to current debates concerning the pedagogical and policy decisions guiding the education and support of novice doctors.

For these doctors medical school had a more limited role in socialisation and identity formation as a doctor than the existing literature would suggest. Much of this previous work, however, concerned medical students rather than junior doctors and took place in now historical models of undergraduate education and medical workplaces (*for example,* Becker et al., 1961, Sinclair, 1997). These doctors, now in practice, saw their time at medical school as focused on learning codified professional knowledge rather than for learning *how to be* a doctor. The final year at medical school was important in forming some sense of what a 'junior doctor' is and does, particularly if assistantships, shadowing or other activities that provide responsibility and exposure to the life-world of the junior doctor were included.

Once in practice induction procedures, mandated by the Foundation Programme (DoH, 2005, 2010), were often not helpful and indeed were targeted at only one transition. Being

well supported in the early days in *each* new post was more helpful for these novices in finding their feet and being able to ask for guidance. I would assert that the notion of newcomer needs to be extended to *every change of post* rather than at initial entry into the Foundation Programme as it is clear that each transition creates a sense of not belonging and not knowing what to do and constitutes a consequential transition (Beach 1999). The current focus in the medical education literature and policy is the impact on issues such as patient safety of easily identifiable transitions, such as the transition from medical school to work or into specialist training (Brennan et al., 2010, Wilson et al., 1998). It is clear from the experiences and stories of these doctors that these destabilising transitions and returns back to newcomer status happen much more frequently than is currently acknowledged.

Belonging, learning, and understanding one's role and position were all felt to be compromised by the current organisation of the early years of work, and the consequent fragmented journeys this produced. For these doctors meaningful work-place learning was often linked to a sense of belonging and the job having personal meaning. Learning *from* the job was frequently obfuscated by *learning the job,* which itself was made problematic by a lack of explicitness of both of 'rules of the game' and the expectations of others. Barriers to learning were compounded by constant changes in roles, responsibilities, co-workers and settings.

Professional learning was stimulated by responsibility and the variability in responsibility between posts rather than a graded introduction to responsibility, with increasing levels as expertise develops, meant some junior doctors were afforded too much responsibility while others not enough. When what one does, what one can learn, and one's positionality within each post is very variable, boundary work – maintaining and developing identity across boundaries (Wenger 1998) – is also made problematic. Moreover, the support structures and the organisation of the Foundation Programme cast the roles, opportunities and levels of expected performance of foundation doctors as relatively uniform and the first two years post qualification as a continuum. This does not appear to be the case.

The process of becoming a doctor is a mediated one and identity forms through activities and experiences that create learning, belonging and becoming. Whilst there has been much debate in the medical and lay press about the effects of new working time directives and patterns of postgraduate training on the potential for *learning* (*for example* Chikwe et al., 2004, Kendall et al., 2005, Garvin et al., 2008) there has been little focus on the effects of

126

these changes on belonging or formation and how these are compounded by frequent changes in role during the early formative years. A recent review of the Foundation Programme (Collins, 2010) overlooked the whole process of formation, belonging and identity. This inattention to formation results in pedagogical decisions that focus simply on learning opportunities, overlooking the changes to the social world of junior doctors as a consequence of such workplace reorganisation.

This study also highlights how a number of assumptions, and the implication of those assumptions, regarding the organisation of the first two years in practice remain unexamined. I would argue that the belief that rotation is generally a good thing and that exposure to lots of different jobs provides a wide range of experiences and equals good learning are not borne out by the findings in this study. Rather than using rotations bundled to provide a wide range of experiences, it may be more helpful to look at the affordances of the individual workplaces to ensure rotations contains exposure to at least some workplaces that have the structural and social 'expansive' features that provide maximal opportunities for learning and formation (Fuller and Unwin, 2003). In the same vein, I would also argue that a brief exposure to a 'recruiting' speciality where the doctor feels marginal because of their junior status and where the mismatch of post with personal trajectory creates a lack of impetus for newcomers or old-timers to work on membership and belonging may be counter-productive at this stage of formation.

Finally, the Foundation Programme is one formative stage in the development of the new doctor. The Collins report (2010) and other documentation associated with the Foundation Programme cast the experiences and affordances of the thousands of rotations as uniform by virtue of following a single curriculum with each two-year set of experiences creating a single type of 'product' for entry into further postgraduate training. This description did not resonate with the experiences of these doctors in two important ways. Firstly, the amount that doctors can carry forward between posts, particularly as so much of their time was consumed with learning the job with each transition, is overestimated by viewing these two years as a linear process of increasing learning, responsibility and professional adherence. Secondly, what constitutes the 'field' of practice for these junior doctors varied in many dimensions as already described. If we understand professional identity formation as occurring at the articulation between the novice and the world of that novice, the variability of this site of practice to facilitate socialisation, developing expertise, membership and learning will be impacting on this formation. A single 'product' equally

ready to enter the next stage of development is unlikely to be the result of the current structures.

6.4   Contribution of this study to the research area

Through this study I have provided an in-depth insight into the socio-cultural dimension of the professional development and identity formation of novice doctors. By exploring the personal, structural and situational factors newly qualified doctors identify as having shaped their identity and development, the study provides a nuanced understanding of how and why resultant identities develop and the effects of workplace and education reform on professional identity formation: which ultimately influences the ways in which these doctors approach practice.

This work adds to the medical education literature by focusing on the relatively overlooked sociocultural dimension of the transition from student to novice doctor. The timing of this study provides a contemporary understanding of how doctors perceive their growing sense of development of self-as-doctor to help to address this gap in the existing empirical literature, mindful of the ways in which work and the workplace have changed. By using a relatively underused methodology in medical education of non-participant observation together with interviews, I have been able to access aspects of identity and impacts on that identity that are not readily accessible by interviews alone thus providing a more complete account of how individuals become doctors.

I have also revealed the significant diversity of experiences and perceptions, not just between doctors who hold the same nominal role but for the individual doctor as he/she moves across different posts. This finding has important consequences for future research that samples 'junior doctors' as a homogenous cohort. Even if those juniors are, as in this study, at the same grade and in the same geographical location, researchers may need to account for a very wide range of experiences and perceptions that are not solely attributable to the differences between individuals.

Policy in the arena of postgraduate medical education changes rapidly and the medical education community does not always have the opportunity to contributed to an understanding of the consequences and impacts of this change before it takes place. What research that does exist tends to focuses on the impacts of these changes on learning and

training opportunities. This work adds to the literature by highlighting the *social* impacts of these reforms that might have unanticipated impacts further down the line. I have shown that belonging is an important element in identity formation and learning and that very brief attachments, combined with shift work, is resulting in a situation where efforts to belong (or enable belonging) are sometimes frustrated, sometimes neglected. I have also revealed that far from a linear and problem free accumulation of professional knowledge, know-how and a move towards a more central position in communities of practice, these first years of practice are consumed with a need to keep learning and relearning non-transferable context specific know-how and a repeated need to create new relationships and memberships. As a consequence, novice doctors follow a very peripheral trajectory and do not necessarily engage with, or benefit from, anticipated work-based learning opportunities.

This study also makes important contributions to the theoretical understandings of how lay individuals become professionals and the role of the workplace in that formation that is relevant beyond the medical education literature. It provides an account of identity formation in professions where the status of newcomer is complicated by entry to the workplace with high status professional standing, knowledge capital and a relatively high degree of autonomy but with a low level of practical know-how of how to get jobs done. These circumstances will be common to a range of professions as they enter contemporary workplaces which are increasingly multi-professional, and increasingly fragmented by modern working practices. It suggests that identity and expertise in these circumstances can develop to some extent whilst the individual remains marginal to fellow practitioners and many aspects of practice, but not solely through the processes put forward by situated learning theory.

One final note of caution should be raised when considering the potential contribution of this work to the medical education literature. I have previously highlighted how my interpretivist approach is in considerable contrast to the medical perspective. This limits the utility, publish-ability and thus impact of this research. To create impact in the medical education community this work will need to be considerably abridged and, in some areas, claims and assertions backed up with data gathered from a much wider sample of junior doctors.

6.5   Opportunities for further research

Some extensions of this study have been suggested in section 6.2.1. This study focused on initial periods of formation but many questions about the life-course dimension of professional identity of doctors remain unexplored. Whilst this was intentionally an exploratory study the findings indicate that some intervention studies might also be usefully pursued to investigate what, if any, interventions facilitate the social aspects of transitions, how induction might be maximised so that a sense of understanding the rules of the game and local practical and social practices can be established early in the post, and how learning from the job and learning on the job can be maximised in posts not aligned to personal trajectories. Importantly, this study highlights the significant transformation in the worlds of work and learning of junior doctors over the last decade. As identity can be seen to be partly constituted at the point of practice and has the potential to profoundly affect practice, some work is also required in finding the right balance between maximising the benefits of exposure to a range of training posts and staying in a post for long enough to find meaning in the role and become less peripheral in the communities of practice in those workplaces. Furthermore, if we understand the workplace as a key influence on learning to become a doctor, a more nuanced understanding of workplaces and their capacity (or lack of capacity) to operate as 'expansive' sites (Fuller and Unwin, 2003) for which professional formation may improve choices made by Foundation Schools about suitable sites for the placement of very junior doctors.

6.6   Impacts on my professional practice and reflections on the research process

As a medical educator with responsibility for the professional development of future generations of doctors there are a number of potential impacts from the findings of this this study across the range of my professional practice.

As an education academic with the responsibility for an undergraduate curriculum, it seems likely that some small but well considered interventions in the undergraduate curriculum could impact significantly on the experiences of these students as they emerge into practice. These include: ensuring that medical school learning maintains a vocational as well as an academic focus; that existing assistantship opportunities are interrogated to ensure they provide meaningful immersion in the field and initiate the onset of

responsibility; that student attachments, like junior doctor posts, are arranged to balance the benefits of exposure to a range of learning opportunities and fields with staying in a post for long enough to become less peripheral in the communities of practice in those workplaces.

My education role also includes a loose relationship with the Foundation School in which this study took place. I intend to share my findings with my Foundation Programme colleagues to look at ways of reviewing, for example, local induction procedures, support at all transitions, and which placements are chosen as suitable foundation years posts.

With professional development within the current competency culture reduced to a set of learnable competencies and still largely framed in the positivist paradigm in the medical education literature, this study also provides an opportunity for me to offer a different account of professional formation, acting as a persuasive resource to influence policy and practice within the medical education community more generally.

The process of carrying out this study also created further impacts on my professional practice. Through conducting this study I have become mindful of some errors in thinking about situated learning and identity formation both personally and collectively within the medical school faculty. Firstly, I now understand that undergraduate experiences, as they are currently configured, have only a modest effect on professional formation. Secondly, whilst communities of practice and improving membership of communities is an attractive idea, it is important that we are not seduced by this notion as this study suggests that membership of communities of practice as a condition for situated learning is a more diffuse relationship in medicine, that membership is not necessarily the goal of novices as they enter the workplace and that absence of full membership does not prevent meaningful learning. Thirdly, it is important to understand that junior doctors and medical students belong to several overlapping communities of practice to lesser or greater extents and all of these communities will be impacting on what can be learnt and how these learners and novices figure their worlds and identities.

I set out on this research journey attempting to understand how people become doctors; recognising that the focus of much research and policy in the domain of professional development of doctors concentrates on learning rather than on formation and with little idea of how identity developed because I shared this rather narrow focus. I did not know what impact, if any, my actions as an educator and curriculum lead had on professional

formation. Despite recognising the need for a more meaningful engagement with the theory in medical education research, I realise now that my previous work had not always engaged critically with the prevailing theory; often adopting 'best fit' theoretical models wholesale to provide an analytical framework. Conducting this study has provided me with a better understanding of the development of professional expertise, formation and identity and the impacts of a range of factors, not all of them educational but all of them important, on the process of becoming. It has given me the practical experience of conducting a meaningful study in the domain, including overcoming the significant methodological and ethical challenges. Most importantly it afforded me a privileged, humbling, nerve-wracking, highly informative and, I hope, to some extent, agentic opportunity to engage meaningfully with junior doctors, hear their stories, walk with them through snapshots of their lived experiences and gain a quality understanding of the process of the first steps in becoming a 21st century doctor.

Becoming Doctors: the formation of professional identity in newly qualified doctors

Chapter 7: References, acknowledgements and appendices

7.1   References

Abelson, J., Maxwell, P., & Maxwell, R. (1997) Do professions have a future? *British Medical Journal,* (315):382.

Adams, K., Hean, S., Sturgis, P., & Macleod Clark, J. (2006) Investigating the factors influencing professional identity of first-year health and social care students, *Learning in Health and Social Care*, 5, (2): 55-68.

Apker, J., & Eggly, S. (2004) Communicating Professional Identity in Medical Socialization: Considering the Ideological Discourse of Morning Report, *Qualitative Health Research,* (14): 411-429.

Armstrong, P., White, A., & Thakore, S. (2008) Senior house officers and foundation year doctors in emergency medicine: do they perform equally? A prospective observational study, *Emergency Medicine*, 25, (11): 725-727.

Baszanger, I. (1985) Professional socialisation and social control: from medical students to general practitioners, *Social Science & Medicine*, 20, (2): 133–43.

Beach, K. (1999) Consequential Transitions: A Sociocultural Expedition beyond Transfer in Education, *Review of Research in Education,* 24: 101-139.

Beagan, B. (2001) Micro inequalities and everyday inequalities: "race", gender, sexuality and class in medical school, *Canadian Journal of Sociology*, 26, (4): 583-610.

Becker, H., & Carper, J. (1956) The development of identification with an occupation, *The American Journal of Sociology*, LXI, (4): 289-298.

Becker, H., & Greer, B. (1958b) The fate of idealism in medical school, *American Journal of Sociological Review,* 23, (1): 50-56.

Becker, H., Greer, B., & Hughes, E. (1961) *Boys in White: Student Culture in Medical School*, Chicago, University of Chicago Press.

Beijaard, D., Meijer, P.C., & Verloop, N. (2004) Reconsidering research on teachers' professional identity, *Teaching and Teacher Education,* 20: 107–128.

Berger, P.L., &   Luckmann, T. (1966) *The Social Construction of Reality*, New York, Doubleday.

Bess, J. (1978) Anticipatory socialization of graduate students, *Research in Higher Education*, 8, (4): 289-317.

Bleakley, A. (2002) Pre-registration house officers and ward-based learning: a `new apprenticeship' model, *Medical Education*, (36): 9-15.

Bleakley, A. (2006) Broadening conceptions of learning in medical education: the message from teamworking, *Medical Education*, (40):150–157.

Bleakley A. (2010) The proof is in the pudding: putting Actor-Network-Theory to work in medical education, *Medical Teacher*, 34, (6): 462-7.

Bleakley A., Bligh, J. & Brown, J. (2011) *Medical Education for the Future: Identity, Power and Location,* New York, Springer.

Bloom, S. (1973) *Power and Dissent in the Medical School*, New York, Free Press.

Bloom, S. (1989) The medical school as a social organisation: the source of resistance to change, *Medical Education*, 33:228-41.

Boor, K., Scheele, F., van de Vleuten, C., et al. (2008) How undergraduate clinical learning climates differ: a multi method case study, *Medical Education,* 42,(10):1029-1036.

Booth, M., Hargreaves D.H., Bradley, H., & Southworth, G. (1995) Training of Doctors in Hospitals: a comparison with teacher education, *Journal of Education for Teaching*, 21,(2): 145-162.

Bourdieu, P. (1977) *Outline of a Theory of Practice*, Cambridge, Cambridge University Press.

Bourdieu, P. (1990) *The Logic of Practice*, Cambridge, Polity Press.

Brennan, N., Corrigan, O., Allard, J. et al. (2010) The transition from medical student to junior doctor: today's experiences of Tomorrow's Doctors, *Medical Education*, 44, (5): 449-458.

Brown, J.M., Chapman,T., & Graham, D. (2007) Becoming a new doctor: a learning or survival exercise? *Medical Education*, 41,(7): 653-660.

Bruner, J. (1991) The Narrative Construction of Reality, *Critical Inquiry*, 18, (1): 1-21.

Bucher, R., & Stelling, J.G. (1977) *Becoming Professional*, California, Sage Publishing.

Burgess, R. (1984) *In the field: an introduction to Field Research*, London, Allen & Unwin.

Bullough, R. V., Knowles, G., & Crow, N. A. (1992) *Emerging as a teacher*, London/New York, Routledge.

British Educational Research Association (2004) *Revised Ethical Guidelines for Educational Research,* Southwell, BERA.

Brosnan, C., & Turner B.S. (Eds) (2009) *Handbook of the Sociology of Medical Education,* London, Routledge.

Bunniss, S., & Kelly, D. (2010) Research paradigms in medical education research, *Medical Education*, 44,(4): 358-366.

Cavenagh, P., Dewberry, C., & Jones, P. (2000) Becoming professional: when and how does it start? A comparative study of first-year medical and law students in the UK, *Medical Education*, (34):897-902.

Chalkin, S. & Lave, J. (Eds) (1996).*Understanding Practice: Perspectives on Activity and Context,* Cambridge, Cambridge University Press.

Chikwe, J., De Souza, A., & Pepper, J. (2004) No time to train the surgeons, *British Medical Journal*, 328: 418-9.

Clandinin, D.J., & Cave, M-T. (2008) Creating pedagogical spaces for developing doctor professional identity, *Medical Education*, 42: 765–770.

Cohen, H. (1981) *The Nurses Quest for a Professional Identity*, California, Addison-Wesley.

Collins, J. (2010) Foundation for excellence: an evaluation of the Foundation Programme, Medical Education, England, http://www.mee.nhs.uk/pdf/MEE_FoundationExcellence_acc_FINAL1.pdf *(Accessed 13th June 2012).*

Coombes, R.H. (1978) *Mastering Medicine: Professional Socialisation in Medical School*, London, Collin-Macmillan.

Cornford, C., & Carrington, B. (2006) A qualitative study of the experiences of training in general practice: a community of practice? *Journal of Education for Teaching*, 32: 1278-1287.

Coulehan, J. (2005) Today's Professionalism: Engaging the Mind but Not the Heart, *Academic Medicine*, 80:892–898.

Cruess, S., & Cruess, R. (1997) Professionalism must be taught, *British Medical Journal*, 315:1674-1677.

Daaleman, T., Kinghorn, W., Newton, W., & Meader, K. (2011) Rethinking Professionalism in Medical Education Through Formation, *Family Medicine*, 43,(5):325-329.

Daly, C. (2008), *Narrative interviews: Researching learning and assessment in the clinical workplace*, Association for the Study of Medical Education (ASME) Conference, London, 16th November 2011.

Deaux, K. Personalizing identity and socializing self, *in* Blackwell, G. (Ed.) (1992) *Social psychology of identity and the self-concept,* London, Surrey University Press: 9-33.

Department of Health (2005 and 2010) UK National Foundation Programme Curriculum, London, DoH, http://www.foundationprogramme.nhs.uk *(Accessed 20th September 2011).*

Department of Health (2008) *Modernising Medical Careers – Implementing the Tooke Report*, London, DoH, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_090285.pdf *(Accessed 23rd September, 2011).*

135

Department of Health (2009) *The European Working Time Directive for trainee doctors – implementation update*, London, DoH, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/ DH_093939 *(Accessed 12th January 2011).*

Dornan, T., Boshuizen, H., King, N., & Scherpbier, A. (2007) Experience-based learning: a model linking the processes and outcomes of medical students' workplace learning, *Medical Education*, (41):84–91.

Downie, R., & Charlton, B (1992) *The making of a doctor: Medical education in theory and practice*, Oxford, Oxford University Press.

Dreier, O. (2008) Psychotherapy in Everyday Life: Learning in doing: Social, cognitive, and computational perspectives, New York, Cambridge University Press.

Eisenberg, J. (1986) Doctors' Decisions and the Cost of Medical Care, Michigan, Health Administration Press.

Eisenberg, E. (2001) Building a mystery: Toward a new theory of communication and identity, *Journal of Communication*, 51: 534-552.

Engeström, Y. (1987). *Learning by expanding: An activity-theoretical approach to developmental research*, Helsinki, Orienta-Konsultit.

Engeström, Y. (1999) Innovative learning in work teams: analysing cycles of knowledge creation in practice, in: Engeström, Y. et al. (Eds.) *Perspectives on Activity Theory*, Cambridge, Cambridge University Press, 377-406.

Eraut, M. (1994) *Developing professional knowledge and competence*, London, Routledge.

Eraut, M. (2000) Non-formal learning and tacit knowledge in professional work, *British Journal of Educational Psychology*, 70, 113–136.

Eraut, M., Maillardet, F.J., Miller, C., et al. (2004) Learning During the First Three Years of Postgraduate Employment – The LiNEA Project, ESRC.

Eraut, M. (2004) Transfer of knowledge between education and workplace settings, in Rainbird, H., Fuller, A., & Munro, A. (Eds.), *Workplace Learning in Context*, New York, Taylor Francis, 201-221.

Erikson, E. (1964) *Insight and Responsibility,* New York, Norton.

Erikson, E. (1968) *Identity: Youth and crisis*, New York, Norton.

Evans, K., & Kersh, N. (2003) Recognition of Tacit Skills and Knowledge: sustaining learning. *3rd International Conference on RWL*, Tampere, 25th-27th July 2003.

Evans, K., Hodkinson, P., Rainbird, L., & Unwin, L. (2006) *Improving Workplace Learning*, London, Routledge.

Evans, K., Guile, D., Harris, J., & Allan, H. (2010) Putting Knowledge to Work: A New Approach *Nurse Education Today*, 30,(3): 245-251.

Evans, K. (2011) Rethinking Work-based Learning, *Association for the Study of Medical Education (ASME) Conference,* London, 16th November 2011.

Francis, R. (2010) *The Francis Report*: (a second public inquiry into the Mid Staffs NHS Foundation Trust) January 2005-March 2009.
http://www.midstaffsinquiry.com/pressrelease.html   *(Accessed 12th November 2012).*

Friedson, E. (1994) *Professionalism Reborn: Theory, Prophecy, and Policy*, Chicago, University of Chicago Press.

Fuller, A. & Unwin, L. (2003) Learning as apprentices in the contemporary UK workplace: creating and managing expansive and restrictive participation, *Journal of Education and Work,* 16, 407-426.

Garvin, J., McLaughlin, R., & Kerin, M. (2008) A pilot project of European Working Time Directive compliant rosters in a university teaching hospital, *The Surgeon : Journal of the Royal Colleges of Surgeons of Edinburgh and Ireland*, 6 ,(2): 88-93.

Gee, J. (1999) *An Introduction to Discourse Analysis: Theory and Method*, New York, Routledge.

General Medical Council (1993, 2003 and 2009) *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*, 1st, 2nd and 3rd editions, London, GMC.

General Medical Council (1995 and 2006) *Good Medical Practice*, 3rd and 4th editions, London, GMC.

General Medical Council (2009) *The New Doctor*, London, GMC.

General Medical Council (2010) *Standards for curricula and assessment systems*, London, GMC.

General Medical Council (2011) *The Trainee Doctor*, London, GMC.

Giddens, A. (1991) *Modernity and Self Identity: Self and Society in the Late Modern Age*, Cambridge, Policy Press.

Gill, D., & Griffin, A. (2010) Reframing medical education research: let's make the publishable meaningful and the meaningful publishable, *Medical Education*,43, (10): 933-934.

Grant, J. (2006) *Principles of Curriculum Design: Understanding Medical Education*, Association for the Study of Medical Education, Edingburgh.

Gude,T., Vaglum, P., Tyssen, R. et al. (2003) Identification with the role of doctor at the end of medical school: a nationwide longitudinal study. *Academic Medicine*, 78,(12):1203-1210.

Hafferty, F. (1991) *In the valley: Death and socialization of medical students*, New Haven, CT, Yale University Press.

Hafferty, F., & Franks R. (1994) The hidden curriculum, ethics teaching, and the structure of medical education, *Academic Medicine,* 69:861-871.

Hafferty, F. (1998) Beyond curriculum reform: confronting medicine's hidden curriculum, *Academic Medicine*, 73,(4):403-7.

Hafferty, F. (2009) Professionalism and the Socialisation of Medical Students, in Cruess, R., Cruess, S., & Steinert, Y. (Eds) (2009) *Teaching Professionalism*, Cambridge, Cambridge University Press, pp53-70.

Hall, K., Murphy, P., & Soler, J. (Eds) (2008) *Pedagogy and Practice –Culture and identities*, London, Sage.

Higgs, J., & Edwards, H. (Eds.) (1999) Educating Beginning Practitioners: Challenges for health professional education, Auckland, Butterworth Heinemann.

Hodkinson, H. & Hodkinson, P. (2004), Rethinking the concept of community of practice in relation to schoolteachers' workplace learning, *International Journal of Training and Development*, 8, (1): 21-31.

Holland, D., Lachicotte, W., Skinner, D., & Cain, C. (1998) *Identity and Agency in Cultural Worlds*, Cambridge, Harvard University Press.

Huddle, T. (2005) Teaching Professionalism: Is Medical Morality a Competency? *Academic Medicine*, 80:885–891.

Ibarra, H. (2000) Provisional Selves: Experimenting With Image and Identity in Professional Adaptation. *Administrative Science Quarterly*, http://www.hbswk.hbs.edu/item.jhtml?id=1275&t=organizations (*Accessed 10th December 2011*).

Illing, J., Morrow, G., Kergon, C., et al (2008) *How prepared are medical graduates to begin practice? a comparison of three diverse UK medical schools. Final report to the GMC* gmc.uk.org/FINAL How prepared are medical graduates to begin practice September 08.pdf 29697834.pdf (Accessed 27th January 2011).

Jenkins, R. (1996) *Social identity*, London and New York, Routledge.

Jones, A., McArdle, P., & O'Neill, P. (2001) How Well Prepared are Graduates for the Role of the Pre-registration House Officer? A Comparison of New Graduates and Educational Supervisors, *Medical Education*, 35: 578-584.

Kelly, B. (1992). The professional self-concepts of nursing undergraduates and their perceptions of influential forces, *Journal of Nursing Education*, (31):121-125.

Kendall, M., Hesketh, E., & Macpherson, S. (2005) The learning environment for junior doctor training—what hinders, what helps? *Medical Teacher*, 27,(70): 619-624.

Kenny, N., Mann, K., & McLeod, M. (2003) Role Modeling in Physicians' Professional Formation: Reconsidering an Essential but Untapped Educational Strategy, *Academic Medicine,* 78, (12): 1203-1210.

Koens, F., Mann, K., Custers, E., & Ten Cate, O. (2005). Analysing the concept of context in medical education, *Medical Education*, 39, 1243-1249.

Kvale, S. (1996) *InterViews: an introduction to qualitative research interviewing*, London, Sage Publications.

Lamdin, R.J. (2010) *The Professional Socialisation of Medical Students*, New Zealand, Lambert Academic Publishing.

Langellier, K. (2001) 'You're Marked': Breast Cancer, Tattoo and the Narrative Performance of Identity, in Brockmeier, J., & Carbaugh, D. (Eds) *Narrative and Identity: Studies in Autobiography, Self, and Culture*, Amsterdam, John Benjamins: 145–84.

LaPointe, N., & Jollis, J. (2003) Medication errors in hospitalized cardiovascular patients, *Archives of Internal Medicine,* 163,(12):1461-1466.

Lave, J., & Wenger, E. (1991) *Situated Learning: Legitimate peripheral participation*, Cambridge, University of Cambridge Press.

Lave, J. (1988) *Cognition in practice: mind mathematics and culture in everyday life*, Cambridge, Cambridge University Press.

Layder, D. (1998) *Sociological Practice: Linking Theory and Social Research*, London, Sage Publications.

Leary, M. & Tangney, J. (Eds) (2003) *Handbook of Self and Identity*, New York, The Guilford Press.

Lempp, H., & Searle, C. (2004) The hidden curriculum in undergraduate medical education: A qualitative study of medical students' perceptions of teaching, *British Medical Journal*, 329, 770-773.

Lingard, L., Reznick, P., DeVito, I. & Espin P (2002) Forming professional identities on the health care team: discursive construction of the 'other' in the operating room, *Medical Education*,36 (8):728-734.

Mason, J. (1996) *Qualitative Researching*, London, Sage.

Mahar, C., Harker, R., & Wilkes, C. (Eds) (1990) *An introduction to the work of Pierre Bourdieu: The practice of theory,* London, Macmillan.

May, T. (1996) *Situating Social Theory*, Buckingham, Open University Press.

Maudsley, G., & Strivens, J. (2000) Promoting professional knowledge, experiential learning and critical thinking for medical students, *Medical Education,* 34:535-544.

Melia, K. (1987) *Learning and Working: The Occupational Socialization of Nurses*, London, Tavistock Publications Ltd.

Merton, R., Reader, G., & Kendall, P. (Eds)(1957) *The Student-Physician: introductory studies in the sociology of medical education*, Cambridge, MA, Harvard University Press.

Miles, M., & Huberman A. (2002) *The Qualitative Researcher's Companion*, Thousand Oaks, Sage.

Miller, J., Bligh, J., Stanley, I., & al Shehri, A. (1998) Motivation and continuation of professional development, *British Journal of General Practice*, 48:1429-1432.

Moore, R. & Young, M. (2001) Knowledge and the Curriculum in the Sociology of Education: towards a reconceptualisation, *British Journal of Sociology of Education*, 22 (4): 455-461.

Moore, A. (2004) *The Good Teacher*, London, Routledge Falmer.

Monrouxe, L., & Rees, C. (2009) Picking up the gauntlet: constructing medical education as a social science, *Medical Education*, 43, (3):196-198.

Monrouxe, L. (2009a) Solicited audio diaries in longitudinal narrative research: a view from inside, *Qualitative Research*, 9:1 81-103.

Monrouxe, L. (2009b) Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries, *Current Narratives*, 1: 41–59.

Monrouxe, L. (2010) Identity, identification and medical education: why should we care? *Medical Education*, 44 (1): 40-49.

Nasir, N. (2003) Ethnic and Academic Identities: A Cultural Practice Perspective on Emerging Tensions and Their Management in the Lives of Minority Students, *Educational Researcher*, 32: 14-18.

Nielsen, K., & Kvale, S. (1997) Current Issues of Apprenticeship, *Journal of Nordic Educational Research*, 17: 130-140.

Niemi, P. (1997) Medical students' professional identity: self-reflection during the preclinical years, *Medical Education*, 31:408-415.

North Central Thames Foundation School (2012) HCTFS home/About NCTFS, http://www.ucl.ac.uk/medicalschool/nctfs (Accessed 12th May 2012)

Olesen, V., & Whittaker, E. (1970) *The silent dialogue: a study of the social psychology of professional socialization*, San Francisco, Jossey Bass.

Penuel, W.R., & Wertsch, J.V. (1995) Vygotsky and identity formation: A sociocultural approach, *Educational Psychologist*, 30: 83-92.

Philpin, S. (1999) The impact of Project 2000 educational reforms on the occupational socialization of nurses: An exploratory study, *Journal of Advanced Nursing*, 29:1326-1331.

Redfern, M. (2001) The Report of The Royal Liverpool Children's Inquiry, HMSO Crown copyright http://www.rlcinquiry.org.uk/download/sum.pdf *(Accessed 14th June 2012)*.

Rees, C. (2003) The influence of obedience to authority, Rapid response to Coldicott, Y, Pope, C, Roberts, C. The ethics of intimate examinations – teaching tomorrow's doctors, *British Medical Journal,* 326: 87–101.

Rees, C. & Monrouxe, L (2011) Medical students learning intimate examinations without valid consent: a multicentre study, *Medical Education*, 45, (3): 261-272.

Roberts, M. (2004) Producing Tomorrow's Doctor: the new challenge for today's undergraduate medical curriculum, *Journal of Vocational Education and Training,* 56, (4):467-484.

Roberts, L., Green-Hammond, K., Geppert, C., & Warner, T. (2004) The positive role of professionalism and ethics training in medical education: a comparison of medical student and resident perspectives, *Academic Psychiatry*, 28:170-182.

Royal College of Physicians (2005) D*octors in society: medical professionalism in a changing world*, Report of a Working Party of the Royal College of Physicians of London, London, RCP.

Rubin, B. (2007) Learner identity amid figured worlds: Constructing (in) competence at an urban high school, *The Urban Review,* 39, (2): 217-249.

Ryynänen, K. (2001) Constructing physician's professional identity - explorations of students' critical experiences in medical education, PhD thesis submitted to the University of Olu, Finland 2001, http://herkules.oulu.fi/isbn9514265211/isbn9514265211.pdf. *Accessed 16th September, 2011*

Sachs, J. (2001) Teacher Professional Identity: Competing Discourses, Competing Outcomes, *Journal of Educational Policy*, 16, (2): 149-161.

Säljö, R. (2007) *Studying learning and knowing in social practices. Units of analysis and tensions in theorizing.* Keynote Lecture, The Oxford Centre for Sociocultural Activity Theory Research, Department of Education, University of Oxford, March 14, 2007.

Schein, E. (1978) *Career Dynamics: Matching Individual and Organizational Needs*, Addison-Wesley, Reading, MA.

Schiffrin, D. (1996) Narrative as self-portrait: sociolinguistic constructions of identity, *Language in Society*, 25:167–203.

Schön, D. (1983) *The Reflective Practitioner: How professionals think in action*, London, Temple Smith.

Sfard, A. (1998) On Two Metaphors for Learning and the Dangers of Choosing Just One, *Educational Researcher*, 27(2): 4-13.

Shotter, J., & Gergen, K. (1989) *Texts of Identity*, London, Sage.

Shuval, J. (1975) From "boy" to "colleague": process of role transformation in professional Socialization, *Social Science and Medicine*, 9: 413-420.

Sinclair, S. (1997) *Making doctors: an institutional apprenticeship*, Oxford, Berg.

Smith, J. (2005) Sixth Report - Shipman: The Final Report, HMSO, Crown copyright http://www.shipman-inquiry.org.uk/6r_page.asp *(Accessed 14th June 2012).*

Standish, P. (2003) Profession and practice: The higher education of nursing; Profession, knowledge and practice in Drummond, J., & Standish, P. (Eds) (2003) *The Philosophy of Nurse Education,* Hampshire, Palgrave MacMillan: 109-126.

Swanwick, T. (2005) Informal learning in postgraduate medical education from cognitivism to 'culturism', *Medical Education*, 39: 859-865.

Swick, H. (2000) Toward a normative definition of medical professionalism, *Academic Medicine*, 75:612-616.

Tooke, J. (2008) Aspiring to excellence, final report of the independent enquiry into modernising medical careers,
http://www.mmcinquiry.org.uk/MMC_FINAL_REPORT_REVD_4Jan.pdf
(Accessed 14th June 2012).

Testerman, J., Morton, K., et al. (1996) The natural history of cynicism in physicians, *Academic Medicine*, 71, (10): 43-45.

Turner, T., Collinson, S., & Fry, H. (2001) Doctor in the house: the medical student as academic, attendant and apprentice? *Medical Teacher*, 23, (5):514-516.

Urrieta, L. (2007) Figured Worlds and Education: An Introduction to the Special Issue, *The Urban Review*, 39, (2): 106-116.

Winslade, J. (2002) Storying Professional Identity: From an Interview with John Winslade, *International Journal of Narrative Therapy & Community Work,* 4: 33-38,
http://search.informit.com.au/documentSummary;dn=662762822487071;res=IELHEA>
(Accessed 12th June 2012).

Webb, J., Schirato, T, & Dannaher, G. (2002) *Understanding Bourdieu*, New South Wales, Allen & Unwin.

Wenger, E. (1998) *Communities of practice: Learning, meaning and identity*, Cambridge, Cambridge University Press.

Wilson, D., McArtney, R., et al. (1998) Medication errors in paediatric practice: insights from a continuous quality improvement approach, *European Journal of Pediatrics*, 157, (9): 769-774.

Young, M. (2007) *Bringing knowledge back in: from social constructivism to social realism in the sociology of education*, London, Routledge.

7.2   Acknowledgements

Many individuals have supported me in this long journey and deserve thanks and acknowledgement.

I would like to express my sincere thanks to the junior doctors who generously gave their time to talk to me about their lives, their work and themselves and who allowed me to walk with them as they worked and learnt. Without these stories and insights, this study would not have been possible.

I would also like to thank the Foundation Programme Directors in the participating NHS Trusts for being patient with me each time I asked them to sign off (again) the next iteration of the ethics application and for helping with the recruitment of participants and facilitating some of the negotiations about observations.

A heartfelt thank you is due to my supervisor, Professor David Guile, for his insightful and good humoured supervision that helped me to make sense of what I was looking for and what I found. Without his guidance and feedback this would have been a greatly inferior piece of work.

Thanks also go to my boss and mentor, Professor Jane Dacre, without whose support and encouragement the Ed D would probably never have got off the ground and would certainly never have been finished.

This work has been shaped and improved along the way by my fellow EdD student, Dr Ann Griffin, who has been an invaluable source of support and inspiration and has proof read documents and given her insightful comments and advice ad nauseam.

Finally I would like to acknowledge the contribution of my two boys, Mark and William, who have tolerated all manner of short temperedness and neglect over the far too many years. I promise to pay you both a bit more attention now. Honestly!

7.3   Appendices:

7.3.1   Appendix 1: Invitation to take part in the study

FROM DR DEBORAH GILL   UCL SCHOOL OF LIFE AND MEDICAL SCIENCES, UCL DIVISION OF MEDICAL EDUCATION
deborah.gill@ucl.ac.uk   07923 473212

Dear Foundation Doctor,

Would you be willing to take part in a research project called "**The formation of professional identity by newly qualified doctors"?**

This study attempts to understand how your experiences both before qualification and as you have entered the world of work as a new doctor have shaped your sense of identity and your developing expertise as a doctor. The aim of this research is to understand the influences of a range of factors: personal, educational and workplace related on this emerging professional identity. *This is important because how we see ourselves as doctors affects the way we practise.* It is hoped that I will be able to make suggestions to undergraduate and post graduate curriculum designers and policy makers, personal tutors, educational supervisors and Foundation School Directors about ways of supporting this important transition into the world of work.

I would be very grateful if you would volunteer to take part in this study. Ideally this would involve two things: allowing me an insight into your daily work and an in-depth interview with me about your experiences and your opinions. The observation would be at a time convenient to you and your team and would simply involve me watching and noting what you, a junior doctor in the 21st century, do and learn in your day to day work. This would take approximately 1-2 hours but could be shorter or longer depending on what you feel is most convenient. I would like to follow this up with an interview conducted by me and at a place convenient for you. This could be on the same day as the observation or on some later date. This interview should take about an hour.

If you would be willing to take part in this study, or just want to discuss taking part, please email me on deborah.gill@ucl.ac.uk or telephone me on 07923 473212. Any replies or queries will be treated in the strictest confidence.

Many thanks for giving this your consideration.

Dr Deborah Gill, Senior Lecturer in Medical Education

UCL SCHOOL OF LIFE AND MEDICAL SCIENCES

UCL DIVISION OF MEDICAL EDUCATION

Participant Information Sheet

Title: The formation of professional identity by newly qualified doctors

Dr Deborah Gill: Doctoral Student, Institute of Education, University of London and Senior Lecturer in Medical Education, UCL. Supervisor: Dr David Guile, Institute of Education

This study has been approved by the NHS Research Ethics Committee [Project ID Number Project 11/LO/0579]:

I would like to invite you to take part in this research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. If you would like to find out more about the study or discuss any areas of potential concern with me before reaching your decision, my email address is deborah.gill@ucl.ac.uk.ucl.ac.uk and my mobile number is 07923 473 212. I hope the information below will help you decide whether or not to take part. Please talk to others about the study if you wish. Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Please do ask me if there is anything that is not clear.

Part 1
What is the purpose of the study?

I am currently undertaking an education doctorate (EdD) at the Institute of Education. This is a professional doctorate aimed at practitioner researchers. My area of research interest concerns personal and professional development of doctors. This study forms the thesis element of this doctorate and aims to investigate and understand the transition into the first phase of the professional career of doctors, and to discover how novice doctors form a sense of themselves as doctors and the influence of personal, educational and workplace factors in this formation. I will use the data generated in this study to add to the body of what is known about professional identity, expertise and the medical workplace and to inform the development of medical and professional education.

Why have I been invited?

You have been invited to participate along with all other foundation year 2 doctors working in a small number of Trusts in North Central Thames.

Do I have to take part?

Taking part in the research study is entirely voluntary. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw from the study at any time, without giving a reason. There is no organisational (Deanery, NHS Trust or Foundation School) obligation to take part in this study.

What will happen to me if I take part?

This is a qualitative study with a relatively small sample of junior doctors looking at their views about themselves as doctors and their day to day work. If you decide to take part, you will be asked to consent to be interviewed about your perceptions and experiences. As the interviews form the main source of data for this study, these will be in-depth ones exploring a wide range of aspects that might impact on the kind of doctor you are today. Interviews will be arranged to suit your diary and will be conducted in private, close to your place of work. The interview is likely to take from 60 to 90 minutes. In some circumstances I may ask to interview you briefly a second time to explore issues that did not arise in the first interview. The interviews will be audio-recorded, with your permission.

The interviews will be preceded, where practicable, with a brief period of observation by me of you going about your normal duties in your usual place of work. The observations will take place, with your consent, for one to two hours, prior to the interview. The observation should not interfere with your work. The aim of the observations will be to act as both a focus for discussion in the interview and to allow a richer view of the context: the world of learning and work in which you are practising as a junior doctor. I will suggest that you choose a period for observation that is typical of some of the work you do but that minimises the inconvenience or intrusion on the privacy of others, both patients and other professionals.

Will my taking part in the study be kept confidential?

Yes. All information about you will be handled in confidence. The Foundation Programme director will be asked to disseminate the information calling for initial expression of interest only: all later correspondence and eventual recruitment to the study will be conducted solely with the individual doctor. Correspondence with you will be by me using the preferred email offered by you only. The identity of individual participants and their place of work will be obscured by removing all names and identifying features, to the best of my ability, in both the submitted thesis and in any publications arising from the work.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

Conduct of the study

The study sample:
To ensure the most comprehensive representative sample is used within the constraints of the study, the selection of individuals to take part in the study from those expressing an interest will be purposive including: men and women; those who entered medicine as an undergraduate and those who entered as a postgraduate; and those who trained at the medical school associated with the NHS Trust in which they now work as well as those who trained elsewhere. You may not be chosen to take part: this will not be because your contribution would not be valuable but because of the need to use a sampling frame to get the broadest range of participants.

Risks and benefits of taking part:
I do not anticipate any risks to you in taking part in the study. However, in the interviews I will be asking you questions about the past and the present and about work and issues outside work that impact on you as a doctor. I am aware that discussions of your life history and past experiences can sometimes be painful. I am also aware that discussing professional issues in any setting creates challenges for all doctors, particularly new practitioners who experience new demands on their professionalism on an almost daily basis. Due to the

highly personal nature of the interviews and observations, I will return the transcripts of the interviews and field notes to each participant for clarification and comment before using any material as data. Not all data generated may prove usable. I will leave some written information with you after the interview that directs you to sources of support should you be distressed in any way by taking part in the study.

I hope that the opportunity to reflect on your development so far as a doctor in a safe environment with a fellow doctor who is not your peer, employer or education supervisor may be enjoyable and beneficial. There is no payment involved in participating in this study.

The interviews and observations may generate sensitive information about colleagues or patients. Participants may disclose times where they think their own professionalism or the professionalism of those around them has been lacking. You should be reassured that your identity and the identity of those you discuss will be obscured in any document produced as part of this study. However, as I am a fellow doctor, we both carry the responsibility to make the care of the patient our first concern. Although I will be interviewing you in my role as an education researcher and will be present as a nonparticipant observer during the brief observations, we both need to maintain our professional responsibilities as outlined in *Good Medical Practice* (GMC 2006). I will discuss with you before we begin the observation or interview what we will do in the unlikely event of issues arising during the observation where I may feel patient safety is being significantly compromised and together we will decide the appropriate course of action. As our professional responsibility may 'trump' the boundaries of my agreed role as a non-participant observer, incidents may theoretically occur where it is necessary to stop the observation to make a comment or for us to discuss significant breaches of good practice (of your own or others around you). We will agree in detail before we begin the observation and the interview the actions we will both take in the event of a serious breach coming to light. This may include reporting practice that puts patients or fellow professionals at risk through the relevant channels. You are free to withdraw from the study at this or any point. You are free to not take part in the observation element of the study or to terminate the observation at any time.

Managing sensitive data:
All interview data and observation data will be anonymised. Anonymised data from the study will be published in the form of a thesis that may be accessed through a university library. The handling of sensitive data will be vetted by my supervisor to ensure compliance with ethical guidance. If the argument of the thesis is deemed worthy, data collected could form part of a paper for publication in the future. This includes anonymised quotes from interviews. I will conceal identities of Trusts and individuals to the best of my ability but acknowledge that some recognisable features may remain. Therefore, as explained above, the transcripts of interviews and field notes taken during observation will be returned to you for comment. Where you feel notes are not true reflection of events or where either you or I think anonymity of you as the participant or third parties is threatened, we may consider parts of the data to be unusable.

You will be asked to sign a consent form if you wish to participate in this study and will be given a copy of this information sheet and the signed consent form to keep.

Handling data
All information which is collected about you during the course of the research will be kept strictly confidential and any information about you which leaves my possession (for example for transcription of a recording of the interview) will have your identifying details removed. Raw data will only be shared by myself, a transcriber and the project supervisor. I will ensure that all data is anonymised and stored and electronically transferred in a secure way. Stored

and transferred files will not contain data that could identify the individual or the Trust involved. All files will be electronically maintained in a highly encrypted way on a secure, password protected computer. The data will be stored in secure electronic files for up to a one year after the end of the study. It will not be used for any other purposes without your expressed permission.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any point. All data concerning you will be removed and destroyed.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to me and I will do my best to answer your questions or solve the problem in the first instance. My email address is deborah.gill@ucl.ac.uk and my telephone number is 0207 288 3316. If you remain unhappy and wish to complain formally, or wish to complain about an aspect of my conduct, you can do this by contacting the project supervisor Dr David Guile at the Institute of Education: d.guile@ioe.ac.uk .

What will happen to the results of the study?

This work is being undertaken for the express purpose of completing doctoral studies at the Institute of Education. The final report will take the form of a thesis of between 25,000 and 40,000 words. It is anticipated that aspects of the study will also be written up for publication in the form of journal articles. In all cases, identifying information will be obscured to the best of my ability.

Whilst this study is not an evaluative study, it is hoped that the findings might inform the wider medical education community. I propose to produce a summary of key observations and insights to send to all those who take part in the study.

Who is organising and funding the research?

This study has been organised by me and my supervisor Dr David Guile at the Institute of Education. There is no funding for this research.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The NRES London-South East Research Ethics Committee. The proposal for the study has also been approved by an expert panel at the Institute of Education and formal ethics approval has also been received from the Institute of Education.

Further information

If you would like to find out more about the study or discuss any areas of potential concern with me before reaching your decision, my email address is deborah.gill@ucl.ac.uk and my telephone number is 0207 288 3316. I hope the information above has helped you to decide whether or not to take part. Please do ask me if there is anything that is not clear.

Dr Deborah Gill: Academic Centre for Medical Education, UCL.

July 2011
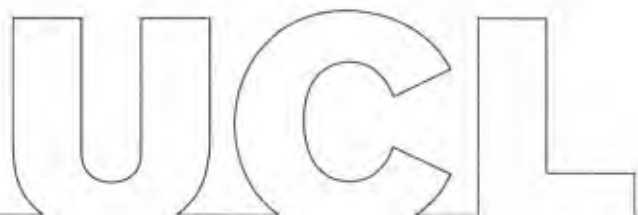
Interview Schedule

Title: The formation of professional identity by newly qualified doctors

Dr Deborah Gill: Doctoral Student, Institute of Education, University of London and Senior Lecturer in Medical Education, UCL. Supervisor: Dr David Guile, Institute of Education

Introduction: I am Deborah Gill and I am a senior lecturer at UCL Medical School. I am conducting this study as part of my studies for a professional doctorate.

I am interested in how professional identity and a sense of self-as-a-doctor is developed during the first phase of a doctor's professional career.

The study data collection takes the form of in-depth interviews supplemented where possible by brief observations of doctors at work.

In this interview I want to explore with you the sorts of things that you think might have helped to shape the doctor you are today. I will ask you about incidents and experiences from when you first decided to pursue medicine right up to the things that influence your practice today.

There are no right and wrong answers: I am interested in your experiences, how you see yourself as a doctor and what you think has shaped this identity.

The interview should take about an hour to an hour and a half but I am happy to stay and listen for as long as it takes.

Your participation is completely voluntary and you can withdraw at any point without consequence to yourself. If, at any point, you decide you no longer wish to take part in the study please let me know.

With your permission the interview will be audio-recorded and fully transcribed and I will be jotting down some notes during the interview.

Excerpts from these transcriptions and field notes will be used in the write up of my thesis however your identity will be obscured by removing all names and identifying features to the best of my ability.

Can I confirm that you have read the information sheet?

Do you have any further questions before we proceed?

Please sign the consent form

1. Initial questions:

If an observation took place before the interview:

Thank you for letting me watch you in your place of work today.

- What was the most enjoyable feature of the last few hours?
- What was the most frustrating feature during the last few hours?
- Was today a typical day? If not, do days like this happen often?
- Tell me a bit about this post; is it a good foundation doctor post? In what ways?
- Is it similar to the other foundation posts you have completed? If not, in what ways does it differ?
- Tell me about the professionals who work alongside you: what do you enjoy about your working relationships? Is anything frustrating? How do you deal with tensions if they arise?
- Tell me a bit about this Trust: is it a good place to be a junior doctor? In what ways?
- What about this job as a learning post? What kinds of teaching or training do you receive? What is supervision like?

If no observation took place before the interview:

- Tell me about the some of things that you did at work today.
- What was the most enjoyable thing that happened today at work?
- What was the most frustrating thing that happened today at work?
- Was today a typical day? If not, do days like this happen often?
- Tell me a bit about this post; is it a good foundation doctor post? In what ways?
- Is it similar to your other posts you have completed? If not, in what ways does it differ?
- Tell me about the professionals who work alongside you: what do you enjoy about your working relationships? Is anything frustrating? How do you deal with tensions if they arise?
- Tell me a bit about this Trust: is it a good place to be a junior doctor? In what ways?
- What about this job as a learning post? What kinds of teaching or training do you receive? What is supervision like?

2. Historical questions:

Thank you that is very helpful. I wonder if we could now look at your personal journey to where you are today.

Before Medical School:

- Do you recall the first time a medical career appealed to you? What was it about medicine that appealed to you?
- Who if anyone influenced that decision?
- Did your commitment ever wane? What brought it back on track?
- Did you have any role models in mind during this time? What was it about them as a doctor that appealed to you?

And medical school:

- What experiences do you recall that had a profound effect on you in medical school?
- What experiences sustained your interest in becoming a doctor?
- Did any incidents or experiences make you question medicine as a career?

- Did you meet any role models during your time at medical school? What was it about them as a doctor that appealed to you?
- In what ways do you think you learnt to be a doctor at medical school? what did you learn from your teachers? from your fellow students? from junior doctors?
- What about things outside of medicine: what other things were important to you while you were at medical school?
- Did you feel like a doctor when you graduated – if so in what ways? If not, in what ways did you not yet feel like a doctor?

Tell me now about your first few days at work:

- What was it like in those first few days?
- Did you feel prepared for work? – if not, in what ways did you feel unprepared?
- Who did you turn to in this time for help or guidance?
- What roles and responsibilities were different from those of a final year student?
- Were any roles or responsibilities required of you unexpected?
- How long did it take to feel like a doctor? What experiences helped create this feeling?

Now tell me a bit about the last year or so:

- Tell me about the roles and responsibilities you have undertaken over the last year: How have you gone about learning to do your work? Which roles/ responsibilities have been particularly hard? Have any of them been unexpected? If so why do you think so?
- Can you identify any experiences with patients that have influenced the way you practice as a doctor? What was it about these experiences that was so powerful?
- What about others around you: have they been a powerful influence? If so in what ways?

Finally I would like you to think of the kind of doctor you see yourself as now:

- How would you describe yourself as a doctor?
- Why are these attributes important to you?
- Do you think these attributes are common to most junior doctors?
- What about your life outside of medicine: how has this impacted on the kind of doctor you are?
- Do you ever feel any tension between the doctor you want to be and the doctor you (sometimes) have to be? if so how do you deal with this tension?
- What are your career aspirations? What will you have to do between now and then to achieve that goal?

Thank you very much for your time. Is there anything else you think we should have covered to help me to understand you as a doctor?

(If one of the early interviews: if I have any further questions in a couple of months time when I have conducted further interviews would it be Ok to contact you again?)

UCL SCHOOL OF LIFE AND MEDICAL SCIENCES

UCL DIVISION OF MEDICAL EDUCATION

Observation Schedule

Title: The formation of professional identity by newly qualified doctors

Dr Deborah Gill: Doctoral Student, Institute of Education, University of London and Senior Lecturer in Medical Education, UCL. Supervisor: Dr David Guile, Institute of Education

Before the observation

Introduction: I am Deborah Gill I work at UCL Medical School in undergraduate medical education. I am conducting a study about junior doctors and how they develop a sense of self as a doctor in the initial years of practice as part of my doctoral studies.

This study involves interviews as the primary data source and observations as an additional source of contextual information.

The purpose of the observation is simply for me to get a better understanding of what it is like to be a junior doctor in 2011/12 and in this Trust.

I would like to 'shadow' you for a short period as you go about your day-to-day tasks. I am not watching to see if you are doing things in a certain way or 'correctly' I am just observing what you do. Because being a junior is being part of a team within an organisation, as well as observing your activities I am observing as much as I can about the environment and other people with whom you interact as you go about your work. I hope to be as unobtrusive as possible.

As outlined on the consent sheet I will only interject in the very unlikely event that I consider a patient is in danger of significant harm. This is part of my responsibility as a fellow doctor.

The observation should ideally take a few hours but I am happy to stay and listen and observe for as long as you like or leave at any time.

Reconfirm they have read the information sheet and get signed consent form.

Are you happy for me to proceed?

Observation Proforma

1. Basic details:

- Who
  - Dr identifier and basic demographics..
    What is that individual's post/role title?...
- Where
  - Hospital Trust identifier..
  - Where in the hospital is the observation taking place? ....
- When
  - time of day..
  - how far into the day's work is the doctor ? ....

2. What general sorts of activities were observed/what was the context of observation?

....
....
....
....
....
....
....

3. Which professional others were observed?

....
....
....
....
....
....

4. What were the interactions with the professional others? (formal support, informal support, feedback, inclusion?)

....
....
....
....
....
....

5. What learning was taking place? (formal/informal, tacit/purposeful?)

....
....
....
....
....
....
....

6. Observation *(after Eraut et al 2004)*

Activity	What? (see key)	Comments
Task Performance		
Role Performance		
Decision Making & Problem Solving		

Judgement		
Academic Knowledge and Skills		
Teamworking		

Awareness and Understanding		
Personal Development		

Key:

- **Task Performance :** Speed and fluency, Complexity of tasks and problems, Range of skills required, Communication with a wide range of people, Collaborative work .
- **Role Performance:** Prioritisation, Range of responsibility, Supporting other people's learning,
- Leadership, Accountability, Supervisory role, Delegation, Handling ethical issues, Coping with unexpected problems, Crisis management, Keeping up-to-date.
- **Decision Making and Problem Solving:** knowing when to seek expert help, Dealing with complexity, Group decision making, Problem analysis, Formulating and evaluating options, Managing the process within an appropriate timescale, Decision making under pressure.
- **Judgement:** Quality of performance, output and outcomes, Priorities, Value issues, Levels of risk .
- **Academic Knowledge and Skills:** Use of evidence and argument, Accessing formal knowledge, Research-based practice, Theoretical thinking, Knowing what you might need to know, Using knowledge resources, Learning how to use relevant theory,(in practical situations).
- **Teamwork:** Collaborative work, Facilitating social relations, Joint planning and problem solving, Ability to engage in and promote mutual learning.

- **Awareness and Understanding:** of Other people: colleagues, patients etc., of Contexts and situations, of One's own organisation, of Problems and risks, of Priorities and strategic issues, of Value issues.
- **Personal Development:** Self evaluation, Self management, Handling emotions, Building and sustaining relationships, Disposition to attend to other perspectives, Disposition to consult and work with others, Disposition to learn and improve one's practice, Accessing relevant knowledge and expertise, Ability to learn from experience.

Observation Notes:

| Time	what	reflections

Theme 3: 'Taking on Responsibility'

Origin marker

DG identification at stage 1, 14.4.12 AG and HS identification on reading of a selection of transcripts 15.5.12

Memos

- Appeared in all 12 interviews – direct questioning and volunteered
- Interpretation: usually talked about directly usually without need for question.
- **Links to major themes:**
- A sub theme of major theme 1: **developing professional capabilities**: (at medical school: *interviews*, in work: *interviews and observations*)
- Also to some extent a sub theme of:
  - o Major theme 2: **Belonging**: (link between belonging and affordances @ responsibility: *interviews and observations*)
  - o Major theme 3: **Becoming a good doctor**
    - Mantle of good junior doctor: (onset of responsibility: *interviews*, the 'list' as a mediator/signifier of responsibility: *interviews and observations*)
    - Being a good doctor: (the uninspected spaces: *interviews and observations*)
- **Links to other themes: 'transitions'** (theme 7)

Component parts:
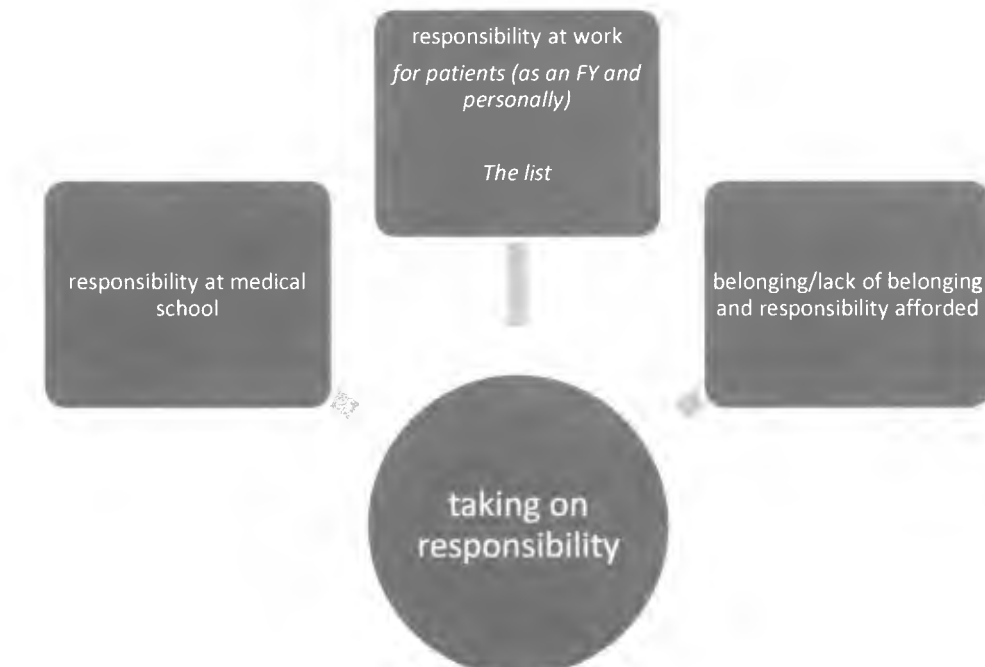
1.Responsibility at medical school (interviews)

Tulip: Yeah there were um ... taking blood. Um ... I think going to meet patients early on. At any point where I was given some sort of responsibility I felt a bit more involved and included and like I was there for a purpose.

Lavender: I *always* come back to this, but I think that there's something about when you have responsibility and when people have expectations of you. Because I did part of my training in the States, I went back and did several kind of three-month blocks and trained there. The way that they treat medical students is *very* different, and as a medical student you're a part of the team, and you have responsibilities. And you have some of this kind of sorting the list and doing the phleb – that's part of your role.

Oak: Until you *actually* spend time on a ward and you know you have responsibility for patients, that's the key thing for me where you can ... No matter how involved you are as a student, you know deep down inside you don't have ownership and responsibility of those patients.

Clematis: So I think ... and also in the last few weeks of that rotation actually ... so you know how as a student ... well I don't know maybe ... as a student, nurses ... ... people will say to you, people will call you 'Doctor' ... and I think.... the first 2 ½ years clinical I was *obsessive* about pointing out that I wasn't.....And I think in the last few weeks of that rotation I was sort of slightly aware that I was letting it go a bit.... Whereas I think in the first half of that I was ... so I suppose ... I suppose I was. I mean I was really acting an F1 in that... so I think I did feel very ready, because it was a very pleasing experience.

Rowan: I had absolutely no idea at medical school about what being a doctor was actually like. Even though we did shadowing I really, I had no responsibility for anything other than passing my exams.

2a. Responsibility and work: interviews

Lavender: Yeah, so um ... at UCH F2s are on the general SHO rota, so you would have the *same level of responsibility as the core medical trainees ... and that makes a big difference.* And so it might ... if you're doing acute medicine you're covering the whole tower and so that is very different than being just the kind of extra on the take. But that feels good actually because you think well I can do this and I can have a bit more responsibility and make some decisions.

Lavender: it's not what you imagine being a doctor is going to be….the majority of your job is admin, so it's kind of keeping **lists**, ….It's the only thing you're in charge of. You're not clinically responsible for really any patients…And if people praise you on the list, you know your list is really good, or you're clearly on top of – that's massive praise….Because it's *all* your jobs, it's *all* your responsibility is on that piece of paper ... which is *crazy.*

Clematis: On that first morning they said 'This is what we like in our notes, this is how we'd like you to set it up. This is where the list is kept. …And it's very ... and you hand over every patient ... everything gets done. Anything that anybody hasn't done goes into the bottom of the list ... nothing gets lost. And it ... just it flows very nicely

If something clinically goes wrong with your patients it's not your fault as a foundation doctor...... somebody's supposed to be looking out for that. So it's either the SHO's fault or the registrar's fault. If something goes wrong in a clinic that's definitely not your fault, that's the admin fault ... **if something ... if a patient gets missed, that is your fault**.

Oak: I probably told them I wasn't so interested in psychiatry as a career, more interested in general medicine and gastroenterology, so I think they almost perhaps wanted me to take that role. Perhaps if I told them I was more interested in psychiatry they would have given me more responsibility in that sense.

I   And do you think perhaps in other jobs where you've been more keen for that to be your pathway, you've done different things?

R   *Absolutely.* I think the post before this was in gastroenterology at UCH which is a very, very busy ward job. Which perhaps made it a bit difficult for me to extra things, but at the same time because I'd told the consultants and the registrars I was very interested in this and they knew I'd done some reading, they were always happy to accommodate perhaps me presenting at research meetings or the internal meetings. I think it made a big difference, compared to the other trainees who weren't so interested, just wanted to get their head down and get through the day.

I'd say perhaps my responsibility and role isn't so clear in my identity as a doctor in that setting. I find it quite hard to understand what I'm really doing there. Sometimes I feel quite supernumerary, which is understandable – perhaps I am. And in terms of the psychiatric decisions that need to be made, they often ... I don't blame them ... they take the opinion of the nursing staff perhaps more over me, even though perhaps sometimes I spend more time with the patients, because I just don't have the experience in psychiatry. And that can be quite difficult because I find in the ward rounds perhaps I don't contribute very much, whereas on a medical ward on my previous jobs ward rounds I always said a lot ... so it can be a bit more difficult, a little bit more isolating. *(responsibility and belonging)*

Tulip: I think it's being able to make ... I think it's being able to make decisions about things and I've started to gain confidence doing that ... and that's what's made me feel more like a doctor.

2b. Responsibility and work: Observations

Lavender:

Decision making/judgement and responsibility: discharges without consultation: *'What are you going to do with Thomas?' 'I'm going to discharge him', 'Not sure what is wrong or whether the confusion is new or old, its nearly midnight...she's coming in'.*
Task performance and responsibility: looking at x-rays, writing up drugs, writing on computer, making photocopy of letter for GP taking the next patient, discharge with consultation
Other: The busy workstation but each dealing with own 'responsibilities'(cases)
The stamp: uses to authorise and take responsibility
Answers the 'red phone' at midnight: and phones through to alert thrombolysis team

Thistle:

Decision making/judgement and responsibility: sees all patients on own, decides what to do for them. Consults once (not a senior colleague but an old colleague by phone)

Tulip:

Decision making/judgement and responsibility: decides to go and see other consultant's patients after the ward-round -'*I am carrying his bleep so maybe I should review them'*
Task performance and responsibility: checking board for 'who are my patients?', getting the notes out for the ward round writing in the observation charts and drug charts during the ward round. When consultant suggests she writes up a drug - she ask the patient *'do you have any allergies?'* before writing up drug, given jobs to do by consultant, nurse and registrar– writes them on list.
Teamworking: has to decide what to do next: asks physios - sharing responsibility and asking for advice
Other: the list: consulted/added to/checked to see it was still there 14 times in 5 hours. Tulip: Tells be the story of bypassing orthopods to get a sick patient sorted (asks anaesthetist for support) – taking responsibility

Jasmine:

Decision making/judgement and responsibility: sees and sorts out patient in ED without consultation: 'I think he can just go ' ' are here any for the medics? **Task performance:** consults with senior about management plan, writing up notes and investigation requests, teaching medical students

Saffron:

Decision making/judgement and responsibility: sees and sorts out patient in ED without consultation: 'I think I'll let him go' ' I think this bruising might mean something'

Rose:

Decision making/judgement and responsibility: getting the list ready, division of roles on WR
Task performance: checks she understands about management plan, writing up notes, drug charts and investigation requests. Booking tests
Other: taking calls on behalf of registrar

3a. Reflections on actions of taking on responsibility:

- Personal responsibility – the uninspected space with patients and taking responsibility
- Links to the mantle of good junior doctor: this is what a good junior doctor does – personal and expected
- Tasks and responsibility
- Use of knowledge and know how in stepping up to take responsibility
- Transition from medical school to work and fy1 to fy2
- The objects of responsibility: the stamp and the list

3b. Reflections on narratives of responsibility

- They don't give me responsibility because I am not one of them – obstruction by old timers (Oak)
- Tulip: the orthopods who got it wrong – bypassing seniors and taking responsibility – the story of the good doctor
- The stories concerning the lists
- No storying of putting knowledge to work - the use of knowledge and know how in stepping up to take responsibility
- Tulip – the breaking bad news story in response to question about feeling like a doctor– no one else around to do it – stepping up to the plate

4. Links between belonging, being given things to do and responsibility (subtheme): Actions

Tulip:

On ward round – often listens but she is rarely spoken to directly – needs to work out what to do
'surgery avoidance': offered chance to assist in theatre. Manufactures a reason not to get there in time.

Oak:

Sits on periphery on 'ward round'
X2 suggestions not taken up; becomes quiet and offers no further suggestions
Lets Matt (career psychiatrist) do all of the formal handovers (even of his patients)
Drug charts to write in given to Matt despite both in the room
Use if term 'we' for jobs to be done that are his

Narratives

- *Oak:* Animated description of 'the PE': when Oak has known something (medical not mental health) and picked something up that others had overlooked and had managed a patient well – taking responsibility, the good doctor
- *Thistle:* Described taking initiative to start patient on a new drug regime learnt as best practice in hospital. *They phoned me and told to change it back. They said 'it is not what we do here'.*

Tulip (20 minutes of a 69 minute interview)

I: interviewer, R: respondent

R   ... do you want me to sign something?

I   Um, I left the bit of paper in the back of the book. I'll give it to you in a moment. (laughs). There you go. Sorry about that. So thank you very much first of all for letting me come and watch you work today. It's absolutely fascinating. Do you want to just give me some reflections about today? For example what was the most enjoyable bit about today?

R   Um ... most enjoyable part? Um ... I think probably seeing one of the patients who was very low in mood the other day and seeing her doing so well – that's probably the most enjoyable part.

I   Mm, yeah. So patient based then.

R   Yes.

I   And what about the most frustrating thing you had to do this morning?

R   Um ... probably dealing with problems for a patient that I haven't been directly involved with throughout their stay, so taking care of somebody else's (inaudible) somebody else's list.

I   Yeah, absolutely.

R   And when it becomes a bit complicated it's very frustrating.

I   And as far as you know from this job, having been in it for quite a short time, is this a typical sort of day?

R   Yes, this is a very ... it is a very typical day, there'll be some theatre, some theatre work, but mostly I'll be doing a ward round, sometimes with a senior, but I think so far I've mostly done it on my own.

I   Yeah. So you're thinking that this is kind of how a day will pan out ...

R   Yeah.

I   ... normally. Okay. And one of the things that I noticed and I commented on while we were there was a very big group of professional 'others' knocking about. I mean how have you got to know them?

R   Um, through being on my own and not knowing much about the patients so I have found out who knows what. (laughs)

I   Right.

R   And I probably rely on them quite heavily, particularly in orthopaedics, the nursing staff have the best overall view as to ... as the MDT approach as to what's going on with the patient, when they might be going home, what their current needs are. When my seniors come and see them they give the orthopaedic input, but for the rest of it it's more ... I need to find out from the physios and the OTs what their current level of function is ... and the pharmacists ... the pharmacist, though I've met him only a couple of times he seems brilliant and he's very knowledgeable about what he's doing and it's actually a good opportunity for me to learn off him as well so

I   And how did you kind of broker those relationships, and what did you do when you arrived on that first day?

R   I just introduced myself and let them know who I was and said it's my first day, I don't know how the ward works, can you help me. It's mostly yeah ... mostly asking for ... asking for help politely..... cos I think people get so stressed when they have so much to do and you know everyone's under pressure, not just the doctors, that I find being quite a bit softer and asking for help actually usually goes down fairly well.

I   Uhuh. And there were lots of different people to ask, I mean there were a numbers of physios, there were a number of OTs, how did you negotiate which ...

R   Little bit pot luck.

(both laugh)

R   'Do you know this patient?' and if the answer is yes, then I can ask them what's going on, if they don't then I'll find somebody else. But I don't know ... I don't know everyone's names yet, and I don't know the structure of who is in charge of who and ... but I'm slowly finding it out.

I   A lot of people knew your name.

R   Yeah I think ... my name's up on the wall as well.

I   Right.

(both laugh)

R   So they have a little chart, and who's under which consultant and what our bleep numbers are.

I   Right right.

R   But again I think I'm one of the busiest firms, so they have to bleep me quite frequently. And ... yeah.

I   And you said when you first arrived that actually the foundation doctors were really good.

R   Yeah.

I	And they told you what to do. Is that because they had been there for a bit longer?
R	(inaudible) yeah so they'd been there for a month longer, and they'd been also on the wards for the rest of the year. So they know how ... if I didn't know how the firm functioned, they know how to organise things ... which is essentially what I'm doing in this job, as being a bit of a PA. So they all the ... all the tricks of the trade, and that's what I ... that's what makes things a bit longer.
I	And you mentioned you're a bit like a PA. It was interesting looking at you on the ward round – you take a quite backward role in the ward round, is that because you feel you're there to listen and do jobs and work out what the jobs are?
R	Yes, yeah. When I'm doing my own ward round I can get a bit of an overall picture as to how the patient is. I think I'm quite medically minded so I sort of take an overall view ... look at um ... anything else that might be going on, but when the orthopaedic seniors are there ... I don't know anything about orthopaedics so I let them tell me what they want done, and if there's something that ... for instance in the discharge letters I need to know if they need follow up. At the moment it's still not clear to me which ones ... if there's a pattern as to follow up. (laughs) So I manage to ask those sorts of questions when I go round with the seniors.
I	Yeah. And it's interesting also watching was that you were never actually told what to do, you were just expected to kind of listen in to the conversation. Is that your experience or ...
R	Yeah I remember feeling ... we did a shadowing week before FY1 years, and I remember feeling *absolutely terrified* because I didn't know what ... I didn't know what I made a jobs list from ...
I	Right.
R	And I saw the FY1 writing things down, and I heard the senior saying something, and I was thinking to myself is that something that I should be organising or is that for the physios to organise. I think in my first week or so I just asked directly 'Is that something you want to me organise?'
I	(laughs)
R	They said 'Of course not, it's the nursing staff organising that!' or something. And I think you just sort of get to grips with it after a while.
I	Yeah. And what about working in this Trust. You mentioned that you liked the idea of coming to work in this Trust, what was it about this Trust that ...
R	I had quite a bad experience in my first year, to the point where I was nearly put off doing it altogether. I don't think I would have *ever* have stopped doing medicine, but I was so downhearted by everything ... the structure of my Foundation Year 1, it was really tough, and here there seems ... I mean it's probably a lot coloured by doing 6 months of A&E and the A&E department here for a junior is brilliant ... it's actually what's ... I've now

applied for A&E, when I thought all my life I was going to be a GP – so it was that good.

I   Yeah.

R   And things just seem to work well. You know you've got Dr Gxxxx doing the ward round on an orthopaedic ward essentially, and like there was no medical doctor to be seen in my last hospital on the orthopaedic ward, it was all down to the F2. So there's ... the seniors again, they are a little bit Type A personality, but they are approachable still ... and if I ask them a question I may get a snappy answer, but I'll get an answer rather than being you know made to feel small.

I   And this sort of being a good place, is that to do with the work, people, the learning?

R   For me one of the most important things is the learning.

I   Right.

R   And again, as I say, I've only really experienced the A&E department here and that was my main ... the main thing that attracted me, the learning opportunities were *amazing*, the senior support was brilliant. I think that's probably partly any A&E but here the set-up with who was on the shop floor was just ... *it was really good.* I haven't really experienced that in orthopaedics yet, but my consultant is very nice and very approachable and very keen for me to learn the things that I'm ... the aspects of the job that I'm going to take for the rest of my career so .. which again is nice cos they weren't really interested in my last hospital. We got through our induction meetings and ticked a few boxes, and they didn't know who I was at all.

I   So that induction meeting you had here felt a bit different. You described it earlier on as sort of being ... happening – happening properly, and happening very early.

R   Yeah. So that happened for both A&E and for orthopaedics. My supervisor contacted me and arranged the meeting – which is a bit unheard of – and we went through ... we went through things properly, you know they asked me what I wanted to get out of it and didn't just ask me that and left it at that, they sort of probed a little bit more to find out a bit more about me and about my worries and the things that I wanted to improve on. And in this particular job my consultant has highlighted areas that I can come and get experience. So for instance in a fracture clinic he doesn't necessarily need an F2 there, but he said it would it be excellent experience I'd like you to be there for X number of times ... which is good.

I   Good. Now, rather than talk about this job, I'm going to take you all the way back to the beginning.

R   Okay.

I   I just want to go a little bit back, and I want you to think back to before you even came to medical school, and when it was you thought about becoming a doctor and how it came about.

R   I think if you asked my family they'll tell you a different story. I used to when I was little perform surgery on people in the back of the car.

(both laugh)

R   But I don't remember being interested in being a doctor at that stage. I think it all sort of came around picking my GCSEs and AS levels, and I naturally gravitated towards the sciences, I did Chemistry, Biology ... and I also did Psychology and Theatre Studies. And so the combination of all of them ... it seemed to be the right way to go, and I think what actually happened ... my older sister tells me is what happened ... is that my mum wanted to do medicine, but she never really went into it, she did other things ... and I think that she perhaps planted the seed of the idea to do it, and that's where it grew from. But it was never ... I was never forced into it, I think it was something that ... the idea was given to me and I thought 'Yeah actually that seems like the natural way to go'.

I   And did it become more and more appealing as you got older or thought about it more?

R   Yeah it did. And I couldn't see what else I would enjoy doing more. I mean I didn't really understand what it involved at the time if I'm honest.

I   (laughs)

R   But I didn't see a ... I guess I didn't really see a job or a career in doing anything else.

I   Yeah yeah.

R   I saw a degree but nothing further to that.

I   And was it ... when you were thinking then, you said you didn't quite know what the job was ... what was it about being a doctor or doing that job of doctoring that appealed to you at that stage?

R   Um, I think it was probably the combination of interacting with people and the sort of intellectual challenge – I think it was that combination ... rather than a straight science or a science based subject ... I think it was that combination of having to deal with people at the same time.

I   And did your commitment to medicine ever wane before you got in?

R   Yes. Uh, yes I guess so. I went and did some .. what was it called? ... work experience at an old people's home.

I   (laughs)

R   *It was awful, it was really awful.* And then lots and lots of people ... I mean none of my family are medical, and lots of people who I met at various ... I guess work experience and family friends all said don't do it ... don't do it, it's a really tough career, do something else with your life – that sort of made me a bit cross that people were trying to put me off before I even got there, so that made me more determined to do it.

I   So even though you were slightly put off by the experience in the old people's home, you ...

R   Yeah I took a year out before coming to uni. I applied and deferred a year, and I went to Ghana and did some medical work experience.

I   Right.

R   And it was brilliant, it was really ...I don't know, I sort of just felt like I was ... *it all felt exciting* and that I was in the right place.

I   And were there any role models then? You know can you think of any doctors before you even came into medical school that you thought 'I wouldn't mind being like that'?

R   I don't think so no.

I   I mean the telly or ...

R   I think partly ... not it wasn't ... that didn't influence me at all. I think partly it was that I ... I'm the youngest of four and I wanted to do something different. I mean all my brothers and sisters, we're all very close, but then they all do different things to each other. But I think it was um ... we're all very competitive, and I think it seemed like a good competitive thing to do that was different. (laughs)

I   You won. (?) (laughs)

R   Yeah.

I   And tell me a little bit about medical school, once you'd taken your year out and you'd got to medical school, what sort of place was that?

R   It was a great place. My first year I found quite tough, because I had been ... I had been up until about a few days before coming to London, working on a cattle ranch in Australia in the middle of nowhere. (laughs) So I sort of ... I think you know it took me a little while to settle back into doing things. But it was a great place, it was a great place to meet people and I had ...

(bleep goes, interruption: 1 min 12 secs)

R   So we were talking about medical school.

I   We were. You were talking about how it was all a bit tough, but you really enjoyed it, it was a good place to meet people.

R   Yes, a good place to meet people. I quite like learning, I *love* learning. I missed learning a little bit in my foundation years, but I loved getting back into a system of being directed with my learning, which was quite nice. But I also sort of threw myself into pretty much everything in medical school ... did sports and Spectrum and MDs and everything. (laughs)

I   Were there any ..... were there any experiences that you recall now that you think had a profound effect on you at medical school?

R   Effect on my career or ...

I   Anything, in any way? Things that come to mind when you think about medical school.

R   Football, the football club I think, had a profound effect on my confidence ...

I   Right.

R   ... and my sort of place in medical school. I think that's where I finally settled in.

I   Yeah.

R   And the MDs I guess, cos that came first, and then football later. Um ... nothing that springs to mind.

I   Yeah. What about when you were on the ward and started doing clinical things, do you think about things that ...

R   Yeah, I remember feeling quite lost. I remember feeling how am I ever going to learn to be a doctor when I keep getting told to go away. (laughs) Or told 'Don't worry about this, this is really boring, you might as well go home' when it was the bread and butter stuff of being a house officer.

I   Right right.

R   It was the TTAs and the jobs list and all that sort of stuff. But I remember ... I remember doing my A&E placement and really enjoying it ... surprising myself and enjoying it. Yeah I think being on the wards it was great when I saw pathology, I loved that, but I didn't ever feel ... I didn't ever feel that sort of included as a medical student or welcome in the team.

I   So you felt very much removed from what was going on in the hospital.

R   Yes, I always felt very much like I was putting upon people being there.

I   Mm. It was funny the medical students sat in the background with me in the seminar today.

R   There was a hierarchy did you see?

I   Yeah (laughs)

R   Consultants in the front row, then the registrars ...

I   What's the benefit of sitting further back, is it you're less likely to get ...

R   Well I thought it was you were less likely to get asked a question ...

I   You were asked today.

R   I was asked to day. He did say that he was going to start doing that on a Tuesday so I was pre-warned but I wasn't paying attention.

I   (laughs)

R   Any incidents at medical school where you did feel like a doctor?

I   Yeah there were um ... taking blood. Um ... I think going to meet patients early on. At any point where I was given some sort of responsibility I felt a *bit* more involved and included and like I was there for a purpose.

R   Mm, what about your shadowing time?

I   Um ... I think I just remember feeling so panicked about starting. (laughs)

R   Yeah.

I   But I was trying to learn *everything* really quickly, so all those things that I hadn't learnt as a medical student, because I'd been told don't worry about it ... rewriting drug charts for instance which now is so simple. At the time I didn't know ... I didn't know how to do it. So I had to sit down with someone in that three days that I was shadowing and go through how to rewrite a drug chart and how to write it ... what is relevant to go on a discharge letter. Cos again I think my GP placement, I hadn't really got to grips with how the system worked and how they interacted with each other and what actually the GP needed to know rather than everything. So ... and that has ... I don't know whether that's partly because I wasn't interested in it as a medical student and I saw that I needed t learn about the different antibodies in rheumatology or at the time I just didn't learn about it in medical school, I didn't prioritise it until suddenly I realised that *I* was going to have to do it.

I   So learning medicine sounds like it took priority over learning to be a doctor.

R   Yes, absolutely. I had no idea how to be a doctor when I started.

I   And when did you start to feel like yes, I'm going to be being a doctor soon, when did that kind of creep up on you?

R   That came about a month or two before finals.

I   Right.

R   Pretty late.

(both laugh)

I   And were there any experiences while you were at medical school that made you think, you know, 'Maybe I don't want to be a doctor'?

R   I think there probably were, I think it was probably seeing people dealing with things that I thought were way beyond what I would ever be capable of. We had ... I don't know whether this is relevant, but we had ... you know Dxxx Axxxx?

I   U-huh.

R   So he's my boyfriend, and has been for 6 years ..

I   Oh right okay.

R   And he did some revision sessions for us before finals.

I   Right.

R   It was just me and a group of friends at the time. And his way of teaching, really it linked in pre-clinical to clinical to what are you going to do as a house officer. And I think that scared us ... you know in a good way ... it suddenly made us realise it wasn't all about the exam.

I   Right.

R   And we all started thinking about 'Uh-oh ... no one's really talked to us about what we're going to be doing in our first few days'. And subsequently you know he's done it for the next few years and myself and one of my colleagues who I worked with last year, who's a good friend of mine, we did a session on common bleeps that you'll get as a house officer and how to deal with them. Cos you know that was ... this guy did his first few days on call and just didn't know what he was doing.

I   And do you think you would have been ready for that kind of information when you were at medical school sooner, or do you think your focus was still on medicine and not being a doctor?

R   I think it could have come sooner. I think if it had been highlighted by somebody in the medical school ... I felt a lot that the focus was very much on academic achievement and understanding ... and I can see why it is now, because it's great, my knowledge of medical conditions is ... if I wanted to sit the MRCP it would be revision rather than learning. And I sort of feel that's partly what the foundation years are for is to learn how to be a doctor. But I think there could have been ... and I think there now is, I'm not sure, but I think there could have been a bit more of a 'This is what you're going to be doing on the wards, this is actually what you're doing as a doctor'. You know and not an awful lot, it doesn't take long to learn how to do a TTA, but ... it's those sorts of things would have taken ... definitely would have taken the fear out of first year and it might have helped me be able to get those jobs done so that I could then learn in my first year.

      (both laugh)

I   And what about people at medical school ... students, doctors, consultants, people you came across...

R   Um ... my final year consultants were probably the most influential on me, cos I think at that point I was starting to think about you know I haven't got much time left. I remember my A&E consultant ... oh goodness what's his name? ... he always used to call himself JC, he was at the XXXXXX.

I   CXXX?

R   CXXXX.

I   Yes.

R   *He was brilliant.* And he was ... he was.. *inspirational.* And in fact I've been thinking as I said all my life that I was going to be a GP, and my first ever work experience was in A&E and the placement I enjoyed the most throughout medical school was A&E and I think he was the first person that didn't say A&E's an *awful* career, don't do A&E. And he was so passionate about teaching ... you know he was told off by some of the nursing staff for having the students in the resusc room, and he said 'No, this is my department. They need to see this, they need to learn' and I was very grateful for that. So he was inspirational. My GP in my final year was ... she was very good cos she identified things in my character that I needed to work on, which was good. Cos I think I was quite similar to her in terms of ... in terms of where I draw the line with my emotional interaction with a patient. When you're delivering bad news or something like that, and not getting overwhelmed and not getting ... I think she found in her consultation, she said 'Look I do the same' – she can get very emotionally attached to the patient and that sort of stuff ... so that was *really* good learning for me.

I   It's nice to know somebody else feels the same thing.

R   Yeah, really was very very nice. And Dr Lxxxx here has also done teaching on breaking bad news and she .... I spoke to her afterwards about the same thing actually. So that was nice.

I   And do any of them make you feel like 'I would quite like to be like that doctor?

R   Yeah yeah definitely. Um ... and I think Dr Lxxxxx certainly ... she's great ... but I've never worked with her myself.

I   Yeah.

R   But again I saw that in most of my A&E seniors here, and that's again one that I chose to go for. I sort of ... I saw they were very personable, there wasn't that 'I'm a consultant, you're my junior, go and do these jobs', they talked to me like another person (inaudible)

(both laugh)

R   Which was really nice.

I   And what about how people were with patients, anyone influenced the kind of doctor you want to be with patients?

R   Yeah, I had a registrar in A&E and she was ... in fact most of the A&E doctors, they're fantastic with the patients. I think there were probably a couple last year that I saw that I sort of picked little bits from how they dealt with things. Um, yeah I think ... yeah I think it's mostly my registrars, I don't really see my other F2 (inaudible)

I   And what about patients, have any patients had an effect on you and made you stop and think about who you are as a doctor?

R   Yeah, yeah. And actually quite a lot in GPs, that's probably where you get the most feedback from patients. I had some really nice feedback from my

172

GP patients. In fact one of them said 'What are we going to do when you're leaving?'

I   (laughs)

R   'But I've been doing so well' I said 'Yeah you have been doing well, I haven't been doing well for you'.

I   (laughs)

R   So that was really nice, and you know one of them wouldn't see anyone else in the practice apart from me, and I think perhaps it was ... she's a medical student herself and I think perhaps she saw a sort of ... an ally with her problems, so that was nice. I certainly learnt a lot about my character in A&E cos I think you deal with all sorts of different difficult characters. And I learnt a bit about being more confident. I think that my first job in my F2 year was when I started to feel confident enough to really do health promotion I guess. Cos I didn't really still feel like a doctor for most of my FY1 year.

I   Really?

R   Yeah.

I   Yeah. Let's think about when you did first feel about a doctor, what about when you graduated and you received that little scroll? Did you feel like a doctor then?

R   Um ... I did in my family's eyes, but I didn't to anybody else who knew what doctors actually do.

I   Right. (laughs) Do you remember the first time you used the title?

R   Um no I don't. I still call myself one of the junior doctors or Tulip ... I call myself Tulip in A&E. I called myself Dr xxxxx probably for the first time in my GP job because I was asked to.

I   Right. But it wasn't something that came naturally to you.

R   No, not at all.

I   So you said you didn't feel like a doctor in your foundation jobs ...

R   Yeah.

I   ... how long did it take, what was going on?

R   I guess I sort of ... I started to feel like a doctor perhaps on my on-calls.

I   Right.

R   But before that any time, doing ward jobs, I'm just doing jobs – I wasn't really making decisions on patients, I was ... no maybe not ... I had started on care of the elderly – hugely under-staffed, hugely under-supported to the point where the Deanery came in and changed the structure of the department.

I   Right. Was that your doing or ....

R   It might have been yes. (laughs)

I   Good for you! (laughs)

R   Yeah it was probably a good learning experience, but it wasn't anything that I wanted anyone else to go through.

I   Right.

R   So I had a word with a few people ... particularly in the Deanery meeting. But I think I was ... I was left to talk to patients' relatives ... a room full of relatives ... in probably my first month about the LCP and (inaudible) and ... from a baseline of them not knowing anything. And I think that's probably where I first felt like a doctor because none of my seniors were around to do it, or they ... in fact I didn't think that they had communication skills to do it. You know they said to one patient's relatives 'Well we don't want to jump on her chest up and down for a few hours, we'll break her ribs' or something ... you know it was just ... and you saw their face drop and you wanted to intervene. But in terms of the medical side of things, I didn't feel like a doctor for a long time, cos I didn't know ... I knew my ABC, but I didn't know how to ... the sort of intricacies of dosing with the drugs and ... I didn't really know the practical side of stuff. You know a lot of the stuff that the nurses do naturally and they know ... cos they've been doing it for years .. which is they have to run by the doctor were things that I just ... I hadn't really ... I hadn't come across practically. I'd learnt about it, but it was somewhere back there in my memory. And to put it into practice ... you know someone on my first day came up to me .... I did a ward round on my own on my first day ... of 45 patients on a care of the elderly ward (laughs) ... my consultant said 'Oh I'm in theatre today, and your registrar's in theatre as well, so let us know if you have any problems.' And you know the first patient I came to had chest pain, and I had to ... I started doing the work up with chest pain and I eventually called my registrar and he said 'Yeah she's always got chest pain, don't worry about it'. So I spent a long time trying to figure out what was going on and ... I think it was the assimilation from learning it to doing it was very difficult.

I   Right, so from what you are saying it feels like feeling like a doctor is important ... what's important about it is knowing how to do the job, and knowing how to do the job in an unsupported way, so you could do it unconsciously almost, you know what the right thing to do is.

R   Yeah. Knowing how to react to things. I think I've gained a lot of confidence and a lot of comfort in knowing how to react to things after having done A&E. And having done night shifts as a junior they were horrible at the time, but I think that was ... making decisions and knowing how to respond to abnormal physiology or um ... that sort of thing.

I   It goes back to what you were saying about you feel like a doctor sometimes when you've got some responsibility.

R   Mm. Yeah definitely.

Observation: Lavender   2.4.12

1. Basic details:

- *Who? Dr identifier and basic demographic*

Lavender is a young woman in her early 30s. She studied in the US She is married and expecting her first baby in 3 months time.

- *What is that individual's post/role title?*

Lavender has completed 1, 4 month FY post and was in her penultimate week of her second 4 month FY 2 post.

- *Where?* ABCD NHS Trust. At observation she was working in ED with many other doctors in training on site.
- *When?* Completed observation before the interview

The observation was for the first 5.5 hours during a weekend night shift –. This was the first of a week-long series of nights having just come back from a holiday. Although this was a Saturday night in central London, the ED was relatively quiet, especially in 'majors'.

2. What general sorts of activities were observed/what was the context of observation?

Lavender was initially on minors: seeing the 'walking wounded' and more minor complaints (for first 70 minutes) calling patients from waiting room, finding out problem, giving treatment, discharging them (often without consulting others). Then the waiting time on majors became too long and charge nurse moved her to Majors. For rest of observation period (four and a half hours) on 'majors' seeing the more unwell patients who attended ED. Most came by ambulance; others came in on their own. All patients seen had already been 'triaged' and were in cubicles waiting to be seen. Like the other doctors working in ED Lavender would collect the next patient's notes to be seen and the see and treat them. At times this system was bypassed by a patient to be seen or reviewed 'jumped the queue to ensure they did not 'breach' a 4 hour wait in the ED.

3. Which professional others were observed?

Other members of Ed staff, nurses and doctors (including Lavenders peers and seniors) ambulance crews, ED porters and security guards, ED administrator other doctors from the wards visiting ED to see patients referred to them.

4. What were the interactions with the professional others? (formal support, informal support, feedback, inclusion?)

Formal instruction: from senior and junior nursing staff, from her supervising doctor (registrar)
Formal support: from nursing staff, from charge nurse, from junior nurses (@ tasks), porters

Informal support: peers, nurses (senior and junior)
Feedback: from charge nurse, from senior colleagues (registrar) and doctors she referred patients to
Inclusion: formal from charge nurse, senior colleagues (registrar) and doctors she referred patients to. Informal from one junior nurse, from peers

5. What learning was taking place? (formal/informal, tacit/purposeful?)

- Learning about computer system – need to learn to be able to perform a task
- Learning about CT scan from a senior colleague – why didn't need CT scan/ need to go to med reg
- Learning in handover to senior colleague (med reg) : case based discussion about cellulitis
- Incidental: listening to two doctors discussing causes of painful eyes
- Learning about what to do: the paramedic told her putting up a drip on an aggressive patient unwise and what else she could do/alternatives and how to document
- Looked up a drug in a book

6. Observation

Activity	What?	Comments
Task Performance	Calling patients in from waiting room, seeing patients	FY in ED a very task based role
	(or completing notes if no answer when called)	' I'm having a lucky night' when calls 3 no-shows in a row
	examining patients	
	looking at X rays and ECGs	'I did the Ortho job here before this so that helps'
	discharging patients	
	getting medication for a patient	Had been away and forgotten password for computer. Needed to borrow one to complete tasks.

	completing notes on computer	The usual cycle for tasks was: identify next patient to be seen-see patient-computer/notes-see patient again- go back to computer to complete notes.....then the next patient
	collecting urine sample and bloods, labelling them and sending for analysis, writing a letter to a GP	
	making a photocopy of letter to GP, updating computer list of waiting patients (or informing charge nurse about progress)	
	referring patients to other doctors, arranging a transfer and scan for a patient	Rather a solo worker (to what extent Lavender's character and to what extent the job?) – others doing same job did not seem to be so solo and not working so systematically and speedily
	answering 'red phone', taking details and putting out crash call	Knew how to do most tasks independently (got help for a computer issues form a peer, for where to find a form from nurse, and how to book CT from senior)
	looking up drug doses	
	writing up drug charts	
Role Performance	Getting on with it: no introduction, no handover	*Being a good ED doctor-*
	Completing paperwork after a case	

	Seeing patients in order requested by charge nurse to prevent 'breach'	*being a good self-sufficient doctor*
	Moving between minors and majors when needed	
	Taking 'no shows' off computer	
	Getting all own stuff	
	Getting on with seeing patients and discharging them	
	Helping a patient put on a gown	
	Putting ID sticker on an ECG that had been missed off	
	Referring patient to med reg	Made sure she was ready – knew case and results, knew protocol – again being a good junior
	Trying to sort out a drunk	Tries to do what she 'ought' to do
Decision Making & Problem Solving	Discharging patients without review by any other member of staff	Joining the quest to 'avoid a breach' is a key task of whole team
	Working out (with help) how to take patients off computer to avoid breach	Tries to do what she needs to do but listens to advice from more experienced but much less senior colleague (ambulance tech) and takes advice
	Referring patient:	

	discussion with other doctor	
	Not putting drip in aggressive drunk after discussion with ambulance crew about what is best for patient (and doctor) Checking a child had been seen in children's ED and not missed Putting a line in on a deteriorating patient before next steps taken – ' in case he goes off'	
Judgement	Discharging minors Deciding ECG is fine Saying – nothing is broken on X ray; you can go how with some pain killers Going to resus to help 'stroke reg' Referral to stroke team (discussed with senior nurse first)	
Academic Knowledge and Skills	Decision making about patients, interpreting investigations Looking up a	Mostly tacitly used knowledge and know how No looking at books

	protocol on computer before starting referral to med reg Adding some causes to the list of 'painful eyes' being discussed by 2 colleagues	Looks up local proceedure
Teamworking	Facilitating the work of the ED team: Moving from minors to majors Staying to help Offering to move back when things got quiet in majors Joining in the 'avoid a breach' action Taking the initiative to answer red phone and to start the resus call Working in a team: Seeing whoever charge nurse directed as next 'can you see 22 and decide what to do?' Handover to stroke team Sorting out what to	Key to being good (compared to slower working, less eager co-workers) First break not til over 4 hours in and that was a loo break (amazing for a 6 months pregnant woman!) Explained social and denial rather than 'sick' to others

	do with the drunk Informal team relations: 'chat' Discussion about work based assessments Joining in the painful eyes chat Working with peers/charge nurse to sort out how to do tasks x2	Happens in breaks in work and alongside work. Formal conversations sometimes switch to chat especially those who haven't seen her since her holiday Everyone called her Lavender Chat not limited to core staff
Awareness & Understanding	Its nearly midnight so she is coming in (but said in a way that suggested asking permission not assertion) Asking nurses – do you know anything about him – did you get a collateral history Safety @ drunk	
Personal Development	Feedback from reg Sticker book – to follow up whether she was right/what happened	Listened and learnt (and wrote in book to look up later) Took a sticker from every patient she saw in majors – asked – *does everyone do that?* *'its something I learnt on AMU;it's a good way to follow up and work out if you did the right thing'*

Notes at observation

- Lavender explains my presence by saying 'she is getting a feel for the work I do'
- Lavender knows how to do this job. She is quietly confident and capable 9we are 2 weeks before the job is over and she things some previous jobs help (ortho for injuries, AMU for majors) Treated as an independent practitioner: others must also know she is competent and safe too so have given her this level of autonomy (but this is at interface with patient not about what job to do next) at one point Lavender is 'gifted' like an object: *' you can keep lavender for now- she can sort out CTs and that – that will help the stroke reg'*
- Busy work stations, queuing to use computers so natural place to chat and learn and work alongside
- People working at different rates and wasting different amounts of time. This seems to be tolerated.
- Lots of chat about holiday -most people asked
- Talk to other juniors is not about the job: how many days left til they finish this post, how many night shifts left, workbased assessment – have you got your portfolio up to date? What you are doing next?
- A lot of writing and not so much seeing patients: 'sometimes it takes longer to write up the notes than to see the patient, especially if it is straightforward patient'

Observation reflections

- Belonging: you can be quite private, solo working and insular her in many dimensions and still be good at the job.
- blend of talking, relationship building, learning, doing – talk is important – Lavender is well known and people are interested in her holiday ? because she involves herself in chat outside just the doctors
- who is in control – the nurses and seniors - not the FY – the good FY does what they are told (although they should be in charge in the face to face with minors and get on without bothering others). The charge nurse sits infront of a computer screen , with patients details in red amber or green, she does not see patients -she is the 'conductor ' on her platform directing the whole show
- Relentless working - others doing much less. Not rushing but never stopping
- Friendly relaxed relationships
- Asked about learning to use clinical information system on computer: just had to learn on the job even though she had a brief induction
- No list in ED – but new artefacts – the stamp in pocket and the book of stickers!
- Talk with other juniors is about personal trajectories and the trials of being an FY – an interstitial CoP?
- A lot of helping each other and nurses 'second guessing what next, jobs to do without being asked. Helping each other out with bloods, what next etc. rather driven by avoiding breach -what is this doing to relationships and working practices: will I only help you to help me

8.3.8.1 Consent 1

UCL SCHOOL OF LIFE AND MEDICAL SCIENCES

UCL DIVISION OF MEDICAL EDUCATION

www.ucl.ac.uk/dome

Participant Consent Form

Title: The formation of professional identity by newly qualified doctors

Dr Deborah Gill: Doctoral Student, Institute of Education, University of London and Senior Lecturer in Medical Education, UCL. Supervisor: Dr David Guile, Institute of Education

This study has been approved by the NHS Research Ethics Committee [Project ID Number11/LO/0579]

Please initial box

1. I confirm that I have read and understand the information sheet dated.................... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and any data already collected will not be used.

☐

3. I agree to take part in the <u>observation</u> element of the above study.

☐

4. I agree to take part in the <u>interview</u> element of the above study.

☐

Signed...(participant)

Signed...(researcher requesting consent)

Date ....
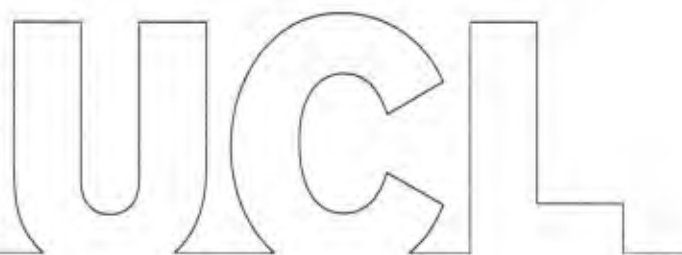
UCL SCHOOL OF LIFE AND MEDICAL SCIENCES

UCL DIVISION OF MEDICAL EDUCATION

Study Information Sheet and Consent for Observation *(Consent 2)*

Study Title: The formation of professional identity by newly qualified doctors
Dr Deborah Gill: Doctoral Student, Institute of Education, University of London and Senior Lecturer in Medical Education, UCL. This study has been approved by the NHS Research Ethics Committee [Project ID Number 11/LO/0579]

The study
I am currently undertaking a study to identify how new doctors form a sense of themselves as doctors and the influence on this of personal, educational and workplace factors. I will be observing a small number of doctors in this Trust for a brief period of their day to day work and then conducting an in-depth interview with them. I will use the findings generated in this study to add to the body of what is known about professional identity, expertise and the medical workplace and to inform the development of medical and professional education.

The participants
One of the junior doctors working in this Trust has agreed to take part in this study. I will be discretely observing the work of this doctor for a few hours before the interview to better understand the work and workplace of the doctor and to act as a focus for some parts of the interview.

The observations
The observations will take place, with the consent of all involved, for a few hours. The focus of the interview will be the junior doctor. I have asked the doctor to choose a period for the observation that is typical of some of their work but that minimises the inconvenience or intrusion on the privacy of others, both patients and staff. Although I am a doctor myself I will not be participating in any activities. I will be keeping brief notes of what I see but will record no personal information and no individuals will be identifiable.

Consent
You do not have to consent to take part in this study. You can decide not to agree to the observation taking place and I will arrange an alternative time and place for the observation of the doctor concerned. You will be asked to sign a consent form if you are happy for the observation to take place and will be given a copy of this information to keep. You can withdraw your consent at any point by simply asking me to terminate the observation. You do not need to give a reason for withdrawing your consent. Declining to take part in the observations or withdrawing your consent will have no detrimental effect on your employment if you are a staff member or your treatment if you are a patient.

If you have a concern about any aspect of this study, you should speak to me and I will do my best to answer your questions or solve the problem in the first instance. My email address is d.gill@medsch.ucl.ac.uk and my telephone number is 0207 288

3316. If you remain unhappy and wish to complain formally, or wish to complain about an aspect of my conduct you can do this by contacting the project supervisor Dr David Guile at the Institute of Education: d.guile@ioe.ac.uk.

Dr Deborah Gill: Academic Centre for Medical Education, UCL Division of Medical Education. June 2011

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my consent to the observation is voluntary and that I am free to withdraw at any time without giving any reason and the observation will be terminated

☐

3. I agree to consent to the observation taking place.

☐

Signed...

Date ....

8.3.8.3 Policy 1

Becoming Doctors: The formation of professional identity by newly qualified doctors
REC Reference number 11/LO/0579

Policy on the Discovery of 'Poor Practice'

Context:
Best practice for all doctors is encompassed in the GMC document *Good Medical Practice* 2006. http://www.gmc-uk.org/guidance/good_medical_practice.asp
This guidance is supplemented for junior doctors by the publication: *The Trainee Doctor* 2011. http://www.gmc-uk.org/Trainee_Doctor.pdf_39274940.pdf

This study involves junior doctors and concerns factors that impact on their development of an identity as a doctor in the early years of work. It involves both interviews and brief observations in the workplace.

There is the potential for uncovering episodes of practice that falls short of this guidance. This may concern the practice of the research participant or his or her fellow professionals. It may arise in the context of discussion or observation.
For the purpose of the safe and ethical conduct of this study a policy is required for *what* will be done, *when* and *how* with regard to the uncovering of sub standard practice. However, as breaches of good practice may be fleeting or enduring, may be minor or more serious in nature and may range from having the potential to cause minimal harm to the potential to cause significant harm, a proportionate response, related to the nature of the breach, that maintains the safety of the patient but also acknowledges the complexity of medical practice and the dignity of the professional(s) concerned is required.

Breach	Action
Minor and fleeting (self or other, interview or observation)	Judgement made as an experienced professional concerning potential for harm. Discuss with project supervisor: likely no action.
Significant but fleeting (observation)	Judgement made as an experienced professional. If no perceived immediate patient safety issues: discuss with doctor concerned at early opportunity during observation. If imminent danger: interrupt observation and discuss/ensure remedied by appropriate senior immediately. May require report through relevant channels.
Significant but fleeting (interview)	Judgement made as an experienced professional. If no perceived immediate patient safety issues: identify with

doctor concerned at end of interview
and ensure appropriate remedial action
is taken. May require report through
relevant channels.

Breach	Action
Minor, enduring (self or other: observation)	Judgement made as an experienced professional. If no perceived immediate patient safety issues: discuss with doctor concerned at early opportunity during observation. If imminent danger: interrupt observation and discuss/ensure remedied by appropriate senior.
significant, enduring (self or other: interview)	Judgement made as an experienced professional. If no perceived immediate patient safety issues: identify with doctor concerned at end of interview and ensure appropriate remedial action is taken. Outline my professional responsibilities as detailed by GMC. Report through relevant channels.
Significant, enduring (self or other: observation)	Judgement made as an experienced professional. Immediately interrupt observation discuss/ensure remedied by appropriate senior immediately. Outline my professional responsibilities as detailed by GMC. Report through relevant channels.

Title: Becoming Doctors: The formation of professional identity by newly qualified REC Reference number 11/LO/0579
Policy on the measures to be taken if research participants become distressed

Context:
This study involves junior doctors and concerned in factors that impact on their development of an identity as a doctor in the early years of work. It involves both interviews and brief observations in the workplace. The questions have been sensitively phrased and the observations designed as non-intrusive and non-threatening and it is hoped that the opportunity to reflect and articulate in this difficult area of learning and development with a thoughtful listener who is not their work colleague, workplace manager or educational supervisor will be beneficial to participants. However there is the potential for the research participants to become distressed by the interview questions, their response to these stimuli or during the period of observation.
For the purpose of the safe and ethical conduct of this study and the protection of research participants from harm a policy is required for *what* will be done, *when* and *how* with regard to distress either observed or articulated.

If a doctor becomes distressed:
- I will offer to terminate the interview or observation immediately
- I will offer to listen to the doctor' concerns or problems: stressing that I am offering a 'listening ear' and direction to resources rather than entering into a doctor-patient relationship
- I will offer to intervene on the doctor's behalf if there is a work-related issue that they feel needs to be drawn to the attention of their supervisor but that they cannot address themselves
- I will direct the doctor to an appropriate support resource depending on the nature of the concern/distress (see resources list below)
- I will give the doctor my contact details on leaving the observation interview

I will leave a copy of the support resource sheet and my contact details with all participants regardless of whether or not they appear to be distressed or articulate distress.

Resources for Research Participants

Thank you for taking part in this study. Your insights and experiences have been invaluable in helping me to understand the ways in which doctors form their identity as doctors and the influences on this formation.

Sometimes the practice of medicine is stressful and difficult. Talking about this is usually helpful in itself. However at times doctors, like all other people can become distressed or unwell because of their experiences and talking about your difficulties can sometimes make you more distressed or determined to do something about it. Friends family or trusted a colleagues can sometimes help. Your GP is also an invaluable confidential source of help. Your education supervisor or Foundation Programme director can also be approached for practical, professional or personal help. However there are a range of other services available that I would like to make you aware of should you feel upset by any of the events or discussions of today.

If you would like to discuss an thing with me in confidence as a 'listening ear' or ask about resources for support, please contact me on 0207 288 3316 or d.gill@medsch.ucl.ac.uk

Local resources: Health

- Your GP
- The Trust Occupational Health Service
     UCLH: 56-58 Gower Street 0207 380 5096
     Royal Free: rfh.healthandworkcentre@nhs.net 0207 830 2509
     Whittington: occupationalhealth&wellbeing@whittington.nhs.uk 020 7288 3351

London Deanery Sources of support: Health

- Mednet: confidential counselling service
  http://www.londondeanery.ac.uk/var/supporting-professional-performance/mednet/?searchterm=mednet

London Deanery Sources of support: Careers

- London Deanery Mentoring service
  http://www.londondeanery.ac.uk/var/supporting-professional-performance/coaching-and-mentoring
- Careers unit
  http://www.londondeanery.ac.uk/var/careers-unit

National services:

- NHS Practitioner Health Programme http://www.php.nhs.uk/
- The BMA Counselling and Doctor Advisor Service   08459 200 169
- Sick Doctor's Trust http://www.sick-doctors-trust.co.uk/   0370 444 5163
- Samaritans   http://www.samaritans.org/ 08457 90 90 90