

**Learning processes and identity construction of newly
qualified doctors: a narrative study**

By

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Abstract

This thesis reports on a narrative research study of medical internship experiences focusing on the learning processes, identity construction and aspirations of newly qualified doctors (NQDs). The aim of the study was a better understanding of how medical graduates negotiate their learning experiences and construct their identities during internship in South Africa. Six doctors who were graduates of a problem-based learning curriculum participated by reflecting back on their internship experiences. Qualitative data in the form of written reflections three years post-qualification were initially analysed using socio-linguistic methods. The same participants were followed up with one-on-one, in-depth interviews at six years post-qualification.

Using interpretive methodology, this qualitative study was underpinned by social constructionist thought. The theoretical framing innovatively combined psychology- and sociology-based theories; for example, the classic theories of Vygotsky and Bourdieu, and more contemporary theories of Situated Learning and Dialogical Self Theory were used. A contemporary philosophy of recognition and disrespect further illuminated the nature of various relationships with regard to positive identity construction.

‘Ways of being’ of doctors were found to impact considerably on the nature and quality of relationships with patients, colleagues, institutions and the self. Insight was gained primarily into networks of relationships, especially with senior colleagues in the context of clinical workplace environments, which enabled or constrained positive identity construction.

Tracing the journeys of medically qualified professionals at a more mature stage of their development revealed the importance of personal dispositions and aspirations.

Learning processes during medical internship were found essentially to involve significant others. Identities of NQDs were not rigidly organised, and the study developed an understanding of multiple I-positions in dialogical interaction within the self. Internship communities of practice enabled or constrained not only the development of knowledgeable skill, but also powerfully shaped identities.

Strengthening the possibilities for positive identity constructions during internship would be a possible means of transforming medical culture to be more responsive to the needs, beliefs and abilities of NQDs. Deeper consideration for internship learning and promoting mutual recognition between NQDs and healthcare institutions may also lead towards more patient-centred care.

Declaration

I, Lakshini McNamee, declare that:

- a) this thesis is my own original work, and all the sources I have used or quoted have been appropriately acknowledged as citations.
- b) this thesis has not been previously submitted for any other degree or examination at any university.



Signature: _____

As the candidate's Supervisor I agree to the submission of this thesis



Signed: Dr Peter Neville Rule

Dedication

This thesis is dedicated to my mother, who I now know as having occupied a 'promoter position' in my 'self' for the longest time. Sometimes in challenging me with words that should not be uttered; at other times with encouragement to believe that the goal is within reach. She has modelled being a scholar, researcher, educator, author; balancing these roles with being a wife, mother, loyal friend, and woman of God. She set the bar and showed me that being all these could coincide in achieving excellence.

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To the FAIMER – SAFRI community, you got me started on this health professions education research trajectory, and built up my confidence, especially Stewart Mennin, who 'grilled' me at the outset and convinced me that it was quite normal to go to bed with a laptop.

Above all, my eternal gratitude goes towards Almighty God for His leading, guiding and ever-present inspiration. I often felt that this endeavour was actually His idea, and I was just privileged to carry it out.

List of Tables and Illustrations

Tables

Table 1:	Honneth's three forms of reciprocal recognition	74
Table 2:	Phases of data generation and analysis	99
Table 3:	Models of clinician	217
Table 4:	Aspirational contours	242

Illustrations

Figure 1:	Diagrammatic representation of theory lenses	53
Figure 2:	Relational influences	171
Figure 3:	Patient positioning in relation to NQD identity claims	186
Figure 4:	Levels of medical hierarchy	189
Figure 5:	Repertoire of I-positions	221
Figure 6:	Contextual layers	240

List of Appendices

Appendix A	Questions to guide written reflections (previous study)	260
Appendix B	Interview schedule	261
Appendix C	Information sheet	262
Appendix D	Consent form	264
Appendix E	Ethical clearance (previous study)	265
Appendix F	Ethical clearance (this study)	266

List of Abbreviations / Acronyms

AAMC	Association of American Medical Colleges
ACGME	Accreditation Council of Graduate Medical Education (USA)
CanMEDS	Canadian Medical Education Directives for Specialists
COP	Community of practice
Comm. Serve. / CSO	Community Service / Community Service Officer
DoH	Department of Health
DST	Dialogical Self Theory
ECL	Early career learning
GMC	General Medical Council (UK)
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
LPP	Legitimate peripheral participation
MBBCh	Bachelor of Medicine & Bachelor of Surgery (equivalent to MBChB)
MDR	Multi drug resistant
MO	Medical Officer
MOPD	Medical out-patients' department
NI	Narrative Interview
NQD	Newly qualified doctor
NRMSM	Nelson R Mandela School of Medicine
O&G	Obstetrics and Gynaecology
PBL	Problem based learning
POPD	Paediatric out-patients' department
Reg.	Registrar
TB	Tuberculosis
T, L & A	Teaching, Learning and Assessment
UK	United Kingdom
UKZN	University of KwaZulu-Natal
USA	United States of America
VAD	Vacuum assisted delivery
XDR	Extreme drug resistant
ZPD	Zone of proximal development
Key to conventions in presenting narrative data	
Name, int.	participant interview
Name, writ refl.	participant written reflection
P:	participant
R:	researcher
[]	denotes insertion of missing word or explanatory note
[R:]	researcher interjecting during interview
(.)	pause while speaking
()	description of pitch or tone
===	sustained sound of preceding vowel / consonant
<i>italics</i>	emphatically expressed

Table of Contents

Abstract	i
Declaration of originality	iii
Dedication	iv
Acknowledgements	v
List of Tables and Illustrations	vi
List of Appendices	vii
List of Abbreviations / Acronyms	viii

Chapter 1:	Introduction	1
1.1	Focus of the study: learning and identity of newly qualified doctors	2
1.2	Background and regulation of medical internship	4
1.2.1	Introduction to internship in the South African context	5
1.3	Limitations of dominant research methodology in medical education	6
1.4	Introduction to study design	8
1.4.1	Key research questions	9
1.4.2	Researcher motivation	10
1.4.3	Introduction to narrative methods	11
1.5	Introduction to socio-cultural theoretical framework	12
1.6	Organisation of the thesis	13
Chapter 2:	Literature Review	16
2.1	Introduction	16
2.2	Methodological state of medical education research on internship	19
2.2.1	Problem-based learning in medical education	19
2.2.2	‘Preparedness for practice’	22
2.2.3	Research involving NQDs in the South African context	24
2.2.3.1	Competency evaluations	25
2.2.3.2	Holistic experience-centred research	26
2.2.4	Competency approach in medical education	28

2.2.5	The identity construction gap	29
2.2.5.1	Identity, the 'self' and relationships	30
2.2.6	Need for a paradigm shift	33
2.3	Experiences of medical internship	34
2.3.1	Hours of work	34
2.3.2	Emotionality and stress	36
2.3.2.1	A view from the outside	37
2.4	Internship learning	38
2.4.1	Apprenticeship and conceptions of learning	38
2.4.2	Early career learning (ECL) across the professions	40
2.4.2.1	A multi disciplinary theory of relationships	42
2.5	Power, identity and leadership	44
2.5.1	Power dynamics, socialisation and influence of undergraduate medical education (historical perspective)	44
2.5.2	Power discourse (current)	46
2.5.2.1	Discourse of transformative learning for change	47
2.5.3	Discourse of patient-centred practice	49
2.6	Conclusion	50
Chapter 3: Theoretical Framework		52
3.1	Introduction	52
3.2	A theory of learning	54
3.2.1	A Vygotskian framework for learning and development	54
3.2.1.1	Engaging constructivism and constructionism	55
3.3	A theory of social practice	58
3.3.1	Situated learning, COP and LPP	58
3.3.1.1	Medical internship as early career learning?	61
3.3.2	Bourdieu's theorising: habitus, capital and field	62
3.3.2.1	Habitus and social constructionism	65
3.4	A theory of self, identity and identification	67
3.4.1	A case for synergising psychology and social theory through DST	68
3.4.1.1	Link to Vygotsky and Bourdieu	70

3.4.2	Self-representation in narrative form	71
3.4.3	Relationships and identity construction	72
3.5	Summary	75
Chapter 4:	Research Methodology	76
4.1	Introduction	76
4.2	Paradigmatic considerations	76
4.3	Selection of participants	80
4.4	Narrative approach	81
4.4.1	Rationale for narrative research methods	85
4.4.1.1	Limitations of narrative methods	86
4.4.2	Narrative data generation	89
4.4.2.1	Written reflections	89
4.4.2.2	Interviews	91
4.4.2.2.1	Interview process and schedule	92
4.4.3	Narrative data analysis	95
4.4.3.1	Structural analysis	95
4.4.3.2	Thematic analysis	97
4.5	Summary of phases of data generation and analysis	99
4.5.1	Phase 1 – socio-linguistic analysis of written reflections	100
4.5.2	Phase 2 – interviews	100
4.6	Ethics of research	100
4.7	Limitations of the study	103
4.8	Conclusion	105
Chapter 5:	The Narrative Data	106
5.1	Ezera	107
5.1.1	Introduction	107
5.1.2	Internship experience / journey	107
5.1.2.1	Critical incident – New Year at casualty	110
5.1.2.2	Medical Zulu Competence	112
5.1.2.3	Critical incident – patients uprising	113

5.1.3	Links to the undergraduate medical curriculum	115
5.1.4	Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)	117
5.2	Gillian	119
5.2.1	Introduction	119
5.2.2	Internship experience / journey	120
	5.2.2.1 Contextual factors and organisation of work	121
	5.2.2.2 Critical incident – poor supervision	124
5.2.3	Links to the undergraduate medical curriculum	126
5.2.4	Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)	128
5.3	Ian	130
5.3.1	Introduction	130
5.3.2	Internship experience / journey	131
	5.3.2.1 Language barrier	132
	5.3.2.2 Critical incident – failed vacuum assisted delivery	132
5.3.3	Links to the undergraduate medical curriculum	134
	5.3.3.1 Communicating bad news	135
	5.3.3.2 Foundational sciences vs developing a social life	136
5.3.4	Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)	136
	5.3.4.1 Developmental continuum metamorphosis	138
5.4	Juanita	140
5.4.1	Introduction	140
5.4.2	Internship experience / journey	141
	5.4.2.1 Learning processes, strategies and dispositions	143
5.4.3	Links to the undergraduate medical curriculum	145
5.4.4	Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)	147
	5.4.4.1 Power flows in medical internship	148
5.5	Lana	149
5.5.1	Introduction	149
5.5.2	Internship experience / journey	150

	5.5.2.1 Balancing family responsibilities and internship	154
	5.5.3 Links to the undergraduate medical curriculum	155
	5.5.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)	157
5.6	Philip	160
	5.6.1 Introduction	160
	5.6.2 Internship experience / journey	160
	5.6.2.1 Language barrier	160
	5.6.2.2 Critical incident – racial prejudice	162
	5.6.2.3 Time / resource constraints and biopsychosocial approach	163
	5.6.2.4 Learning strategies and dispositions	164
	5.6.2.5 Additional qualification Master of Business Administration (MBA)	164
	5.6.3 Links to the undergraduate medical curriculum	165
	5.6.3.1 Critical incident – acting (role-playing) doctors	166
	5.6.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)	167
Chapter 6: Relationships		170
6.1	Introduction	170
6.2	In relation to patients	172
	6.2.1 Positioning of patients by referential narrative content (what was 'told' by participants)	173
	6.2.1.1 Biomedical vs biopsychosocial approach	174
	6.2.1.2 Culpability	176
	6.2.2 Communicating with patients	177
	6.2.2.1 Issues of language	178
	6.2.2.2 Emotional distance or clinical detachment	180
	6.2.2.3 Issues of racism	181
	6.2.2.4 Breaking bad news	181
	6.2.3 Positioning of patients by narrative language (the 'telling') in relation to identity claims of NQDs	182
	6.2.3.1 Patients as work / learning / calling	185
	6.2.3.2 Patients as problems	187

6.3	In relation to internship COPs	189
6.3.1	Models of clinician	191
6.3.1.1	Caring (self-sacrificing) doctor	192
6.3.1.2	Excellent generalist	193
6.3.1.3	Supportive supervisor	194
6.3.1.4	Comrade CSO	195
6.3.1.5	Professional researcher / scholarly clinician	195
6.3.1.6	Medicine's 'Greats'	196
6.3.1.7	Power misuser / abuser	197
6.3.1.8	Self-interested senior	198
6.3.1.9	Contextually toughened clinician	199
6.3.2	Nurse practitioners	200
6.3.3	In the context of the South African Healthcare System	200
6.4	In relation to God	202
6.5	In relation to family	205
6.5.1	Female participants & family	205
6.5.2	Male participants & family	207
6.6	In relation to self (dispositions and aspirations)	208

Chapter 7:	Framing Relational Influences in Theory: learning, identity and power relations	210
7.1	Introduction	210
7.2	Learning in the clinical workplace	211
7.2.1	Learning Processes: from "Mind in Society" (Vygotsky) to "Society of Mind" (Hermans)	212
7.2.1.1	Development of clinical skills and clinical reasoning	213
7.3	Identity and ways of being in clinical practice	217
7.3.1	Modelling clinical practice	217
7.3.1.1	Covered or exposed	218
7.3.1.2	Positive 'other-positions' based on practice	220
7.3.1.3	Repertoire of possible 'I-positions'	220
7.3.2	<i>Habitus</i> , capital, and field in negotiating internship as 'fish-in-water' or 'fish-out-of water'	222

7.3.3	Disrespect	225
7.4	Power and relationships	227
7.4.1	Patterns of recognition or disrespect in power dynamics of medical culture	227
7.4.2	Shaped by and shaping influences	230
7.5	Conclusion	231
Chapter 8: Conclusions and new insight		232
8.1	Introduction	232
8.2	Research question one: What learning processes are evident in medical practitioners' reflections of their internship experiences?	232
8.3	Research question two: How do medical practitioners construct their (retrospective) identities as interns when reflecting on their development as NQDs?	236
8.4	Research question three: In what ways did internship experiences enable or constrain NQDs to become the practitioners they aspired to be?	239
8.5	Final reflection	245
8.5.1	An unasked question about relationships	245
8.5.2	Patient-centred practice?	247
8.5.3	Further research into power and identity	247
Reference List		250
Appendices		260

Chapter 1: Introduction

Medical internship is an essential but problematic part of the healthcare system in South Africa and internationally. A vast literature has interrogated the internship experience from the perspective of undergraduate medical curricula and competencies that newly qualified doctors (NQDs) might be expected to demonstrate on graduation, or to develop during internship. Historically, aspects of socialisation during internship have also been studied extensively by psychologists and sociologists. While the South African healthcare system depends on NQDs to provide a service in the public sector, especially in semi-urban settings, little is known about their lived experiences or their learning and identity construction.

The study presented in this thesis is an exploration of medical internship experiences through the reflexive medium of narrative. The focus of inquiry, which is clarified up-front in this chapter, especially pertained to the learning processes and identity constructions of NQDs during internship. The broad context for the study is the public healthcare sector in South Africa where medical interns engage in a clinical workplace-based learning programme prior to full registration as medical practitioners.

In the following sections of this introductory chapter, I describe the purpose and basic structure of medical internship elsewhere in the developed world, and then more specifically in South Africa. The limitations that arise in medical education research due to methodological constraints are then outlined, followed by an introduction to the design of this study and my personal motivation to conduct the research. I conclude the chapter by elaborating on the motive behind most medical education interventions; which is the intent to 'transform' healthcare delivery. However, a sense of disappointment prevails globally, expressed by various authors in the field of medical education, that some primary objectives, including greater patient-centredness, remain elusive (Gibbs, 2011). 'Medical culture' somehow manages to reproduce itself in ways that are found to be less than ideal (Apker & Eggly, 2004). This appears to me to be a distinct cue for more social and educational research studies to be conducted and to offer theory-rich explanations that would make explicit some of the socio-cultural aspects of medical internship.

1.1 Focus of the study: learning and identity of newly qualified doctors

A quotation drawn from a newly qualified doctor in this study points to key features of this study's focus. To quote Lana, "asking connects people ..." – it was a statement she made to emphasise her point that doctors should be approachable and be able to respond to the patient's questions in a manner that provides hope. This emblematic quotation points to the concerns of the thesis as a whole, since it indicates the centrality of learning – "asking [questions]" and of identity (being a questioner, being approachable and connected to others) and the relation between the two, which in this case, directly impacts on patient care – "connects people".

A question of learning

Research into learning processes associated with NQDs' learning in the clinical workplace has largely been guided by the notion that medical internship comprises an 'apprenticeship'. The term has generally been applied in the traditional sense of novices learning from experts (Sheehan, 2010). However, a contemporary model of apprenticeship is expounded, for example, in situated learning theory (Lave & Wenger, 1991), that offers conceptual tools for viewing internship learning in a more holistic manner. Bleakley, Bligh and Browne (2011) suggest that socio-cultural theories would best fit inquiry into the learning processes of NQDs. Although behaviourism and cognitivism are privileged perspectives in medical education, there are considerable motivations in the recent literature to broaden the theoretical underpinnings of medical education research, in order to gain fuller understandings of the contextual and relational aspects of clinical workplace-based learning (Bleakley et al., 2011; Hodges & Kuper, 2012; Mann, 2011).

Studies of Early Career Learning (ECL) across several professions have devised frames for thinking about the development of expertise in broad and general terms (Eraut, 2007). These frames have previously highlighted the importance of learning from others in the workplace, and therefore the need for 'good' relationships. However, the question of how a

person gains entry into medical culture, and is able to assume an identity within that culture (Bleakley et al., 2011) needs further elaboration of those relationships, and of their influence on the way NQDs negotiate learning in the clinical workplace. As I considered the learning processes of doctors to be socio-culturally mediated, with knowledge being constructed in interaction with others, the approach to this study broadly follows the philosophical tenets of social constructionism (Loftus & Higgs, 2010).

A question of identity

About identity and identification in medical education, the question has been asked “why should we care?” (Monrouxe, 2010, p. 40). Identity construction is arguably as important, if not more so, to the professional development of doctors as competence at concrete tasks and knowledge of foundational sciences. However, matters of identity have, by comparison, been neglected in medical education research. In the context of my study, identity construction is understood to be the process by which individuals position themselves in relation to others, the way they see themselves, and how they perceive that others see them; but also involving some expression of who they are not. Identities are seen as fluid and multiple and as an integral part of learning that acts as a “pivot between the social and the individual” (Wenger, 1998, p. 145). In conducting this study I aimed to answer Monrouxe’s (2010) question to some extent, as to why we should care about identity.

Medical internship is recognised as a crucial stage of development in shaping future medical experts. It is undoubtedly a time of intensive workplace-based learning, particularly when NQDs first transition from undergraduate medical education into clinical practice; and hence it is ideally placed for studying identity construction (Bleakley et al., 2011). In line with this reasoning, it seemed to me that medical practitioners’ reflections on their internship experiences were an apt place to start. In this study I document insights and understandings gained into the professional development journeys of six medically qualified participants in South Africa. Their personal experiences of medical internship, as they reflected on them from a more mature perspective, were the basis of my learning and theorising on the subject.

1.2 Background and regulation of medical internship

In most parts of the world, medical internship is a period of 12 – 24 months of postgraduate learning in clinical practice environments that are accredited healthcare facilities, and under the supervision of senior medical practitioners. The main aim of this period is to allow NQDs to build on their undergraduate education, gain experience in a range of clinical procedures, grow in independence and demonstrate competent performance as safe doctors (Prinsloo, 2005; Sein & Tumbo, 2012). Internship is also referred to by various terms, such as the 'Foundation Programme Years one and two' (FY1 and FY2) in the UK, previously known as the 'Pre-registration House Officer' (PRHO) year and 'first year as a senior house officer' (Higgins & Cavendish, 2006). In Australia the internship period is referred to as 'Postgraduate Years one and two' (PGY1 and PGY2), and this broadly equates to early 'residency' in the USA and Canada.

The regulation of medical internship varies considerably in different countries, leading to varying levels of infrastructure and support, which in turn is likely to result in quite different learning environments. For example, Canadian postgraduate medical education (PGME) is unique, in that all residency programmes are offered at universities, and residents are able to attend clinical rotations at multiple teaching hospitals affiliated to the university at which they are based (Pardhan & Saad, 2011). In the USA, residency programmes are based either at community hospitals or at tertiary institutions, introducing an element of choice or preference between academic medicine and solely clinical practice. All programmes are accredited by the Accreditation Council of Graduate Medical Education (ACGME). In the UK, on the other hand, the General Medical Council (GMC) regulates FY1 and FY2, but the programmes are implemented by postgraduate deaneries, not necessarily affiliated to any tertiary institution, and demarcated by geographical regions. Australia has a similar system where PGY1 and PGY2 are managed by postgraduate medical education councils of provincial and territorial regions (*ibid.*).

In countries where there is a greater involvement of tertiary institutions in the regulation of formal internship programmes, this generally appears to benefit the learning and

development of NQDs. For example, where Canadian universities are central to postgraduate medical education, it is claimed that NQDs are consequently provided with a more satisfactory internship learning experience. However, this degree of involvement is not the norm globally, and even in countries where universities do regulate internship, there are variations in how active a role they play (ibid.).

1.2.1 Introduction to internship in the South African context

Internship in South Africa is organised, regulated and administered by the Health Professions Council of South Africa (HPCSA) without involvement of tertiary institutions (Sein & Tumbo, 2012), except that the clinicians employed by the Department of Health (DoH) who also supervise interns might be affiliated to a university. Placement of NQDs at internship sites is based on an individual's ranked preferences of regions as indicated during their final year at medical school, and depends on the availability of internship posts at particular teaching sites. Teaching sites comprise facilities at various levels of the healthcare system, including national and provincial hospitals (Level III), regional hospitals (Level II) and community hospitals (Level I), either on their own or in combination (Smuts, 2011). Interns are required to remain at the same institution(s) for the two years of internship; therefore the choice of site becomes an important factor in their development as practitioners. During this time, NQDs rotate through the major clinical disciplines of medicine, namely Internal Medicine, General Surgery, Paediatrics, Obstetrics and Gynaecology, and Family Medicine / Primary Care. The current programme of rotation includes four months in each of these specialities as well as two months each in Anaesthetics, Orthopaedics and Trauma (Smuts, 2011).

Medical internship was introduced in South Africa in the 1950s as a loosely structured year-long period and has evolved since then (Meintjes, 2003). The current structure of rotations as a two-year programme was phased in from 2005 for some graduating cohorts and 2006 for others (Sein & Tumbo, 2012). All NQDs in South Africa are currently required to complete two years of internship followed by one year of mandatory community service at

various healthcare facilities as designated by the HPCSA. Therefore, it is only after completing three years of post-qualification service that NQDs are free to commence employment, or to embark on further specialisation, entirely of their own choosing.

Although the HPCSA has accreditation criteria in place, there are numerous situational challenges relating to the management of healthcare facilities in South Africa, which give rise to considerable variation between healthcare facilities, and although it is hoped that interns receive an adequate learning experience (Jaschinski & De Villiers, 2008), the topic of internship learning has not been adequately researched. Support for NQDs is dependent on a range of factors such as the motivations of senior colleagues, and numerous, specific, situational factors at internship sites. Whether clinical learning contexts for medical interns comprise of academic, community-based or rural healthcare facilities, on their own or in combination, would also influence the learning experiences of NQDs. Therefore it is important that research into internship learning should attend adequately to the environmental, cultural and other contextual details and the different ways in which diverse individuals may relate to these contexts.

1.3 Limitations of dominant research methodology in medical education

To extend the idea that questions can serve a variety of relational functions in research studies on medical internship, the kind of questions and how they are asked would frame the depth of insight and understanding gained. Many of the research questions that have been asked about internship appear to have focused on teacher-centred or systemic political interests and miss the mark of a genuinely intern-centred world. Medical educators, whether their efforts are concentrated on lecturing, facilitating learning, administration or clinical tutoring, appear motivated to find out whether their work has accomplished what was intended. Knowing whether the stipulated learning outcomes of undergraduate curricula have been realised is also of considerable importance to inform further curriculum design and development. Therefore the literature abounds with studies that have focused on 'preparedness for practice'. The question has been asked if curriculum design makes a

difference to preparedness and it has been answered, not surprisingly, in the affirmative (Bleakley & Brennan, 2011). As institutions of higher education need to be accountable for the quality of their undergraduate learning programmes, graduates have also been assessed and compared on their ability to demonstrate various competencies (Wijnen-Meijer, Ten Cate, van der Schaaf, & Borleffs, 2010). Lists of capabilities and graduate attributes deemed necessary for internship have been compiled and evaluated (Wijnen-Meijer, Kilminster, Van Der Schaaf, & Ten Cate, 2012).

Giving and receiving feedback (A. N. Kluger & Van Dijk, 2010), role modelling (Passi et al., 2013) and demonstrating professionalism (Parker, 2006) are also prevalent discourses that have been highlighted by studies aimed at the scholarship of clinical teaching. Hopefully these endeavours have been motivated by more than simply needing to validate current practice in medical education. Descriptive studies abound. However, there is a disturbing lack of in-depth understanding regarding the effects of pedagogical change on the lived experiences of NQDs (Gibbs, 2011).

Some specific long-standing issues associated with medical internship such as elevated stress levels, excessive workloads and sleep deprivation have also been investigated. However, studies that have holistically explored the personal experiences of NQDs are not commonly found in the literature (Tallentire, Smith, Skinner, & Cameron, 2011). Studies that focus on self-categorisation in medical students and junior doctors have been all but invisible (Monrouxe, 2010). A reasonable explanation for this deficit is the mismatch between the methodology that medical education researchers generally consider valid and acceptable and the methodology needed to meaningfully explore identity construction. While positivist research methodology dominates the field of medical education, some authors have called for medical education to be structured rather as a social science (Monrouxe & Rees, 2009). Regehr (2010, p. 38) advocates replacing the ever-present “imperative of proof” with an “imperative of understanding” and suggests that moving from an “imperative of simplicity to an imperative of representing complexity well” would possibly revolutionise the educational endeavours of medical educationists.

Studies that adequately employ educational and social theory frameworks have been scarce in the medical education literature overall (Brosnan, 2013; Bunniss & Kelly, 2010; Hodges &

Kuper, 2012; Rees & Monrouxe, 2010b). Meaningful research using more appropriate theoretical framing is increasingly called for (Mann, 2011), and would be essential to gaining an understanding of various facets of internship experiences. Thus studies founded on more reflexive methodology and framed by social theories (Brosnan, 2013) are needed to establish a deeper understanding of clinical workplace learning and identity construction during internship (Bleakley et al., 2011). Therefore this study is situated within the interpretive paradigm and employs a theoretical framework consistent with social constructionism. The following section introduces the reader to the research methodology, the theoretical underpinnings of the study and my own interest behind engaging in this research.

1.4 Introduction to study design

When initially conceptualising this study and influenced by the extant literature, I too set out with the notion of finding links between internship practice and a problem-based learning (PBL) curriculum innovation at the University of KwaZulu-Natal (UKZN), South Africa. This curriculum was first implemented in 2001 (referred to as 'Curriculum 2001' within the institution) and all the participants in this study belonged to the pioneer cohort of graduates. I solicited written reflections on internship experiences from a group of NQDs three years post-qualification, when participants had completed their two-year internship and one year of community service. In relation to the broad question 'What prepared you for internship and community service?' participants responded to a set of sub-questions to guide their reflections (see Appendix A). What emerged from the participants' written narratives, however, was that the lived experiences of internship involved rather 'steep learning curves' with which *they* had been primarily concerned. Although some links to the PBL curriculum were duly provided, undergraduate learning was relegated to being foundational, while all participants emphasised the intense learning that inevitably took place *after* graduation in the clinical workplace environment. Therefore I adjusted my focus

accordingly to explore the learning processes and identity construction taking place during internship.

The original written reflections were socio-linguistically analysed for narrative positioning and used to generate questions for seeking further elaboration and explanation during follow-up interviews with the same participants. This introduced a longitudinal element to the study, whereby I was able to gain insight into the professional development journeys of NQDs from their more mature perspective six years post-qualification. The change of focus also made it possible to elicit a detailed account of participants' aspirations, how these might have changed over time, and what had enabled or constrained participants in becoming the kind of practitioners they aspired to be. These aspects relating to identity constructions of NQDs are rarely mentioned in the extant literature in medical education, and I hoped that this study would shed light on some of the persistent problems associated with medical internship. With this goal in mind, the key research questions addressed by study were as follows:

1.4.1 Key research questions

- What learning processes are evident in medical practitioners' reflections of their internship experiences?
- How do medical practitioners construct their (retrospective) identities as interns when reflecting on their development as NQDs?
- In what ways did internship experiences enable or constrain NQDs to become the practitioners they aspired to be?

1.4.2 Researcher motivation

My personal interest in medical education research developed from various involvements in the above-mentioned PBL curriculum innovation, and from being a mentor in a Christian faith-based mentorship programme to a group of students from the pioneer cohort of PBL students. I had the questionable privilege of listening to a group of about 12 – 15 medical students express numerous concerns and complaints about the “new curriculum” and the challenges they had encountered with the administration thereof. Various things that bothered them about being the so-called ‘guinea pigs’ of this newly implemented curriculum were regularly articulated with considerably heightened emotion. I was therefore most interested to find out how they had fared as NQDs and how they had developed as medical practitioners. Thus by engaging in this study, I intended to formally document and learn from the (auto)biographical experiences of doctors who had been pioneer graduates of the PBL curriculum.

Reflecting back on my own life history, I realised that I have had a lengthy and close association with medical professionals throughout my career; first as a medical biochemist working in a clinical chemistry laboratory, and then as a research assistant, technician and administrator in Forensic Medicine. As a result I have had ample opportunity, for more than 25 years, to work with doctors from various disciplines, particularly pathologists, but also clinicians while I participated in teams that planned and co-ordinated undergraduate curriculum activities. During this time, I also obtained a Masters degree in Higher Education, for which I engaged in a research study of medical students’ perceptions of learning from autopsies. I attribute my innate curiosity about how doctors learn empathy (or a lack thereof), and how they develop as professionals, to my associations with numerous medical students and various medical practitioners.

However, I need to declare upfront that it is possibly my personal experiences of being a *patient* at various points in time, as well as my role as the spouse of a patient who suffered a prolonged period of illness, that have motivated me the most towards wanting to ‘grow good doctors’. My motivation to formally undertake this study arose from closer interactions with students as a facilitator and mentor in the PBL curriculum, *and* while being at the receiving end of a lack of patient-centredness demonstrated by specific medical

professionals. I thus positioned myself as a researcher in a combination of both insider (to the field of medical education, with knowledge of foundational sciences and higher education) and outsider (non-clinician) roles. I have been both a confidante and friend to many medical practitioners and students, but am also able to exercise a high degree of criticality as a student of medical culture and medical education research overall.

In this in-depth qualitative exploration of practitioners' personal experiences, using narrative research methods, I was able to investigate the developmental journeys of becoming doctors, with particular reference to learning processes and identity construction during internship.

1.4.3 Introduction to narrative methods

Narrative research methods, employing a hermeneutic approach, are 'fit-for-purpose' in a study aiming to elicit a deeper understanding of others' experiences, whether personal or professional (Loftus & Higgs, 2010). Human beings make sense of their lives and the world around them by the stories they choose to tell or not to tell. The intrinsic properties of narratives as temporal (having a time-line or sequence), contextual (providing details of situations, individuals and supporting actors) and capturing transformation (as themes develop or resolve) make them the ideal means to investigate human experiences as they are lived, in time, space and relationship, and how they change over time (Andrews, Squire, & Tamboukou, 2008). Narrative methods are not suited to drawing categorical conclusions and generalisations; however, they are a source of personal truths that are an important way to access the meanings behind particular social and educational issues.

In this study the narrative data were viewed with a considerable degree of transparency in that participants were regarded as the experts in what they had experienced. However, the narratives were also regarded as co-constructions between the author and the audience. Therefore my presence in the texts, as the narrative researcher, whether physically present or not at the time of data generation, needed to be accounted for, and was an essential part

of interpreting the data. The referential content was generally taken to be a particular representation of personal experience, though not considered as a ‘factually accurate’ revelation of the past (see section 4.4 Narrative approach p. 81). As discussed in greater detail in the chapters on theoretical framing and research methodology, close attention to narrative form and language was also regarded as yielding insights into positionality (of the self and other), particularly when narrators might not have been fully aware of the positions being portrayed.

Interpretive research is never a ‘quick fix’ intervention that can be analysed pre- and post-test. It requires extensive engagement with relevant bodies of theory as well as the literature on the subject and a deeply thoughtful approach to make meaningful interpretations of the data. Therefore the findings of this study should be judged on the basis of authenticity, trustworthiness and transferability. Whether readers are able to identify with the stories of NQDs from their diverse perspectives, as educators, educational researchers, doctors, patients or even as fellow human beings, is most important.

1.5 Introduction to socio-cultural theoretical framework

The thesis adopted five main theories to conceptualise and analyse participants’ learning processes and identities, based on the assumption that these are intricately connected. Regarding learning, Vygotsky’s (1978) theories about the role of others in the development of higher mental functioning aligned well with an epistemology of social constructionism. Situated learning theory (Lave & Wenger, 1991) provided some helpful elaborations, demonstrating the explanatory potential of applying socio-cultural learning theories to make meaning of learning processes in the clinical workplace, and to trace the developmental journeys of NQDs.

Theories on *habitus*, capital and field (Bourdieu, 1990) were helpful for interpreting the ‘ways of being’ of medically qualified persons, and for considering social contexts and culture, and the reproduction of social structures. Bourdieu (1992) is also credited with

describing how individuals might be ‘fish-in-water’ or ‘fish-out-of-water’ depending on their *habitus* (or sets of dispositions – see section 3.3.2 Bourdieu’s theorising: *habitus*, capital and field p. 62) and various types of ‘capital’ they might deploy in playing the ‘field’ or social structures to which they belong (Bourdieu, 1990). In my study I have used these ideas to interpret how and why NQDs positioned themselves in particular ways in relation to others in clinical environments in which they found themselves. Networks of relationships within internship communities of practice as well as personal dispositions and aspirations were especially found to enable or constrain internship learning and the development of positive identities as medical professionals. Links between learning and social practice were effectively provided by the concepts of situated learning such as ‘community of practice’ (COP) and ‘legitimate peripheral participation’ (LPP) as defined by Lave and Wenger (1991).

Regarding identity, Hermans’ Dialogical Self Theory (Hermans & Hermans-Konopka, 2010) added an analytically useful psychosocial view to describe the fluidity of identity constructions during internship practice, and the role of significant others in self-positioning. Honneth’s contemporary philosophy of recognition and disrespect (Honneth, 2007, 2012) provided tools for theorising about the quality of learning relationships with various others, particularly with senior clinician colleagues, who enabled or constrained positive identity constructions.

1.6 Organisation of the thesis

The remaining chapters in this thesis have been arranged as follows:

Chapter 2 Literature Review: discusses the methodological landscape in medical education; relevant literature has been grouped into PBL undergraduate curricula and the perceived ‘preparedness’ of graduates, competency frameworks of professional roles, and the need for a shift in research paradigms. Studies on medical internship experiences and related issues are reviewed; the ways in which internship learning might be considered and the

power flows in medical practice that affect internship are outlined. The review is concluded by linking these various aspects to the goal of patient-centred practice.

Chapter 3 Theoretical Framework: organises the theories framing the study into three broad areas: learning, social practice, and the self or identity. Learning as participation is framed by Vygotsky's ideas about intra- and interpersonal thought and situated learning. Individual and collective 'ways of being' are linked to the nature of learning relationships in the clinical workplace by using Bourdieu's concepts of *habitus*, capital and field. I elaborate on the need for 'good' relationships and mutual respect, drawing on a multi-level theory of recognition and disrespect; and theorising about multiple self- and other-positions of Dialogical Self Theory.

Chapter 4 Research Methodology: begins by aligning the study's social constructionist philosophical underpinnings with the interpretive paradigm. Methodological choices pertaining to participants, the involvement of the researcher, and the way this study was conducted in two phases, are communicated here. The rationale for using a narrative approach, the various methods of data generation and analysis employed are detailed. Ethical aspects and the limitations of the study are also deliberated.

Chapter 5 The Narrative Data: presents each of the participants' narratives separately, organised in a similar chronology and thematic arrangement. The internship experience, particular critical incidents and evaluations are presented, followed by links back to the undergraduate curriculum and a retrospective view of internship from the participants' current perspectives. This chapter enables a longitudinal view of the data pertaining to each NQD's story.

Chapter 6 Relationships: discusses the inferences made from the study regarding relational influences during internship, as found in the narrative data. As such, a composite map of the categories of relationships is presented; and comparisons are made by evaluating similarities and differences between cases. Insight into individual dispositions and aspirations, and how internship experiences and learning trajectories are negotiated, is gained through a cross-sectional view of the data.

Chapter 7 Framing Relational Influences in Theory: learning, identity and power relations:

arranges the data according to various theoretical constructs and prevalent discourses. This chapter is therefore another cross-cutting comparison of the narratives that enables different insights, as the data are viewed from an analytic perspective focusing on theoretical coherence. A theoretical suggestion is made regarding the influence of learning relationships as contributing to a repertoire of I-positions for NQDs' identity constructions.

Chapter 8 Conclusions: presents the final arguments of the thesis in relation to the key research questions. A visual summary of findings relating to the aspirational contours of each participant leads to generating further understanding how doctors shape and are shaped by practice. My reflections on my learning from this study and suggestions for future research are included here.

Chapter 2: Literature Review

2.1 Introduction

A literature review should serve to orientate the reader to a panoramic view of the broad 'state of the field' as well as to chart more specific details pertinent to the area of a study. It therefore requires the researcher to demonstrate their engagement in appropriate ways with work that has already been done. It is not sufficient to simply summarise and describe the work of others, but to draw similar schools of thought together, compare and contrast these with differing views, organise the work into themes, and all the while identify where gaps and inadequacies exist (Bell, 2005). Reviewing the literature, as an activity, is therefore part and parcel of every stage and process of a research project from inception to completion, from choosing a topic and designing a proposal to drawing conclusions from the findings. However, as a chapter in a thesis, the 'literature review' is bounded, albeit fuzzily, by the need to justify and provide a rationale for each 'move' of the study. It also aims to communicate to the reader the positioning of the researcher as a scholar within the field. As a professional and practitioner the researcher's pedagogical, methodological and even experiential stance should become evident, and how these influence various aspects of the study. In other words, why things are done a certain way and not another needs to be made explicit in this chapter (Murray, 2002).

With the above expectations in mind, in this chapter I first substantiate my belief that many of the conceptual gaps in the literature on medical internship are due to an over-reliance on the research methods of the natural and physical sciences in general. I discuss how and why these research methods are often inappropriately applied to medical education research. Accordingly I begin with an overview of the methodological state of medical education research globally, as relevant to this study. I also propose that, due to the dominant positivist orientation of the majority of researchers in the field (Mann, 2011), there is a need for more reflexive studies framed by social theories (Bleakley et al., 2011; Brosnan, 2013). Such studies would have the potential to add a depth of understanding and enable the generation of meanings needed to adequately explore long-standing issues and concerns around medical internship.

‘Preparedness for practice’ following various curriculum innovations is a dominant discourse found in the literature pertaining to postgraduate medical education. As problem-based learning (PBL) has been a widespread vehicle for these innovations, I provide some background information regarding the broad landscape of PBL in medical education. Studies that have focused on preparedness and the methodology employed in these studies are discussed, along with some trends noticeable over time. An overview of the literature pertaining to NQDs in the South African context is included next, with possible reasons for the lack of research or ‘gap’ that is apparent in this area.

The ‘competency approach’ within medical education is also identified as having contributed to a reductionist trend in research methodology. There are, however, authors in the field deliberating what is awry in medical education research and advocating that researchers move away from the constant quest for proof of what has ‘worked’ or has not, towards gaining deeper understanding (Regehr, 2010). Therefore I explain how I have deliberately tried to counter dominant methodology with the application of narrative methods, which have arguably become commonplace in social and educational research, but are yet rarely employed in medical education research (Bleakley, 2005).

I then attempt to tease out the multiple possible ways in which internship learning might be viewed, for example as an apprenticeship, an induction/initiation/right-of-passage, as situated learning whilst joining a community of practice (COP), and as early career learning (ECL). Studies that explore various aspects of internship experiences are included throughout, with a broad overview of their findings, as this is the primary area relevant to my study. Not many of these studies of medical internship are explicitly framed by socio-cultural theories; however, the few that exist highlight the importance of identity construction (Bearman, Lawson, & Jones, 2011; Sheehan, Wilkinson, & Bowie, 2012). I argue that the previously mentioned methodological constraints have resulted in a notable absence of in-depth research into the identity construction of NQDs. This is the gap that I have aimed most comprehensively to address in this study, especially regarding the role of NQDs’ relationships to significant others, to organisations, and to institutions in the learning processes of becoming doctors.

A review of the literature concerning learning and identity construction during medical internship would not be complete without some exposition of the historical work done, mostly by researchers *outside* the field of medical education. Research into aspects of medical socialisation of undergraduate students and NQDs has been conducted by psychologists and sociologists who have long questioned the power imbalances in medical education and why there is an overarching theme of stress and suffering persistently associated with medical internship. They have engaged in scholarly discussions of the topic for over 50 years and reported that a regimented hierarchy and overwhelming workloads contribute to the stressfulness that is reportedly experienced by NQDs (Light, 1988). Some of these researchers have made suggestions that seem highly relevant even to current problems facing the medical profession; however, it appears that sociological methodological traditions that might yield a better understanding of the subject, have largely been side-lined by clinician-led institutions in the past (Levinson, 1967).

More recently, however, there has been a resurgence of interest in issues of power, dominant hierarchies and hegemony in medical practice (Bleakley et al., 2011; Donetto, 2012; Gabel, 2012a; Schryer, Lingard, Spafford, & Garwood, 2003). Considering the developmental journey of a NQD through a lens of transformative learning provides another useful perspective (West, 2014). In addition to negotiating the inevitable crisis or “disorienting dilemma” (Mezirow, 1990, pp. 13-14) of transitioning from medical school into the world of healthcare service, there is an expectation that leadership qualities will be developed through transformative learning (Frenk et al., 2010). Doctors are also expected to function as leaders and in other powerful positions in the course of their daily work (Gunderman, 2011). As identity construction and relational aspects are inseparable from power dynamics, I conclude the chapter with a brief look at some relevant literature pertaining to the outworking of power during medical internship, and the possible impact on patient-centred practice.

2.2 Methodological state of medical education research on internship

Research from within the field of medical education into the early career learning (ECL) of medical interns has thus far been primarily concerned with the development of “knowledgeable skills” (Lave & Wenger, 1991, p. 94). Various clinical capabilities are essential for medical practitioners to demonstrate (World Health Organisation, 2013), and they are the easier attributes to quantify and report on from the technical perspective that predominates over experiential and socio-cultural approaches. Therefore the tradition of measuring competence for practice is likely to continue as the mainstay of research done by clinical educators. Typically these kinds of studies emanating from various parts of the world focus on some curriculum innovation or assessment-related activity and investigate whether graduates are able to translate what they have learned as undergraduate medical students into their practice as NQDs (Wijnen-Meijer, Cate, Rademakers, Van Der Schaaf, & Borleffs, 2009; Wilkinson & Frampton, 2004).

2.2.1 Problem-based learning in medical education

Innovations in undergraduate medical curricula have been widespread and on-going in recent decades, especially since the advent of PBL. Howard Barrows is widely acclaimed to have been the originator of PBL at McMaster University in 1968. In his book *Problem-Based Learning Applied to Medical Education* (Barrows, 2000), he suggests that students of a PBL curriculum could be expected to become independent, reason their way through patient problems, and recall and apply to the care of their patients what they have been taught in medical school. They should also recognise when their skills and knowledge are not adequate to the clinical task they are confronting and acquire new information and skills as they need them; and as medical research moves ahead, keep contemporary in their knowledge and skills. Clearly some of these outcomes, especially those pertaining to patient care and keeping updated, can only be adequately assessed *after* graduation as they pertain to the work and the continued learning of practitioners.

Two cohorts of graduates from Liverpool were asked about their PBL curriculum six years after graduation and it was found that, despite being conscious of some deficiencies in their science knowledge (considered as basic to medicine), they were satisfied with the way they had been prepared for medical practice (Watmough, O'Sullivan, & Taylor, 2010). Previously, during internship, the same graduates had reported concerns about their perceived lack of knowledge in the sciences such as anatomy, pathology and therapeutics, although this had not appeared to affect their clinical work as junior doctors (Watmough, Garden, & Taylor, 2006). Canadian graduates from McMaster and other medical schools, when asked to reflect back on their PBL curricula, valued the opportunities they had for collaborative learning, the memorable contextualised teaching material, and the capacity for evaluation developed through the PBL process (Lohfeld, Neville, & Norman, 2005). Similar findings have been reported in a South African study that compared graduates of a traditional curriculum with those of a new Graduate Entry Medical Programme (GEMP) incorporating PBL at the University of the Witwatersrand. Graduates of the GEMP programme compared favourably on communication skills and teamwork, although these graduates also perceived some gaps in their science knowledge, specifically referring to the coverage of the microbiology and therapeutics content in the programme (Smuts, 2011).

It is generally understood that PBL was originally intended to be an overarching curriculum concept rather than simply one of many teaching strategies; though in recent times hybrid curricula combining PBL with other teaching methods have been introduced (D. Taylor & Miflin, 2008). PBL was not devised as an outworking of educational theory per se, but several theories have been linked to PBL over time in attempts to explain how and why such curricula may be effective (Hamdy, 2008). Cognitive theories of learning such as discovery learning, learning in context, the importance of activating prior knowledge and the retrieval of information, apparently dominated the discourses in the seventies; whilst more of the social aspects of learning and emphasising the importance of small groups, were prominent in the eighties (Hamdy, 2008). As the use of PBL spread, theories of constructivism, student autonomy (Boud, 1988), elaboration of knowledge, integration, surface (strategic) and deep learning (Newble & Entwistle, 1986) have also joined the “constellation of concepts or educational principles associated with PBL” (D. Taylor & Miflin, 2008, p. 743). Kolb’s (1984) experiential learning theory and andragogy or adult learning theory (Knowles & Associates,

1984) have been traditionally linked to PBL pedagogy. However, a more recent view is that PBL curricula are also consistent with complexity theory and socio-cultural approaches towards workplace learning, where learning is seen as gaining access to knowledge distributed across persons and artefacts (Bleakley, 2006).

There are some core elements of a PBL curriculum which have remained consistent despite numerous adaptations to suit contextual parameters and to accommodate various conceptions of learning held by practitioners. These elements include the presentation of clinical problem(s) to students prior to them engaging with specific resources related to issues in the cases, and small group tutorials which are facilitated by a tutor in the role of 'facilitator of learning' rather than of 'subject expert' or conveyor of knowledge. Further common elements include: small groups participating in a collaborative learning process to identify the main issues, during which they access prior knowledge, generate hypotheses and formulate learning goals; a student-driven inquiry process follows over a few days, when students select appropriate resources; and finally, groups return to a feedback tutorial to present and share new knowledge gained and apply this to the problem(s) at hand (D. Taylor & Mifflin, 2008).

It appears that PBL curricula were designed primarily to improve the student learning experience during undergraduate medicine compared to traditional curricula based on didactic lectures and tutorials. PBL pedagogy is also expressly aimed at producing doctors who are self-directed, lifelong learners. Reformation of medical curricula in general has also been, implicitly or explicitly, to bring about a shift in the ideology of medical practice by focusing more on a biopsychosocial approach towards patient care instead of the traditional biomedical approach (Wilkerson, Stevens, & Krasne, 2009). In this climate of widespread curriculum reform, however, there remains a lack of clarity regarding the effects of pedagogical change on the lived experiences of NQDs. Researchers have attempted to compare graduates of PBL curricula with those of traditional curricula using very large numbers of participants (± 750 -1500 medical practitioners), for example in the Netherlands (Prince, Van de Wiel, Van der Vleuten, Boshuizen, & Scherpbier, 2004) and Canada (Tamblyn et al., 2005). The question of whether continued competence many years after graduation might be linked to the undergraduate curriculum experienced by a practitioner has also been investigated in the Netherlands (Schmidt, Vermeulen, & van der Molen, 2006) and

Canada, despite the authors of the latter study recognising such a link to be tenuous (Norman, Wenghofer, & Klass, 2008). Medical educators therefore have not reached a consensus on whether PBL curricula are any better than traditional curricula (Tavakol, Dennick, & Tavakol, 2009). Barrows (2000) himself expressed his disappointment with the many studies that have been carried out supposedly to evaluate the effectiveness of PBL, as it is not known whether the curriculum changes have in fact eased the school-to-work transition for graduates or produced in them the kind of attributes which were anticipated.

2.2.2 *'Preparedness for practice'*

As NQDs are likely to be a source of crucial information regarding the impact of curricula, numerous studies have focused on surveying generalised preparedness for practice (Lempp, Cochrane, Seabrook, & Rees, 2004) or measuring some aspects of graduate performance as indicators of whether a particular curricular innovation had been effective or not (Tamblyn et al., 2005). Graduates from medical schools across countries such as the UK (Bleakley & Brennan, 2011; Brennan et al., 2010; Illing et al., 2013), Canada (Lohfeld et al., 2005), and Australia (Bearman et al., 2011) have been asked for their opinion on how well they were prepared for practice as NQDs. The general consensus about undergraduate curricula appears consistently to be that 'learning on the job' in supportive environments is of paramount importance. Therefore institutions that do not offer meaningful opportunities for workplace learning fall short of graduate expectations (Bearman et al., 2011; Bleakley & Brennan, 2011; Illing et al., 2013).

Graduates of UK medical schools were recently reported to concur that they were adequately prepared for clinical skills, communication skills and teamwork, regardless of the medical school they had attended (Illing et al., 2013). This finding differs from some older studies, for example where Goldacre, Davidson and Lambert (2003) reported over 40% of NQDs in the UK felt inadequately prepared and that there were considerable differences between graduates' preparedness depending on which medical school they had attended. Even follow up studies done a few years later reported that the variations between different

schools had persisted, although perceptions of preparedness to perform a variety of clinical functions had improved considerably (Cave et al., 2007). The contrasting findings of more recent studies are most likely to be a reflection of the various refinements to curricula aimed at increasing the relevance of undergraduate learning to clinical work, and better support being provided to NQDs (Cave, Woolf, Jones, & Dacre, 2009).

Quantitative methods have been used in many of the studies conducted globally, to survey self-perceived preparedness for practice (Cave et al., 2009; S. F. Smith, Roberts, & Partridge, 2007; Wijnen-Meijer et al., 2010). Qualitative methods have also been employed for data generation, especially within the past decade. For example, focus group discussions (Watmough et al., 2006), one-to-one interviews (Illing et al., 2013; Lempp et al., 2004; Watmough et al., 2010), and audio-diaries (Brennan et al., 2010) are methods used to generate data about graduates' preparedness, using a grounded theory approach (Illing et al., 2013). However, the processing and interpretation of findings are often limited to thematic descriptions emerging from the data, with data analysis being restricted to referential aspects alone (see section 4.4.3 Narrative data analysis p. 95).

Essentially positivist notions are commonplace in the handling even of qualitative data, such as, reducing the "possibility of bias" (Watmough et al., 2010, p. 3) by requiring interviewers to be unknown to interviewees, and requiring multiple researchers to agree on a set of themes as an essential step for validity claims (Brennan et al., 2010). I would argue that these positivist conceptions pertaining to objectivity and generalisability, which are prevalent in medical education research, curtail opportunities for interviewer sensitivity in generating and interpreting data. Using a very different social research approach, West (2000, 2001) examined the (auto)biographies of doctors working under stressful conditions in the inner-city of London. His work deliberately connects the subjectivities of learners and researchers for a deeper understanding of learning processes and for deciding on themes. West (2001, 2014) advocates resisting the temptation to adopt a conventional 'objective' and distant stance, in favour of "taking time to build trust and mutual understanding" (p. 171). In my view, opportunities would be missed by assuming such an objective and distant stance, to probe for further detail when researchers intuit that there might be important information not being disclosed. Where participants are either unaware of or uncomfortable with vocalising certain sensitive socio-cultural or relational issues, these

would also remain unexplored. This argument has been further elaborated in the chapter on research methodology (see section 4.4 Narrative approach p. 81). Furthermore, novel ways of thinking about data are made possible through the use of appropriate theoretical framing in interpretive studies (see Chapter 3 Theoretical Framework p. 52) rather than relying on several researchers having to agree on themes for processing data.

Despite a global climate of extensive curriculum reform in undergraduate medicine, minimal research has been done on the first two years of post-university training with the specific aim of obtaining holistic and meaningful data from graduates. Existing research relating to internship has arguably focused too broadly on the theme of preparedness for practice, or too narrowly attempted to measure various competencies and skills necessary for clinical practice (Tallentire et al., 2011). Qualitative feedback and an in-depth perspective of NQDs would be crucial for purposes of informing curriculum revisions taking place at undergraduate level, and for understanding internship learning and identity construction.

2.2.3 Research involving NQDs in the South African context

Very few studies have explored the translation of pedagogy to practice or the lived experiences of NQDs in South Africa. Within the past decade, the gap in the literature pertaining to NQDs from within South Africa has been even more pronounced (Smuts, 2011) than in the literature emanating from more developed countries described in the previous section. Most South African medical education research on graduate attributes is done by medical faculty members and focuses on students currently enrolled for either undergraduate or postgraduate learning programmes at accessible institutions (Burch et al., 2011; Draper & Louw, 2011; Jaschinski & De Villiers, 2008; Peters, van Wyk, & van Rooyen, 2015). Access to former graduates is a likely constraint, as the internship period in South Africa is not directly regulated or managed by universities (see section 1.2.1 Introduction to internship in the South African context p. 5). In addition, a considerable number of South African graduates emigrate (Burch et al., 2011), while others might be dispersed around South Africa, including placements in remote, rural areas (Peters et al., 2015). Therefore,

due to various challenges, studies that evaluate NQDs' experiences, in relation to undergraduate curricula, or that explore other aspects of internship learning, are generally scarce within the South African context.

2.2.3.1 *Competency evaluations*

Using a competency approach (see section 2.2.4 below, p. 28), Smuts (2011) conducted a study, claiming to be the first of its kind in South Africa, to determine whether there were measurable differences between graduates of the two curricula at the University of the Witwatersrand. Using a mixed methods approach combining both quantitative and qualitative elements, a 'competent intern model' was generated and validated in the first phase of the study, which was then applied in a second phase to measure preparedness for practice. NQDs who participated in that study were reportedly located too far apart to administer an Objective Structured Clinical Examination (OSCE) or any other formal assessment as part of the research process. Therefore, multiple other sources were used to generate data in a '360° approach' adopted for the evaluation of intern competence, whereby supervisors, colleagues (nurse practitioners and fellow interns) and patients were consulted regarding specific interns they had observed in addition to interns' self-evaluations. Graduates from both traditional and reformed curricula were satisfied with their overall preparedness, although the graduates of the new GEMP curriculum were rated by others as marginally better prepared (Ibid.). Interestingly, recommendations for further research included follow-up studies of the participants once they had commenced independent practice to find out which benefits of the curriculum had persisted, while acknowledging that "the problem of confounding due to post-MBBCh experiences intensifies with time" (Smuts, 2011, p. 366). However, based on the inconclusive results of previous longitudinal studies done elsewhere (Norman et al., 2008) it seems unlikely that new insight would be generated by such lines of questioning. The difficulty appears to arise from attempts to objectify doctors as being the 'products' of a particular curriculum or pedagogy, as the wide variety of intrinsic and extrinsic influences that potentially come to bear on the development of NQDs, and continue to shape practitioners throughout their lives, should not be disregarded (Luke, 2003).

A few studies from the Western Cape have assessed NQDs' ability to perform practical procedures and clinical skills at the commencement of internship (Burch et al., 2005) or towards the end of the first year of internship (Jaschinski & De Villiers, 2008). Another study investigated perceived preparedness of final year medical students immediately prior to commencing internship, as perceived by students and staff at the University of Cape Town (Draper & Louw, 2011).

In an older study conducted at a rural hospital in the North-West Province, Cameron, Blitz and Durrheim (2002) asked NQDs to rank their experience and confidence in managing a broad spectrum of medical conditions, in addition to performing commonly encountered procedures. Experience and confidence indices were measured in that study, and both were found to increase considerably for interns during their first year of practice, which may well be explained by the extensive experiential learning taking place during internship. The importance of experiential learning was confirmed in a more recent study at another district hospital in the North West Province, based on interviews with seven doctors opting to remain at the same institution on completion of their internship (Sein & Tumbo, 2012). Interestingly, the same authors briefly considered some personal attributes or dispositions of practitioners as well as their interpersonal relationships as factors influencing internship learning. As mentioned previously, these socio-cultural aspects are inadequately discussed in the medical education literature overall. In this study I attended explicitly to relational influences and the *habitus* of individuals and groups, and I explored the various enabling or constraining factors during internship within a socio-cultural theoretical framing (see Chapter 3 Theoretical Framework p. 52).

2.2.3.2 *Holistic experience-centred research*

Some limited aspects of internship experiences, for example, the prevalent theme of stress and suffering, have been holistically evaluated in unpublished theses of Doctoral or Masters studies. For example, Essa (2010) found the lived experiences of South African NQDs at three Johannesburg hospitals to be overly stressful due to long working hours and other

contextual parameters including endemic disease profiles and issues relating to the management of the South African public health sector.

Recent studies emanating from UKZN (the institution at which the participants of this study completed their undergraduate education) have considered how the very diverse socio-cultural backgrounds of medical student populations in South Africa might influence experiences of the PBL process (Singaram, Sommerville, van der Vleuten, & Dolmans, 2011; Singaram, van der Vleuten, Stevens, & Dolmans, 2011). However, there are no similar studies that have paid attention to such issues of diversity influencing the early career learning of graduates, where they are likely to have an even greater influence on the relationships of NQDs within complex networks of health-care practitioners, and as they encounter diverse populations of patients. Therefore, in this study, aspects such as dispositions, aspirations, and socio-cultural contexts have been foregrounded to better understand how NQDs negotiate their internship experiences.

Also at UKZN, Reddy (2010) explored the relationship between PBL pedagogy and clinical learning environments by conducting interviews with NQDs in a phenomenographic study. As reported elsewhere following the implementation of a new PBL curriculum (Watmough et al., 2010), the pioneer cohort of graduates at UKZN perceived that they had been treated as inferior in clinical settings, and held self-conceptions of a “guinea-pig identity” (Reddy, 2010, pp. 78-83, 159-160). Participants felt undermined by clinical educators, who had themselves been trained in a traditional curriculum, which they deemed superior to the PBL system. Consequently, during participants’ undergraduate education, they reported that clinical educators drew negative comparisons between the PBL students and students who were concurrently in a traditional curriculum. Reddy (2010) further reports that participants encountered incidents of racism, marginalisation and discrimination, which were potentially damaging to the NQDs’ identities. As my study involved participants from the same PBL cohort some years after graduation, and focused more explicitly on identity construction, I was interested to find out if participants would recount similar experiences.

2.2.4 Competency approach in medical education

Although this study does not involve evaluating competencies per se, a brief discussion of the competency approach that has arisen in medical education in recent times is necessary, in order to contextualise research in the area of professional development during internship. There are several ‘competency frameworks’ (not to be mistaken for the narrow use of the term ‘competency’ indicating competence or capability of performing a clinical task) that have been developed by professional accreditation bodies mostly of the northern hemisphere. These frameworks include clinical work-related professional roles formulated according to what society expects of doctors (Kuper & D'Eon, 2011). For example, the most widely adopted CanMEDS Framework addresses the following roles: medical expert, communicator, collaborator, manager, health advocate, scholar and professional (Frank, 2005). None of these professional roles are possible to perform in isolation, and to be judged successful at most of them, requires particular ways of relating to others, be they patients, colleagues, allied health practitioners, organisations or institutions. For this reason I would argue that any meaningful evaluation of the professional development of NQDs should include their interactions with these various others over time.

However, in postgraduate medical education, a wide variety of assessment methods have been formulated to evaluate some or other aspect relating to competencies. It is beyond the scope of this thesis to provide details of the various assessments; suffice to say that there is no lack of information regarding the various assessment tools or attempts to evaluate the tools in the medical education literature. Regehr et al. (Regehr, Eva, Ginsburg, Halwani, & Sidhu, 2011) usefully categorise these numerous assessment tools into three manageable categories based on whether they are conducted in or out of the workplace context, and whether they are formal and structured, or informal and cumulative. The same authors suggest that engagement with broader areas of physician development, including the “conceptualisation of practice and/or identity formation” (Regehr et al., 2011, p. 10) would offer a more fruitful approach to researching professional development. Other authors have questioned whether it is even possible to measure competencies, as a systematic review showed no direct correlation between the behaviours that were empirically measured and the ACGME competencies from the USA (Lurie, Mooney, &

Lyness, 2009). However, the current literature continues to report on numerous efforts to determine with some degree of certainty whether graduates have attained competency-based objectives, resulting in the proliferation of a reductionist trend.

2.2.5 The identity construction gap

In the medical education literature, identity construction is increasingly acknowledged to be a crucial part of medical students' learning, and at least as important as the development of knowledgeable skills (Monrouxe, 2010). However, research studies that focus specifically on identity construction of NQDs are rarely found and identity appears to be a relatively neglected topic when compared to the literature on professional development in other fields. Reasons for this deficit are complex; however, as discussed previously, the existing disjuncture between research methodologies widely employed in medical education and identity construction research, is likely to be a significant contributory factor in considerations relating to NQDs (Luke, 2003). In this section I elaborate on an argument that this relative neglect of identity construction in medical education is also based on a lack of appropriate psychosocial and socio-cultural theoretical framing.

A broader conceptualisation of medical education as a complex transformative journey that incorporates identity construction as a 'process of becoming' is neglected in the literature and requires development. The argument is that professional identity construction is both a personal and social process, which is inseparable from the knowledge and skills developed, and that the community discourse is central to this process (Mann, 2011). Socio-cultural learning theories, particularly situated learning (Lave & Wenger, 1991) and communities of practice (Wenger, 1998) are recommended as offering future potential explanations for learning that occurs whilst essentially embedded in workplace participation (Hodges & Kuper, 2012; Mann, 2011). The theoretical framing for this study aligns well with the recommendations made by these authors, as I combined theories of social practice, learning as participation, and relational aspects of identity construction (see Chapter 3 Theoretical Framework p. 52). The narrative approach employed also deliberately goes beyond what

was 'told', to examine what was inferred by narrative language, as participants expressed positioning themselves in relation to others (see section 4.4 Narrative approach p. 81).

In an overview of theoretical perspectives that have historically influenced the field of medical education, Mann (2011) points out that most of the theories that have shaped curriculum design and the general culture of medical education in the past align with traditions of behavioural and cognitive psychology. Hodges and Kuper (2012) agree that behaviourism has traditionally dominated medical education research, and suggest that socio-cultural theories should be applied, especially in studies of postgraduate learning. Some recent studies from Australia and New Zealand have explicitly used socio-cultural theories for interpreting (or reinterpreting) data that pointed to identity construction being central to internship learning (Bearman et al., 2011; Sheehan et al., 2012). Sheehan et al. (2012) found that the learning of NQDs in New Zealand involved three broad themes, namely, concrete tasks, project management and identity formation. Bearman et al. (2011) re-analysed a data set originally generated to investigate the preparedness of graduates and the impact of medical education across Australia. That study involved multiple organisations and enabled a broad view of internship as a socio-cultural phenomenon rather than an in-depth and situated exposition. Findings of both these studies informed the final data analysis of my study and I was able to meaningfully compare the experiences of NQDs in South Africa with those in Australia and New Zealand.

2.2.5.1 *Identity, the 'self' and relationships*

Research studies and literature relating to the intra-personal aspects of identity construction remain even more elusive than discussions of identity as an abstract concept. Monrouxe (2010) suggests that medical education researchers might use a framework of three main components, namely, the influence of primary identities on new or provisional identities, the self-categorisation process, and how multiple identities might be organised. Primary identities are those aspects of identity that are formed in early childhood through more external than internal processes (Monrouxe, 2010). For example, identifications

associated with gender, ethnicity and social class are included in primary identities, which are not completely fixed, but are less subject to re-shaping than identities developed later on in life, such as professional identities. Each individual would thus have a unique combination of identities which in turn possibly enables or constrains the development of new identities and the way in which these are managed in the identification process (Ibid.). Primary identities would importantly influence the way individuals relate to others and how they position themselves in relation to other social groupings.

To my understanding the concept of primary identities resembles the dispositional “structuring structures” of Bourdieu’s (1990, p. 53) sociological concept of *habitus* that formed part of the theoretical framing of this study. I also used a combination of psychosocial and classic socio-cultural theories to inform the exploration of the self-categorisation process of NQDs. Hermans’ (Hermans & Hermans-Konopka, 2010) Dialogical Self Theory (DST) as an analytic framework further illuminated this process and enabled theorising about how multiple identities might be managed (see section 3.4.1 A case for synergising psychology and social theory through Hermans’ DST p. 68).

It has been said that “medical students have committed themselves to a self-altering course of study” (Montgomery, 2006, as cited in Bleakley et al., 2011, p. 63) implying that there is also a professional identity created through medical education. Progression from medical student to NQD, and then possibly on toward further specialisation, involves much more than the acquisition or internalisation of knowledge, skills and attitudes. Bleakley et al. (2011) recognise that elements of identity are also contained in the various ‘descriptors’ and ‘specialist labels’ related to the medical profession, for example ‘intern’, ‘registrar’, ‘neurosurgeon’, ‘psychiatrist’, ‘dermatologist’, ‘anatomical pathologist’ etc. These labels transcend individual factors and personality traits; although it might be argued that particular personalities are drawn to choose certain specialities over others (Luke, 2003). However, what exactly constitutes a ‘professional identity’ in medical education is a matter of debate. Existing typologies mainly consider the duration and knowledge domains of education in the development of expertise and associated work roles as well as pointing to status (Stern, 2006 as cited in Bleakley et al., 2011). West (2014) makes a useful distinction between ‘identity’ and ‘self’ in exploring learning, where self links better to personal agency than to the more abstract notion of identity.

As much as structural determinism and complexity science might advocate a move away from focusing on the individual (Bleakley, 2010a) and encourage the notion that environmental factors allow adaptive systems to emerge in new ways (Bleakley, 2011; Mennin, 2010). My view is that personal agency in the matter of identity construction cannot be ignored. Thought-leaders in the field of medical education, reflecting on leadership and organisational culture, have cautioned that the person should not be forgotten; that there is a need for more humanity, working with people with trust and in relationship (S. Mennin, personal communication, December 18, 2013). There is always the possibility that persons in less powerful positions might display an appearance of conforming 'front of stage' in the presence of more powerful others, and yet believe differently, and act in quite another way 'backstage' in the absence of more powerful others (Apker & Eggly, 2004). Then again, participants might have been socialised to such an extent, that they are unaware of the changes to their identity as they gradually assume a collective identity by adopting the prevalent professional norms (Bleakley, 2010b).

Identity construction research therefore requires the generation of rich data, thoughtfulness and sensitivity in the dialogue between researcher and participant (Riessman, 2008), as well as appropriate analytic framing to interpret the findings. The nuanced nature of such phenomena demands that the researcher also be aware of and disclose their own subjectivity and influence on the participants' responses. As interpretive researchers cannot separate themselves from what and who they know or from their experiences, they become part of the inquiry process, as "nothing is bias free" (Luke, 2003, p. 42). Therefore it is essential that researchers give due consideration not only to environmental and cultural contexts but also to individuals' aspirations, dispositions and relationships (see section 4.2 Paradigmatic considerations p. 76).

2.2.6 *Need for a paradigm shift*

To conclude the discussion on methodology in medical education and the associated lack of research pertaining to identity construction, amidst a large volume of overwhelmingly positivist studies, some established researchers have voiced their concerns and advocate that a fresh direction is needed. Regehr (2010), as mentioned previously, calls for rich understanding rather than a burden of proof; effectively calling for a paradigm shift in the field. Using an evocative metaphor of health professions education *not* being rocket science, he presents a compelling argument that something is amiss with the hypothesis-testing methodological approach of physical science being applied so widely to researching medical education. Eva (2010) then counters that actually educational research *is* in many ways like rocket science for the same reasons, in that there are a multitude of variables that can impact on the outcomes, making control, or even anticipation of all of these, impossible. Whether or not health professions education is like rocket science, the point is made that as a result of continually requiring proof for educational research, the literature and conference presentations shared within the community have become more akin to ‘show-and-tell’ exercises than genuine efforts to understand learning processes and educational practices.

Bunnis and Kelly (2010) express similar concerns in their overview of research paradigms in medical education research and also advocate engagement in epistemological discussions and increased transparency about the nature of knowledge being sought. Monrouxe and Rees (2009) raise similar issues when they argue for the construction of medical education as a social science rather than as a medical science, because ultimately medical education is about people. Brosnan (2013) summarises the value of applying social theory frameworks in medical education research, emphasising the bi-directional nature of the way theory relates to research, as existing theory can inform studies and the findings from studies can add to theory. This study therefore deliberately aligns with the imperative of understanding, in that its design is interpretive, employing a combination of socio-cultural theories and concepts to make meaning of internship experiences in their richness and diversity (see Chapter 3 Theoretical Framework p. 52). It is hoped that such a paradigm shift in research methodology would yield insight to help ease the transition from medical student to NQD

and maximise postgraduate learning opportunities. Identity construction as a specific focus of learning, viewed through such theory lenses, would potentially allow a theory of relationships and power flows in the clinical workplace to emerge.

2.3 Experiences of medical internship

Medical internship has often been famous for all the wrong reasons. It is recognised as an intensely formative period of doctors' lives when daily experiences shape their professional identities (Ackerman, Graham, Schmidt, Stern, & Miller, 2009). However, an overburden of diseases, gruelling hours of work and otherwise stressful work environments are among the many challenges that have long been associated with medical internship. Several empirical studies have shown that the transition from medical school to internship can be difficult and even traumatic as interns suddenly assume responsibility for numerous sick patients (Issa, Yussuf, Olanrewaju, & Oyewole, 2009; Prince et al., 2004; Sun, Saloojee, Jansen van Rensburg, & Manning, 2008). Mansukhani et al. (2012) attribute many negative effects, on both patient safety and the wellbeing of NQDs, to sleep deprivation alone. However, similar challenges have persisted for many decades (Light, 1988); have extended into the 21st Century (Levey, 2001); and prevail even in the developed world where unacceptably high numbers of NQDs self-report that their lives are excessively stressful (Brennan et al., 2010). Consequences include emotional and mental health problems (J. S. Cohen & Patten, 2005), not uncommonly resulting in depression and burnout (Kasman, 2004; Satterfield & Becerra, 2010).

2.3.1 Hours of work

Health professions' regulatory bodies in some countries have instituted strategies to reduce the hours of work and provide better support for interns (Ackerman et al., 2009; Dabrow, Russell, Ackley, Anderson, & Fabri, 2006; Mansukhani et al., 2012). The ACGME (Mansukhani

et al., 2012; Moonesinghe, Lowery, Shahi, Millen, & Beard, 2011) and the GMC of the UK (Bannon, 2006) have both instituted limitations of working hours for NQDs. It is interesting to note the controversy that has arisen, as some clinicians suggest that postgraduate medical education has been compromised rather than improved by these measures, due to decreased opportunities for experiential learning, for example, in the intensive care unit (Peets & Stelfox, 2012). Moonesinghe et al. (2011) conducted a meta-analysis assessing the impact of reduced working hours for NQDs, recording whether outcomes in 'patient safety' and/or 'training' were evaluated, and whether these were affected positively or negatively, or remained unaffected. They concluded that, at least in the USA where working hours were reduced to less than 80 hours per week, neither patient safety nor training had been compromised by the change. However, in the UK where working hours were reduced to less than 56 to 48 hours per week, the authors opined that insufficient research had been done to correctly determine the impact on clinical and educational outcomes.

In South Africa, work-hour limitations for NQDs are an unlikely consideration, mainly due to the costs involved in their implementation. There is also an explicit 'transformation agenda' towards achieving more equitable distribution of healthcare resources than in the past (Reid, 2002). National policies that aim to correct some of the imbalances of the apartheid era involve the distribution of healthcare personnel in general and therefore also pertain to the workload of NQDs (Burch & Reid, 2011). As interns are expected to provide first-line treatment in most public healthcare facilities, they form a crucial part of the workforce for healthcare delivery in many remote and under-resourced areas of South Africa. Therefore a reduction of working hours comparable to the global North, even if considered to be educationally prudent, is not likely to be regarded as practical.

Erasmus (2012), a South African legal practitioner hailing from a family of many medical practitioners, has recently launched a scathing attack on national government for the exploitation of NQDs to uphold a severely understaffed healthcare system. The overtime hours that interns are currently contracted to work are reported to be grossly in excess of the provisions of the Basic Conditions of Employment Act. However, on the premise that their salaries exceed those stipulated, NQDs receive no protection regarding hours of work from the provisions of this legislation. Erasmus (2012) refers to NQDs during medical internship and community service in South Africa as "slaves of the state" (p. 655) and she

equates the lack of sleep, coercion, and inhumane working conditions they have to endure, with unlawful and forced labour, far removed from any conceivable ideal learning environment for NQDs.

2.3.2 Emotionality and stress

In an exploratory study of how the emotional health of interns might be better attended to, Satterfield and Becerra (2010) followed the progress of 62 NQDs over a period of two years in a support group intervention at an urban, academic medical centre in the USA. In addition to eliciting factors that cause stress, their study enabled insight into the coping mechanisms and some of the developmental changes occurring over time. The need for greater clarity concerning work roles and responsibilities, professional identity construction and concerns about healthcare delivery systems in which internship training takes place, were some of the themes highlighted by the study.

There are a few studies reported where researchers devised other novel ways to attend to aspects of emotionality during internship learning. For example, in a study of self-reported critical events (high points, low points and conflicts), it was found that interns associated emotionality with events that they found memorable, such as developing confidence, interpersonal connections, and negotiating conflicting expectations (Ackerman et al., 2009). This might seem obvious to educational scholars who are well accustomed to discussions of affective outcomes, but it should be borne in mind, that for medical education research, this is not common practice.

In under-resourced settings, the causes of stress for NQDs are further compounded by endemic disease profiles as described in studies of medical internship emanating from Africa (Essa, 2010; Issa et al., 2009; Sun et al., 2008). These studies generally indicate that there is a need for change at a systemic level in healthcare services and the associated organisation of work for NQDs. It is my hope that a better understanding of internship experiences from the perspective of NQDs' personal narratives, as elicited in this study, would be helpful for

finding solutions to these wider issues (see section 4.4.1 Rationale for narrative research methods p. 85).

2.3.2.1 *A view from the outside*

The various stressors associated with medical internship have long been researched and discussed by scholars outside the field of medical education, mainly by psychologists and sociologists. In the 1950s psychologists theorised about various internal coping mechanisms and developmental outcomes of medical internship which they found by manipulating specific variables while using attitude survey research (Bloom, 1965). Again in a review of some of the older sociological studies, Light (1988, p. 314) describes how sociologists observed a “prevalence of suffering” among doctors in training who were “exhausted, demoralised, assaulted, insulted and finally skilled at working the system”.

Therefore it appears that the stressfulness of internship and the socialisation of NQDs in ways that are less than ideal have been long-standing issues in medical education; which begs the question whether medical ideology and culture are responsible, at least in part, for perpetuating a degree of suffering. Light (1988) argues that a sociological view would highlight if it is somehow considered necessary for NQDs to prove themselves capable of surviving the pressure, or whether there is a belief that it is a necessary process of being initiated into the profession. There are also likely to be other pragmatic considerations, for example, the previously mentioned overburden of disease, lack of resources, and even exploitation of NQDs by the state. However, the continued issues of overwork and sleep deprivation of NQDs even in relatively well-resourced settings appears to indicate that the culture of medicine as an establishment considers the emotionality, stress and suffering of internship a ‘rite of passage’ without which a doctor would somehow not be considered to have made the grade (Light, 1988).

2.4 Internship learning

A mandatory period of internship is required of NQDs, as stipulated by the health professions' regulatory bodies in most countries, although different labels might be given to this period, including 'residency', 'Postgraduate Years one and two' (PGY1 and PGY2), 'Pre-registration House Officer' (PRHO) and 'Foundation Years one and two' (FY1 and FY2) – (see section 1.2 Background and regulation of medical internship p. 4). In this section I elaborate on some of the different ways that internship learning is viewed by clinician educators in general, and newer understandings of apprenticeship based on socio-cultural learning theory. The idea of how Bourdieuan concepts, being incorporated in theory frameworks, help to overcome the divide between structure and agency (Brosnan, 2013) is also introduced.

2.4.1 Apprenticeship and conceptions of learning

Medical internship is most often viewed as an apprenticeship and the term is generally understood in a traditional sense when it is used in the field of medical education (Sheehan, 2010). The view that novices learn through immersion in a particular work environment, largely as passive recipients of knowledge, as they closely observe and interact with experts or masters, is still popular amongst clinician educators. However, more contemporary theories of apprenticeship, based on understandings of 'learning as participation' in 'communities of practice' (Lave & Wenger, 1991) are increasingly considered and accommodated.

Where learning is framed as socio-cultural practice, there is a reciprocal influence between persons and their practice environments, and hence acknowledgement that the transforming of cultures is possible even by novice practitioners. Bleakley (2002) advocates moving away from individualistic understandings of apprenticeship and proposes a new model of apprenticeship based on cultural historical activity theory and complexity (Bleakley

et al., 2011). A range of learning conceptions have been hypothesised in the medical education literature as possibly being associated with NQDs learning during internship (Bleakley et al., 2011); from individual-oriented theories describing internal motivations such as in self-determination theory (T. J. Ten Cate, Kusurkar, & Williams, 2011) to distributed cognition in dynamic, adaptive systems and the 'self-organisation' of complexity theory (Bleakley, 2010a; Mennin, 2010). Therefore, although apprenticeship is the 'name of the game' when it comes to medical internship, what exactly is meant by apprenticeship has been questioned. It appears that diverse ideas of how learning might best be 'scaffolded', and how professional identities are developed during internship, arise from the various undergirding philosophies of learning.

Lave and Wenger (1991, p. 23) describe a process where newcomers first engage in "legitimate peripheral participation" (LPP), being fully responsible for some functions and roles while being guided in and aspiring to others. Newcomers then move centripetally towards fuller participation as they grow in "knowledgeable skills" (Ibid. p. 94), and participate in and become responsible for more advanced functions within a community of practice (Wenger, 1998). In this conception, rather than knowledge reproduction where information is sought and internalised by individuals, processes of collaborative knowledge production are foregrounded (Bleakley, 2006).

Lave and Wenger (1991) claim that their goal in the 1980s was to rescue the notion of apprenticeship from the trend they had observed amongst educationalists to apply it as a metaphor for any and every form of learning. With their theory of situated learning they provide analytic lenses through which participation is viewed as bringing together both understanding and experience, they are "mutually constitutive ... [and] thus dissolving dichotomies between cerebral and embodied activity, between contemplation and involvement, between abstraction and experience" (Lave & Wenger, 1991, p. 52). This perspective is potentially ground-breaking for medical education research as it demands a focus on the 'person-in-the-world' rather than adopting a non-personal view of knowledge with skills and activities as measures of learning. Thus the primary strength of LPP as a framework for this study lies in the potential it allows for combining the "development of knowledgeably skilled identities in practice" and "the reproduction and [/or] transformation of communities of practice" (Lave & Wenger, 1991, p. 55) – (see section 3.3.1 Situated

learning, COP and LPP p. 58). Lave and Wenger therefore intend LPP to be a conceptual bridge that enables claims about “common processes inherent in the production of changing persons and changing communities of practice” (Lave & Wenger, 1991, p. 55).

Bourdieu’s (1990) theorising on social practice usefully provides a way to connect structure and agency by focusing on “how practice is both shaped by and reproduces social structure” (Brosnan, 2013, p. 5). For purposes of this study I have therefore extended the conception of situated learning in practice to include the dispositions and aspirations of NQD apprentices, using conceptions such as *habitus*, capitals and field (Bourdieu, 1990). In my view, it is essential that personal ‘ways of being’ in the world be given due consideration, as they are integral to the negotiation of learning opportunities during an apprenticeship, whilst taking into account the enabling and constraining factors of the situation. This is of particular relevance when examining the role of significant others and relational influences that impact on early career learning as discussed below.

2.4.2 Early career learning (ECL) across the professions

Unlike the term ‘apprenticeship’, medical internship is almost never referred to as ‘early career learning’ (ECL). This is in contrast to other professional development literature, as in postgraduate teacher education, for example, where there is a considerable body of research reporting on the ECL of newly qualified teachers. Transition experiences of novice school teachers into practice have been described extensively where participants predominantly value learning processes that are informal and socially constructed (McNally, Blake, & Reid, 2009). In the South African context, Samuel (2009) elaborates on the tensions that newly qualified teachers face as they report being pulled in different directions. Despite the introduction of induction programmes and mentoring relationships in many contexts, there is still an uncomfortable period of transition which has been described as a ‘liminal phase’, when newcomers feel insecure and unsure of their work, and when their professional identities are disrupted (Pierce, 2007). These findings suggest that new ways of

knowing are required of newly qualified professionals in general, regardless of personal qualities and whatever the field or profession.

A widely cited, large-scale, longitudinal study of ECL conducted in the UK, is referred to as the LiNEA project (LiNEA, 2007), and spans learning in several professions, namely nursing, engineering and accountancy. The study aimed to explore the workplace learning of newly qualified professionals using observations and interviews to gain insight into what was being learned, how, and what factors affected the level and direction of learning efforts (Eraut, 2007). The LiNEA project examined both formal and informal learning at work by analysing various practice episodes for multiple learning trajectories of different types of knowledge that came into play. Contextual parameters and situational factors that gave rise to novice practitioners' performance and professional development were illuminated. The findings of that study emphasised the importance of learning from others, and thereby concluded that encounters and relationships with people in the workplace are of primary importance.

In medical education, models of learning principles have been proposed based on experimental findings and deductions regarding how novices become experts through evolving knowledge constructions. These models favour individual conceptions of cognitive learning and involve mostly transferable and abstract principles of learning (Bleakley et al., 2011). For example, Boshuizen (2003) theorises about a gap or mismatch apparent between school and work, and hypothesises a progressive knowledge structuring that can only take place with (clinical) workplace experience. She concludes that the existence of a gap in itself is not the problem per se, but that it becomes problematic under the following two conditions: firstly when "graduates are not prepared for learning in a way very different from what they are used to" and/or, secondly, "when the working environment does not see them as trainees but expects that they can function as fully-fledged professionals" (Boshuizen, 2003, p. 21). Bleakley et al. (2011) claim that such principles of learning are, however, challenged by dynamicist models that favour emergent conceptions of learning framed by systems and complexity theory (Bleakley et al., 2011).

In the clinical setting, much has been said about the value of giving and receiving feedback in the correct manner (Eva et al., 2012); about role-modelling (Passi et al., 2013) and the hidden curriculum (Lempp & Seale, 2004). These are prevalent discourses in medical

education that undoubtedly contribute to the professional development of NQDs. However, they are predominantly teacher-centred concepts where educators' activities and attributes are the focus, whilst the intern-centred world remains indistinct. Luke (2003) highlights the need to examine medical internship experiences with 'new lenses', namely Bourdieu's theories of *habitus*, capitals and field. It is this relatively uncertain world of NQDs' personal experiences that I set out to explore in this study of internship learning and identity construction.

2.4.2.1 *A multi-disciplinary theory of relationships*

Another large-scale study has pioneered the development of a theory of relationships and their influences on adult learners' identity constructions. This study pertains to access and retention issues of non-traditional learners in higher education and is referred to as the RANLHE study (RANHLE, n.d.). Researchers across several countries in Europe, including Germany, Ireland, Poland, Spain, Sweden and the UK, collaborated on this EU-funded endeavour. Participants were interviewed across a range of disciplines to find out how non-traditional students perceived themselves as learners and how their identities as learners developed (Fleming & Finnegan, 2011; West, 2012). Although the RANHLE study was not about ECL as such, the need to make sense of identity constructions negotiated within institutions of higher learning, led to a novel combination of theories being employed. Researchers involved in that study describe a framework comprising two main 'sensitising concepts', combining developmental psychologist Winnicott's 'transitional space' and Bourdieu's sociological theory of *habitus* (Fleming & Finnegan, 2011). In addition, the analytic framework used, included a multi-phenomenon 'theory of recognition' developed by Axel Honneth (2007), who proposes a schema with three levels of outcomes relating to the self: self-confidence, self-respect and self-esteem. This theoretical framework was found useful in exploring broader issues of structure, agency and identity in the participants' experiences (Fleming & Finnegan, 2011). West (2014) also documents his application of Honneth's philosophy of recognition in theorising about transformative and lifelong learning. From his involvement in the RANHLE study, and in extensive biographical research with doctors, trainee teachers and marginalised communities, he postulates the need for an

interdisciplinary psychological and sociological understanding of learners and their whole lived experiences (West, 2010). Similarly, my study involving NQDs assumes that such a combination of theories might be generatively used in studies of ECL to illuminate the quality of learning relationships.

In most ECL-related literature in general, it seems to be taken for granted that 'good' relationships lead to building confidence, and are therefore deemed to be part of the process of positive identity development of newly qualified professionals. However, I have not found any literature pertaining to the actual nature of those relationships and what exactly constitutes supportive, enabling, constraining or damaging relationships in the context of workplace-based learning of professionals. Interestingly, in a study of medical internship from New Zealand, Sheehan (2010) examined the clinical supervisory role and relationship in the light of several Maori cultural conceptions of relationships which value mutual respectfulness. The study resonates with the aims of my study in further deliberating how 'being with' more experienced others influences the development of NQDs' identities (Sheehan et al., 2012).

Furthermore, the possibilities for identity construction in different ways on encountering less than ideal clinician role-models, requires further investigation. For instance, while it is possible to superficially construe negative role-models as potentially damaging to the identity construction of NQDs, responses of learner resilience and resistance (Rees & Monrouxe, 2010a) should not be underestimated. The multiple self-positions, which may be proposed or disposed as suggested in DST (Hermans, 2012), appears to have the necessary theoretical flexibility to make sense of these complex human responses (see section 3.4.1 A case for synergising psychology and social theory through DST p. 68).

As these relational aspects of clinical practice appear to have been inadequately attended to previously, this study afforded me the opportunity to visually map the various relationships experienced by NQDs. I was able to theorise the types of relational influences which are important for internship learning and identity construction as elaborated in Chapter 6 Relationships p. 170 and Chapter 7 Framing Relational Influences in Theory: learning, identity and power relations p. 210.

2.5 Power, identity and leadership

As previously alluded to, the power flows in medical practice and healthcare systems are likely to play an important role in the way internship is organised and structured, globally and within specific healthcare systems and institutions. In addition, the rigid hierarchies of authority and accountability within medicine are found to influence interpersonal relationships in the clinical workplace. For example, NQDs elsewhere have reported socially determined relationships with senior colleagues were based on their perceived status of being on the “bottom rung of the ladder” (Luke, 2003, p. 93). At the same time, however, while NQDs’ identities as professionals are still developing, they are expected to be fully responsible for patient care in many situations and to demonstrate leadership potential, if not leadership roles, in the management of patient cases. Therefore in this final section of the literature review pertaining to power flows, I briefly outline some relevant literature from a historical perspective and then a more current perspective. I have then linked these deliberations on power to the discourses of educating for change and patient-centred practice which are central to medical education overall.

2.5.1 Power dynamics, socialisation and influence of undergraduate medical education (historical perspective)

Several scholars and theorists of psychology and sociology over the past century have expressed a special interest in the power dynamics of teaching and learning in the clinical workplace (Bloom, 1965; Bourdieu, 1988; Levinson, 1967; Light, 1988), and their deliberations in this regard add an essential dimension to the study of becoming doctors. Light (1988) postulates that apart from the pressures of an extraordinary workload, the hierarchical power structures of medicine are a major contributor towards making internship a potentially damaging experience. He further links this entrenched hierarchy to the arrogance observed in various interpersonal interactions of doctors of the global North with ‘subordinates’ and ultimately with patients. This has clear implications for researching

the culture of medicine, and, as Light (1988) also points out, sociology offers the kind of conceptual tools that are necessary to understand such issues of culture and ideology.

Bloom (1965) provides the most comprehensive review of the oldest literature on the sociology of medical education, concentrating mostly on the effects of medical schools on shaping values and attitudes of both individuals and the profession as a whole. Historical studies vary considerably in their methodological approaches to the subject, however, they do emphasise the point that processes of professional development or maturation must be linked to social environments in order to be meaningful. If the contextual details are not attended to, no matter how sophisticated the techniques and instruments, attempts to survey the 'attitude climate' are unlikely to be fruitful. A further illustration of the importance of social contexts is provided by Light (1988) as he reports that specific historical studies on the socialisation of medical students in North America were actively suppressed by the administration of the institutions concerned. Findings of those studies would have apparently exposed the "latent power of the deanery and executive council" and revealed a lack of "democratic processes of decision making" (Light, 1988, p. 314); which was unacceptable to the authorities at the time the studies were conducted. Such misuses of power by powerful institutions may 'cover up' the findings of scholarly efforts, indicating that medical education and practice are also embedded within particular climes of socio-political and economic interests (Waitzkin, 1986).

Renowned psychologist Daniel Levinson, whose theories on adult life transitions have been widely applied to studies of professional development, paid special attention to the role of the physician. In a critique of "Boys in White: Student Culture in Medical School" (Becker, Geer, Hughes, & Anselm, 1961, as cited in Levinson, 1967, p. 253), a widely cited example of a historical study of undergraduate medical socialisation, Levinson (Ibid.) also discusses the dichotomous approaches used by psychologists and sociologists of that time, and suggests that a joint perspective is needed. Taking cognisance of his views, in this study I made use of both psychological and social educational theories and theories of social practice. An analytic framework that synergises psychological and sociological perspectives of identity further supported theorising a dialogical basis to identity construction through relational influences and power flows (see section 3.4.1 A case for synergising psychology and social theory through Hermans' DST p. 68).

Of further relevance to this study, both Levinson (1967) and Light (1988) deliberate the value of investigating the personal professional characteristics developed previously during medical school that would later influence the capabilities and limitations of doctors in their practice. Light (1988) also pertinently observes a generalised denial and safe-guarding against criticism within medical education circles with regards to internship experiences. Despite NQDs being forced to learn how to dispense with patients as quickly as possible to cope with the demands of their work and the sheer volume of patients they are required to see, somehow practitioners who survive the experience evolve to consider that the dehumanising effects of medical internship are necessary for building professional character. Therefore in conceptualising this study I duly considered these ideas from previous sociological studies; deliberately searching for links back to the undergraduate curriculum and for any changes of attitude toward internship with increasing maturity.

2.5.2 Power discourse (current)

More recent studies conducted by educational and communication researchers from the USA and Canada have shown that hierarchy and hegemony are alive and well in the linguistic practices of morning report meetings (Apker & Eggly, 2004) and during ward-based teaching around the bedside of patients (Schryer et al., 2003). The linguistic devices used by doctors, students and patients to maintain asymmetrical power during bedside teaching encounters have also been recently expounded (Rees, Ajjawi, & Monrouxe, 2013). Globally, there is evidence that undergraduate medical students and interns engage in small acts of resistance in these environments (Apker & Eggly, 2004; Luke, 2003). However, Donetto (2010) reports that medical students hold naïve conceptions of power dynamics and are too accepting of the norms and values of existing power relations of the medical profession, thereby assuring their perpetuation.

Gabel (2012a) advocates that power and leadership, and the links between these, need to be studied to a greater extent in medical and health care settings; and that doctors need to exercise leadership and power in appropriate and moral ways in order to promote genuine

patient-centred healthcare services. He also provides a summary of six different types or 'bases' of power (Raven, 2008, as cited in Gabel, 2012a): legitimate or positional power, expert power, informational power, reward power, coercive power and referent power, which might be useful for reflecting on doctors' roles. These forms of power may also provide a framework for evaluating practices that lead to successful interactions and the appropriate use of influence as opposed to inappropriate and abusive power relations. Transformational leadership is suggested by Gabel (Gabel, 2012b) as a model offering potential solutions, and is viewed as a means to bring about transformation in both those who lead and those who are led, ultimately leading to improved healthcare systems.

Donetto (2012) again emphasises the social world in which clinical care is embedded, suggesting that the discourses and practices of cultures, policy and socio-economic contexts need to be considered in being reflexive about the social roles of practitioners. She promotes a Foucauldian understanding of power as 'capillary power', as being generative and productive, where power might be exercised through network or meshwork organisations, rather than power being viewed as a localised entity held by individuals (ibid.). Teacher-learner relationships of more collaborative pedagogical approaches and involving patients as teachers to a greater extent have also been proposed (Bleakley et al., 2011) as strategies to transform the reductive views of medical power. These collaborations may, in turn, prove valuable for promoting a more participative medical professionalism (Donetto, 2010). Although this focus on medical power within the field of medical education is relatively new, it is reputed to be rapidly expanding, further pointing to the need for studies of identity construction that incorporate socio-cultural learning theories, and interpretive and critical research methodologies (Bleakley et al., 2011).

2.5.2.1 *Discourse of transformative learning for change*

The dominant discourses in a field would influence both the participants' and researchers' perspectives, consciously or otherwise, and hence guide the ways in which data are generated and evaluated (Ivanič, 1998). Many of these discourses pertaining to medical education, and particularly to NQDs, have been discussed or mentioned in previous sections

of this chapter. However, I would like to highlight a particular discourse on ‘transformative learning’ (TL) that has arisen in medical education, which also pertains to power differentials. In this discourse, medical educators appear to go beyond the objective of changed ‘meaning perspectives’ or frames of reference – Mezirow’s (1998) conceptualisation of TL – to an expectation that TL will “produce enlightened change agents” (Frenk et al. 2010:1952). In the Lancet Commission Report on global trends in health professions education (Frenk et al. 2010), TL is regarded as the highest of three successive levels of learning engagement: namely ‘informative learning’ – the acquisition of knowledge and skills, ‘formative learning’ – socialisation into values, and ‘transformative learning’ – developing attributes of leadership. In this adaptation of TL, it appears that the goals of transformational leadership to generate self-empowered leaders who are ‘agents of change’ (Gabel, 2012b) have become intertwined with the outcomes of TL. West (2014) points out that discussion around TL, even in education, has become too concerned with cognition, and therefore tends to become disembodied and decontextualised. He suggests a more productive conceptualisation of TL as associated with ‘human wrenching’ which leads to greater self-authorship and agency; a questioning of external values by which life was lived previously, and moving towards a personalised belief system (Ibid.).

Despite the previously described competency frameworks incorporating several leadership roles in the desired attributes of medical practitioners, there is insufficient attention given to specifically educating for leadership in undergraduate or postgraduate medical curricula (Gabel, 2012a). Medical professionals are also not necessarily adequately self-aware of the leadership roles they are required to assume as a matter of course, often seeing these roles as part of their regular work or duties. However, all medical practitioners might be regarded as leaders in society due to the nature of their work, the status and position afforded them by virtue of their qualification (Gunderman, 2011; Warren & Carnall, 2011). The above-mentioned culturally modified reading of TL is arguably likely to place further expectations on graduates that may be beyond them to fulfil, especially within the strong hierarchical power structures found in medical practice (Rees & Monrouxe, 2010a).

2.5.3 Discourse of patient-centred practice

As doctor-patient communication, in all its many facets, is central to medical practice, it is the space where power flows in medicine are most visibly constructed. Most reformed undergraduate curricula explicitly promote education for 'patient-centred practice' which places patients' interests foremost and enables patients to play an active role in decisions relating to their healthcare and medical management wherever possible. The concept of patient-centredness is not new, and combined with the notion that doctors should learn from their patients, has been revisited often, since having been proposed by Osler in the nineteenth century (Bleakley et al., 2011). In keeping with patient-centred practice, the need for a more 'biopsychosocial' approach that takes into account the patient's 'lifeworld', rather than the traditional predominantly 'biomedical' approach to patient-care, has featured in many current discourses in medical education (Apker & Eggly, 2004; Martin, 2011). Undoubtedly, over time, various educational interventions based on these principles would have influenced numerous NQDs to be aware of how they relate to patients. It is also likely that reformed curricula would have brought about changed mind-sets as to what constitutes ethical and unethical conduct on the part of medical practitioners. Bleakley et al. (2011) elaborate that it is an interplay of 'practical reasoning', practical wisdom or 'phronesis' and case-based ethical reasoning that should be involved in thinking about patients holistically. However, as the same authors point out, patient-centredness seems to be an area that has perpetually been found wanting in medical culture overall.

Donetto (2010) suggests, based on her ethnographic study of medical students' understandings of power in the UK, that relationships between clinical educators and medical students might be used to "model some of the dynamics of the practitioner-patient interaction" (Ibid. p. 187). She infers that relationships with educators are crucial in the development of future doctors and that they provide opportunities to promote more critical understandings of medical culture and power.

However, the exportation of the notion of a universal medical culture to any and all contexts has been challenged in a study of professional identity development in Malawi (Wendland & Bandawe, 2007a, 2007b). In the midst of severely mal-resourced healthcare facilities, Malawian NQDs were found to be free of the cynicism reported to develop through medical

socialisations elsewhere. Instead, with further clinical experience, participants in that study were found to become increasingly connected to patients, describing ‘heart’ and ‘love’ for patients as highly valued traits; the difference being attributed to vastly different material and cultural conditions (Wendland & Bandawe, 2007a, 2007b). These authors therefore also recommend exploring the nature of professional identity more deeply, and in a contextually grounded manner, rather than assuming that the same medical culture prevails as a global phenomenon.

2.6 Conclusion

To conclude the chapter, a large portion of this literature review has been dedicated to discussing the methodological insufficiencies in medical education research, to which I have attributed the lack of in-depth understandings of professional identity development. I elaborated on recent research emphases, focusing mainly on ‘preparedness for practice’ and the competency approach, and explained how these have further constrained attending to broader socio-cultural issues and contexts.

The need for change in medical culture was offered as a possible explanation for some of the long-standing problems relating to the ECL of NQDs which are found to have been perpetuated over generations. In introducing the discourses on power flows at the end of the chapter, I might appear to be heading in a direction somewhat removed from learning and identity construction of NQDs. However, I have argued that identity and power are closely interlinked and are dependent on interpretations of personal experiences such as those analysed in this narrative study. Therefore I determined to remain open to the possibility that narrative data generated, though primarily aimed at gaining insight into learning and identity, might also contribute towards understanding issues relating to power differentials in the clinical workplace. The power discourse, yet to establish itself fully within the field of medical education, is an important consideration that is also closely linked to the broader goals of achieving patient-centred healthcare.

The following chapter addresses the theoretical and conceptual underpinnings of this study. An innovative combination of classic and contemporary theorists from both psychology and sociology perspectives is described as enabling new perspectives on learning processes and identity constructions of NQDs during medical internship.

Chapter 3: Theoretical Framework

3.1 Introduction

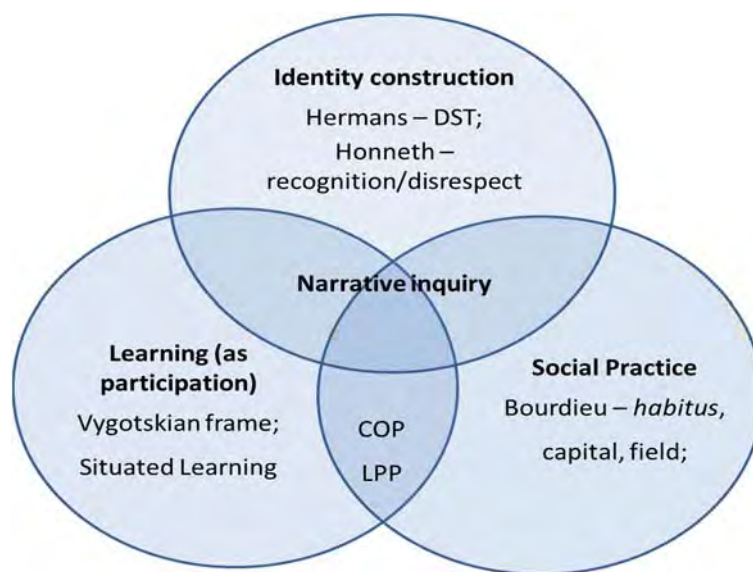
In this chapter I outline the theoretical assumptions of the study and consider the links between various concepts that have framed my thinking about the learning processes and identity construction of NQDs. The epistemological approach that underpins the research is social constructionism and is described first using Vygotsky's (1978) theories of socio-cultural learning in conjunction with situated learning theory (Lave & Wenger, 1991). Concepts of situated learning such as community of practice (COP) and legitimate peripheral participation (LPP) provide a link between theories of learning and theories of social practice such as Bourdieu's (1990) theorising on *habitus*, capital and field. The idea that learning *is* practice informed the data generation in this study and my interpretations thereof. Finally, contemporary psychosocial theorist Hermans' (2013) Dialogical Self Theory (DST) and critical theorist Honneth's (2007) philosophy of recognition and disrespect are outlined. The latter were incorporated as an analytic framework for elucidating the nature of relationships in the clinical environment that were primarily implicated in identity constructions of NQDs.

A theoretical framework provides a useful set of 'lenses' through which researchers are able to filter their work. The broad ethos behind various choices made in the study design, including the literature sourced, methodology, data generation, findings and conclusions are guided by the theoretical and conceptual framing. All research is imbued with theory, whether or not the researcher is aware of the philosophical foundations and the alignment of their ideas with particular theorists. Engagement with the literature pertaining to educational and social theories enables the researcher to position their work in relation to thought leaders in these domains and to formulate an analytic framework for making sense of the data. Therefore in this chapter I provide a synopsis of various theories which best resonated with my ideas and with which this study of medical internship is aligned.

The diagrammatic representation of theory lenses below (Figure 1) is a depiction of the overlapping theory lenses organised into three substantive theories concerning learning as participation, social practice, and identity construction, which I develop in this chapter.

Narrative inquiry, which appears at the intersection of these lenses, aligns well with all the theories that frame the study. It is the methodological approach used in this study and is elaborated in Chapter 4. The relational influences that impacted internship experiences are elaborated in Chapters 6 and 7.

Figure 1: Diagrammatic representation of theory lenses



As a qualitative study situated within the interpretive paradigm (see section 4.2 Paradigmatic considerations p. 76), the aim of this study was to better understand medical internship experiences, focusing on the learning processes and identity constructions of becoming doctors. Appropriate theoretical framing was deemed necessary to address a substantial gap in the medical education literature regarding identity construction (Monrouxe, 2010). The study was also an opportunity to showcase narrative methods by demonstrating a different way of knowing that becomes accessible to researchers making use of subjective processes in their methodology (Chase, 2010), together with creative and diverse combinations of theoretical and conceptual framing. In line with these intentions, I first consider the theories applicable to learning from a socio-cultural perspective of ‘learning as participation’ rather than cognitive processes alone. Then I focus on the theories relevant to social practice, using Bourdieu’s (1990) concepts of *habitus*, capital and

field as these were helpful for thinking about participants' experiences in the clinical work environment more broadly and as influenced by social structures. Finally, I discuss the analytic framing for identity construction using Hermans' (2013) novel ideas about 'I-positions' and 'other-positions' and Honneth's (2007) multileveled theory of recognition and disrespect that provided insight into relational influences.

3.2 A theory of learning

"All theories of learning are based on fundamental assumptions about the person, the work and their relations ..." (Lave & Wenger, 1991, p. 47).

3.2.1 A Vygotskian framework for learning and development

Many contemporary learning theories have expanded on the work of Russian psychologist and scholar of literature Lev Semyonovich Vygotsky (1978). Socio-cultural theories, for example, conceptualising learning as 'distributed' in activity theory (Engström, 1987), and participatory in communities of practice (Lave & Wenger, 1991), are based on Vygotsky's theorising about a Zone of Proximal Development (John-Steiner & Holbrook, 1996). These contemporary theories have in turn provided meaningful conceptual tools, particularly for researching workplace learning and professional development (Illeris, 2009).

Although Vygotsky's work dates back to the early twentieth century, his ideas are still relevant for current debates in psychology and education, and it has been suggested that their relevance has grown in recent decades compared to during his life time (John-Steiner & Holbrook, 1996). Demonstrating a profound interest in problems of education, Vygotsky wrote extensively, using the term "pedology" for what would roughly translate as "educational psychology" (Vygotsky, 1978, p. 10). His critique of tests measuring intellectual ability (such as IQ testing), and his motivation to reform pedology along the lines of his

'Zone of Proximal Development' (ZPD) appear to have been initially misunderstood, leading to accusations that he was advocating mass psychological testing (Ibid.).

In his original work, Vygotsky was primarily interested in the interaction between learning and development. There were three other existing schools of thought considering the process of development. The first viewed development as a totally independent process from learning or as being a pre-requisite to learning. The second understood development as being equivalent to learning, and as simultaneous processes, coinciding on all counts. The third position attempting to avoid the extremes of the preceding views, considered learning and development as based on two quite different but related processes that influence each other – the biological process of maturation of the nervous system, and a developmental process of learning. Rejecting all these major theoretical positions of his time, but analysing them as a starting point, Vygotsky postulated the need to establish two levels of development: an actual developmental level and another level that could be achieved with the assistance of others. For Vygotsky, learning and development are absolutely interrelated from birth; however, he introduced the notion of ZPD to describe the distance between these two levels of actual and potential development. ZPD therefore applies to functions that are "not yet matured but are in the process of maturation" (Vygotsky, 1978, p. 86) and represents a valuable tool for understanding the internal process of human development. Vygotsky's theoretical approach also differs from the others in that he emphasises the "historically shaped and culturally transmitted psychology of human beings" (p. 122), and as a result, enables focusing on the developmental change that occurs in human mastery.

3.2.1.1 *Engaging constructivism and constructionism*

An epistemology of constructivism holds to the view that individuals learn by accessing prior knowledge to actively construct new knowledge rather than passively receiving knowledge transmitted by others (Mann, 2011). In relation to constructivism and constructivist thought, there appears to be some difference of opinion in the literature as to whether Vygotsky's ideas are foundational or if they are divergent (Robbins, 2003). Where

constructivism has more cognitive and individual connotations, it has nevertheless often been associated with Vygotsky. The work of Piaget is more definitively associated with constructivism and Vygotsky is known to have expressed some differences of opinion regarding Piaget's theories of learning (Ibid.). However, Vygotsky's ideas, especially concepts such as the ZPD and 'scaffolding for learning' have been used to explain the outworking of some current educational applications of constructivist principles. For example, problem-based learning (PBL) in medical education is said to be such an application of constructivist thought (see also Chapter 2 Literature Review p. 16).

Vygotsky's main contribution regarding knowledge construction is in theorising the role played by more experienced and helpful others, as he proposed that whatever individual human beings become able to do independently is as a result of social experiences with significant others. Therefore Vygotsky's work adds a collective and social dimension to knowledge construction and a dynamic interdependence between social and individual processes (John-Steiner & Holbrook, 1996). He is credited with having been the first to postulate mechanisms by which culture becomes part of a person's nature (Vygotsky, 1978, p. 6), which in my understanding fits better with the tenets of social constructionism as elaborated below.

Constructionists emphasise that meaning-making is essentially a relational process as it explores how persons learn through engagement in activity together. Therefore social constructionism has similar foundations to constructivism, as knowledge is seen to be constructed through social interaction, but highlights the role of language, such as professional discourse, in shaping both knowledge construction as well as discursive constructions of localised worlds (Loftus & Higgs, 2010). Vygotsky also considered semiotic mediation (involving symbols to make meaning) as central to knowledge co-construction, linking social and individual functioning, the external and internal. He used several examples of semiotic means, including language, counting systems, mnemonics, artworks, schemes, diagrams and maps (John-Steiner & Holbrook, 1996). Therefore it has been suggested that the association of Vygotsky's work with constructivism is not entirely appropriate and that his theories may well fit within an area of commonality between constructivism and constructionism (Robbins, 2003).

Vygotsky's theorising that the higher mental functioning in the individual derives from social life, and his explanations of acquisition and development in terms of "interpersonal" and "intrapersonal" functioning (Vygotsky, 1978, p. 131), were particularly relevant to this study of learning in the clinical workplace. As medical internship learning is largely dependent on interactions with patients and with senior clinicians, links to Vygotsky's ideas were meaningfully extrapolated in this study. Furthermore, a Vygotskian framework was found to correspond well with the study of writer-identity constructions (see section 4.4.2.1 Written reflections p. 89) and foundational to developing a theory about NQDs' identity construction overall (see Chapter 7 Framing Relational Influences in Theory: learning, identity and power relations p. 210).

In the methodological approach to this study, Vygotsky's ideas were again relevant in that I gravitated towards a dialectical approach in thinking about the data and for drawing inferences and findings. A dialectical approach was central to all of Vygotsky's work and involves engaging contradictions, bringing them into interaction, and employing the notion of synthesis to analyse 'verbal thought' in a more productive manner. It is thus distinguished from approaches that rely solely on the commonality of elements (as in thematic analysis), or those leading to traditional Cartesian dichotomies and duality. The interrelatedness of diverse elements and integration of opposites, characteristic of dialectics, allows for more meaningful analysis and explanations of human development (John-Steiner & Holbrook, 1996). For example, in the analysis of NQDs relating to patients, I considered the positioning of patients in conjunction with the identity claims by participants; which gave rise to a synthesis that adds insight into the tension between learning and working that NQDs need to manage in their day to day functions (see Chapter 6 Relationships p. 170).

This section pertained to the Vygotskian framework that in my understanding parallels a social constructionist approach. Despite the foundational differences between psychology and social science, there are areas of commonality that can be exploited to synergise ideas from both domains in educational studies (Illeris, 2009). In the following section the broad principles of learning discussed here are channelled into concepts that are more specifically applicable to workplace-based learning and social practice.

3.3 A theory of social practice

An epistemology of practice also considers both individual and socio-cultural learning theories as complementary (Eraut, 2007). The logic behind this dialectic in a theory of social practice is the assumption that the development of knowledge and skills of mastery are embedded in the development of identities of mastery. Identity construction therefore becomes integral to learning in a socio-cultural theory of learning (Wenger, 1998).

Jean Lave, a social anthropologist and Etienne Wenger, an educational theorist and practitioner, describe a 'think-tank'-like gathering in California, where they both worked in 1988, as the setting in which their ideas were first formulated (Lave & Wenger, 1991, p. 25). An ongoing group of readers in activity theory, critical psychology and workplace learning is credited as the source of discussions that helped them to explore the notion of 'legitimate peripheral participation' (LPP). Lave and Wenger's (1991) theory of situated learning is based on the assumption that learning processes take place within a relational framework of participation and co-participation rather than in individual minds. Their analytic tool of LPP is particularly helpful in making meaning of newcomers' experiences as they join a 'community of practice' (COP) as I explain in the following section. Unlike the more conventional notions of 'learning *in situ*' or 'learning by doing', the 'situatedness' of learning, according to these authors, focuses on the relationships between learning and the social situations *within practice* that give rise to learning opportunities.

3.3.1 *Situated learning, COP and LPP*

In this section I outline how a theory of social practice was applied in this study; and how, when learning is considered to be participation, identity construction becomes the point of articulation between the input individuals receive from the social world and their subsequent interactions with that world. These ideas are foundational to Lave and Wenger's formulation of a COP; and elaborated on by Wenger (Wenger, 1998) when he emphasises the ubiquitous nature of COPs and that everyone belongs to multiple COPs (Ibid. p.6). As

opposed to being conceptualised solely as ‘communities’, including the words ‘*of practice*’ in the term implies a common endeavour, shared understandings and mutual relationships, as meanings about practice are continually negotiated and renegotiated. Thus when participants belong to a COP, in whatever capacity and despite the different interests of individuals, their learning is firmly placed as social and as participatory through mutual engagements (Wenger, 1998). In my view, different ‘ways of being’ (a deliberately broad term that encompasses various explanations for the involvement of social contexts and culture in learning through participation), of individuals and social groupings then become an important factor in COPs. Although Lave and Wenger make mention of ways of being, they do not thoroughly address intra- and interpersonal relationships in their work. Therefore in this study Bourdieu’s theories were included to add that necessary dimension for evaluating how learning opportunities are enabled or constrained by individual and collective ways of being as discussed in the following section.

LPP is defined as a “descriptor of social practice that entails learning as an integral constituent” (Lave & Wenger, 1991, p. 35). In my understanding, LPP describes the process of situated activity in which newcomers engage when joining a COP. Having gained access legitimately through achieving the necessary qualification, though yet to develop mastery of the profession, newcomers are positioned peripherally with regards to their participation. In this peripheral position, rather than simply representing the edge of a broader practice domain, newcomers are likely to be entirely responsible for some parts of practice, subordinate to ‘masters’, and becoming practitioners all at the same time (Ibid. p. 23). In explorations of learning as LPP, the authors intend that the concept be taken as a whole, warning against the seemingly natural temptation to dissect it into three contrasting pairs, “legitimate versus illegitimate, peripheral versus central and participation versus non-participation” (Ibid. p.35). Because each constituent of LPP is inextricably linked to the others, they cannot be considered in isolation as it would be a meaningless exercise. However, for the sake of clarity, ‘legitimacy’ roughly represents the defining characteristic for membership, a prerequisite of further learning, but also being part of the whole. In the same vein, ‘peripherality’ suggests that engagement can be multiple, varied and of various degrees. Furthermore, the term ‘peripherality’ (unlike ‘marginality’) has positive rather than negative connotations within LPP, because it points the way forward for participants gaining

access to resources for development as their involvement (and responsibility) in practice increases. Taking into account the complex and differentiated nature of communities, it is also suggested that ‘full participation’ should be the preferred term used for the centripetal direction in which participation is headed, rather than central or complete participation. The latter would imply that there is in fact a centre to a community, or a finite domain of knowledge or collective practice that can be reached or achieved, which Lave and Wenger are careful to refute.

Lave and Wenger (1991) refer to LPP as being an analytic lens that is a tool for better understanding both the “development of knowledgeably skilled identities in practice” and the “reproduction and/or transformation of COPs” (Lave & Wenger, 1991, p. 55) through practice. Most usefully, LPP also allows for explanations pertaining to a conglomeration of roles that an ‘apprentice’ has to manage. In this study LPP provided the appropriate terminology and conceptual capacity to evaluate the various roles of NQDs during internship.

It should also be noted that a theory of social practice does essentially move away from a theory of situated activity where learning is reified as a particular kind of activity, toward the understanding that learning is an aspect of *all* activity. Hence LPP is not confined to a particular educational form and cannot be ‘operationalised’ or ‘implemented’ as it is not a pedagogic or teaching strategy. LPP as a theoretical perspective illuminates learning processes and highlights aspects that otherwise might be overlooked and in this way informs educational endeavours. The applicability of this type of framing lies in the fact that it allows for the ambiguity and the heterogeneity of life experiences; enabling the researcher to trace the developmental journeys of practitioners holistically, as they move from peripheral to fuller participation within COPs. Communities of (clinical) practice in turn are likely to be diverse; as they are part of society at large and undergo transformation from both internal and external forces. Therefore a theory of social practice was a necessary part of the theoretical framing for the exploration of internship learning and identity construction of NQDs. The following section briefly considers the literature on early career learning, generated through research in professions other than medicine, which also contributes some salient aspects of learning to consider within a theory of social practice.

3.3.1.1 *Medical internship as early career learning?*

The assumption behind including studies of novice practitioners' learning in other professions is that there are likely to be some similarities in the processes of LPP across most professions. For example, by tracing the trajectories of early career learning (ECL) in various other disciplines, especially in education, researchers have found that learning processes are predominantly informal and socially constructed (Eraut, 2007; McNally et al., 2009). A 'liminal phase' has been postulated, when newcomers feel insecure and unsure of their work, and when their professional identities are disrupted (Pierce, 2007). The importance of newcomers learning from others in the field has been repeatedly emphasised, and empirically demonstrated in a study spanning several professions, namely nursing, engineering and accountancy (Eraut, 2007). In this study I was able to evaluate the experiences of medical interns in the light of these findings of studies on ECL, although I did anticipate that medical internship experiences would be further complicated by NQDs having to concurrently assume responsibility for patient care.

Several learning conceptions have been suggested in the medical education literature as being associated with NQDs' learning during internship (Bleakley, 2002, 2006). Traditionally (and many practitioners still hold to this view), the medical internship period is essentially an apprenticeship. A traditional view of apprenticeship dominates (Sheehan, 2010), where learning takes place primarily by NQDs being immersed in the (clinical) workplace; initially by observing experienced practitioners, followed by gradually taking on responsibility for independently managing patients.

A contemporary model of apprenticeship learning has also been hypothesised as relevant, conditionally including LPP in a community of practice (Bleakley, 2006), where novices are able to contribute their ideas and potentially effect changes to healthcare system(s). However, if and how this might take place in reality has not been adequately interrogated, as the ECL experiences of NQDs during internship have not been adequately and appropriately researched (see section 2.2 Methodological state of medical education research on internship p. 19). In fact there is hardly any mention of medical internship in

terms of ECL in the extant literature, which leads me to suggest that the conceptualisation of internship experiences in terms of work (providing healthcare services) has far outweighed considerations about the learning processes of NQDs.

3.3.2 Bourdieu's theorising: habitus, capital and field

In theorising about the nature of persons and their ways of being (and becoming) in the world, French social theorist Bourdieu (1990) adds an important perspective to the way in which practice is conceptualised. For the purposes of this study – as *habitus*, capital and field are interconnected – I briefly discuss them in combination here, inasmuch as they informed my interpretations of the data. The assumption is that each person in practice brings with them tangible qualities that have been shaped by their life experiences and these in turn shape their thoughts, actions, tastes, motivations, intentions and aspirations.

Bourdieu (1990) writes about *habitus* in various ways in his work, and the language he uses seems somewhat convoluted at times. However, the most salient definition I have come across is as follows:

“... systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively ‘regulated’ and ‘regular’ without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at the ends or an express mastery of the operations necessary to attain them, and being all this, collectively orchestrated without being the product of the orchestrating action of a conductor” (Bourdieu, 1990, p. 53).

According to the above definition, my understanding of *habitus* is that it comprises set(s) of dispositions shaped by individual and collective histories, that are not actively controlled or coordinated, yet consistently give rise to particular patterns of expression, action and being. The concept of *habitus* therefore has further significance in that it speaks to the relationship

between structure and agency (Brosnan, 2013) and the way that identities are shaped. The *habitus* as described above does not necessarily involve intentionality. However, even unconsciously or unintentionally, it is nevertheless responsible for organising practice and associated operational strategies. As a person's upbringing, culture, and educational experiences contribute to the *habitus*, it is also likely to be a reflection of various social practices of their time. Social class, for example, is said to be "embodied in individuals in how they dress, speak, stand, present themselves, relate to various capitals, act, interact and work ... through *habitus*" (Luke, 2003, p. 64). In this way, *habitus* tends to produce and reproduce "objective structures of which they are the product, [and] they are determined by the past conditions which have produced the principle of their production" (Bourdieu, 1990, p. 61). However, *habitus* does also acknowledge the agency of persons, recognising their capacity to participate in an actively interpretive manner in how they relate to various cultures and operate within a range of different fields. Between the *habitus* of an individual member and that of a class or group, Bourdieu sees a "relationship of homology, that is, of diversity within homogeneity ..." (Ibid. p. 60). The individual *habitus* is said to be particularly impacted by early experiences, as there is a tendency of *habitus* to gravitate towards experiences through which it will be reinforced rather than be critically challenged or confronted with crises. Therefore the "systematic choices it makes among the places, events and people that might be frequented" (Ibid.) are in accordance with self-preservation. Avoidance of conditions to which the *habitus* is not pre-adapted is exercised, albeit with or without conscious intent. This point becomes clearer in the explanation of how various forms of capital relate to *habitus* and field as outlined below.

Bourdieu (Bourdieu, 1997) describes three main types of capital, namely economic, social and cultural capital. Economic capital refers to a person's material wealth (including one's job and education). Social capital involves a person being connected within networks of social contacts and the relative value of those connections. Cultural (and symbolic) capital is the type possibly most applicable to this study involving medical culture, and refers to the resources and aspects of personhood, generated by *habitus*, that mediate positional standing within organisational hierarchies. Through the exchange of various forms of capital, one may attempt to achieve a respectable reputation, prestige and distinction.

Capital, of whichever type, and the outworking thereof, becomes the means by which the position of an individual in a social field is negotiated.

Each 'field' (Bourdieu & Wacquant, 1992) of practice is characterised by struggles for position based on capital, likened to playing a game such as football and represents "the social space whereby interaction occurs in a distinct social domain" (Luke, 2003, p. 59). Players operate in the field, either individually or collectively, with varying degrees of autonomy, and interactions within the field are operationalised via capitals, structural relations and power flows. Social structures, in Bourdieuan terms, comprise of multiple fields collectively (Ibid.). With regard to this study, medical practice may be construed as a social structure in which multiple intra- and inter-disciplinary fields engage in collaborative action.

These Bourdieuan concepts have been extensively deliberated in the literature pertaining to the social sciences, and they are considered to have the necessary theoretical richness and flexibility to be used in linguistics and education. Social scientists researching identity construction in medical education describe the professional development of doctors in terms of developing a "medical *habitus*" (Brosnan & Turner, 2009; Luke, 2003; Sinclair, 1997). Sinclair (1997) elaborated on eight dispositions that comprise the medical *habitus*: competition, co-operation, economy, experience, idealism, knowledge, responsibility and status. Pertaining specifically to medical internship in Australia, Luke (2003) described the medical *habitus* as an expression of a particular ideology and culture where NQDs learn to 'play the game' and develop as 'social doctors'. Therefore it seems reasonable to suggest that *habitus* (individual and collective) would impact on practitioners' choices of specialisation in various disciplines of medicine. Positions NQDs might aspire to occupy in the interrelated hierarchical systems of medical practice would also depend on organisational cultures and internal politics. For example, in the context of particular hospitals that may privilege certain disciplines over others, this may influence what NQDs declare to be their own career interests in negotiating their learning opportunities during internship (Luke, 2003).

Hence *habitus* consists of a set of principles found to be particularly useful in the research of medical culture (Luke, 2003). With regard to medical education, in addition to the explicit

outcomes of the curriculum aimed at mastering specific knowledge, skills, attitudes and competencies, the *habitus* also operates at the level of one's personhood and signifies dispositions and predispositions that in effect go beyond the curriculum. As such, the concept of *habitus* is useful for explaining the implicit or hidden curriculum emanating from undergraduate and postgraduate education (Brosnan & Turner, 2009; Hafferty & Franks, 1994; Witman, 2014), and why it is that the received curriculum often differs from the intended curriculum, and why it might vary from learner to learner.

Paradoxically, it is when faced with an environment very different from the conditions for which the *habitus* was prepared, that the past conditioning of *habitus* is most clearly demonstrated (Bourdieu, 1990). Bourdieu applied the phrase "fish-in-water" to describe the ease experienced "when *habitus* encounters a social world of which it is the product ... it takes the world about itself for granted" (Bourdieu & Wacquant, 1992, p. 127). Conversely, the discord experienced in situations where dispositions and practices are mismatched to prevailing conditions and to the capitals valued within a social field, may be viewed as being 'fish-out-of-water' (Purwar, 2004). Groups are inclined to persist in their collective ways of being because of the durable dispositions of individual members, which may further outlast various social conditions by which these dispositions were produced. Such experiences of discord therefore have the potential to result in responses of adaptation and resistance, resignation and maladjustment (Bourdieu, 1990).

3.3.2.1 *Habitus and social constructionism*

Other researchers have described how they have meaningfully employed the notion of *habitus* to extend and enhance Vygotsky's theorising in a way that enabled understandings of how broader social contexts tend to produce and reproduce practices (Connolly, 2006). Where Vygotsky claims that learning and development are fundamentally social activities and semiotic mediation is based on social interaction, there are wider dynamics of social relations which have not been extensively theorised. Although there are some neo-Vygotskian studies that have investigated processes of collaboration and co-operation in learning, power dynamics, position and social location, which also have considerable

educational significance, have not been extensively examined (Panofsky, 2003).

Furthermore there are ways in which Bourdieu's ideas concerning the forming of the *habitus* parallel Vygotsky's internalisation of cognitive schemes. For example, both express the notion of social reality (or new ways of practice) existing twice; first on the social level (externally) and then on the individual level (internally). For Vygotsky, there is an explicit role for the adult or teacher in leading the learner to higher levels of understanding. Bourdieu provides related conceptual tools such as field and capital that enable the *habitus* to be contextualised in wider social networks than an individual's immediate interpersonal relationships (Connolly, 2006; Panofsky, 2003). The *habitus* further encourages a specific focus on broader cultural values and practices, and hence, in the study of identity construction, importantly allows for elaborating various culturally determined predispositions for developing particular ways of being over others.

In relation to the views of situated learning expressed in the previous section of this chapter, NQDs involved in LPP are, from a Bourdieuan perspective, persons with a *habitus* and with diverse capitals; they cannot be reduced to mental processes and their learning is a great deal more complex than a cumulative acquisition of knowledge (Lave & Wenger, 1991). The historically determined nature of motivation, the relational, socioculturally mediated means whereby learning experiences are made available, provides a more holistic frame for the study of medical internship experiences. Learning, viewed in these terms, implies "becoming a different person with regards to the possibilities enabled by these systems of relations ... [and thereby] involves the construction of identities" (Lave & Wenger, 1991, p. 53).

Transformation of the *habitus*, both individually and collectively, is therefore another way of understanding internal transformation within COPs. Internal transformation is as likely to effect changes in wider (e.g. healthcare) systems as external determinants such as policies and rules. Therefore in the following sections of this chapter I consider the ways in which developing professional identities might be conceptualised and introduce a theoretical and conceptual framework that sheds light on how identities might be shaped in the context of practice at the level of the self.

3.4 A theory of self, identity and identification

Identity can be portrayed using a variety of terms and concepts. The 'self' (implying aspects associated with emotionality or the affect of an individual) and 'person' (usually bearing an association with socially defined roles), are prevalent in anthropological writings (McKinlay & McVittie, 2011). A perusal of the literature relating to 'the self' and 'identity' reveals that these terms are often used interchangeably. However, they may also refer to a "bewildering array of different notions" (Ibid. p. 4). Rather than attempting an exposition of the various possible meanings of these terms, in this section I focus on how the central issues as relevant to self-categorisation or identification might be accessed by educational researchers. 'Social identities' are assumed to reflect membership of different social groups expressed through language and discourse (see section 4.4.2.1 Written reflections p. 89). Self-categorisation in the context of this study includes the notion of narrative 'positioning' and 'positionality' based on who we think we are and who we think others think we are.

Social theorists also refer to 'subject' and/or 'positioning' to highlight how identities are influenced by the "discourses and social practices in which individuals participate" (Ivanič, 1998, p. 10). However, it is important to note that a person might be positioned simultaneously in a variety of dimensions, as people are not always free to take on any identity they choose. Differential power issues are closely linked to the various constraints placed on people from assuming and performing identities entirely of their choosing. Recognising that identities are socially constructed therefore explains the powerful influence that dominant ideologies exert in controlling people's sense of themselves, as well as the possibility of them resisting and/or struggling against the status quo for alternative ways of being. This adds a sense of identities being multiple, hybrid and fluid, incorporating a "complex interweaving of positioning" (Ibid.).

Ivanič (1998) points out that the focus of social identity theory (Tajfel, 1981) and social categorisation theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) is the way that people position themselves in relation to various social groups, categories and stereotypes. This perspective is useful for understanding the way in which the self is re-categorised especially during critical times of a person's life. In my study these ideas were relevant to inferences of how participants positioned themselves in the narrative data with regards to

various social groups in the clinical workplace. Both the referential content of narratives and narrative language (ways of telling) were analysed for positioning of self and others, noting indications of similarity or sensing boundaries or difference, as these were considered to be the essential means of interpreting identity constructions.

The way we view ourselves and the way we perceive that others view us underlies most of what we do in practice (Monrouxe, 2010). The identification process involves cognitive and social processes by which we make sense of and organise our human worlds. It is a two-way process of simultaneously amalgamating internal self-definition (who I think I am) and external definitions (who I think others think I am). In this self-categorisation process, apart from defining who we are, we also identify who we are not, as identities are constructed through attending to difference (Ibid.). These self-categorisations then construct a version of a person both as an individual and as belonging (or not belonging) to categories of persons, establishing common characteristics of social groups. Characterisations are also imbued with action, inferring that they are integral to social actions such as being inclusive or exclusive, blaming or exonerating, and accommodating or resisting social norms (McKinlay & McVittie, 2011). Exploration of such self-categorisations and characterisations of NQDs could therefore be expected to yield a better understanding of identity construction in the professional development of becoming doctors.

3.4.1 A case for synergising psychology and social theory through DST

Nearly fifty years ago, Levinson (1967) noted a divergence between psychological and sociological approaches towards researching issues of socialisation in medical education and suggested that a combination of these approaches might be more productive. More recently Monrouxe (2010) noted a gap in the medical education literature on matters relating to identity construction and also proposed that a synergistic perspective incorporating psychological and social theories would be a fruitful way to study identity construction. In adopting a psychosocial view, it has been suggested that identity both

arises *out of* social interactions, and *explains* social interaction (McKinlay & McVittie, 2011, p. 6 - own emphasis).

Psychologist Hubert Hermans from the Netherlands proposes that the self includes not only an intrapersonal domain, but that independent others are incorporated as an intrinsic part of the self that extends to a person's social environment (Hermans, 2013). Hermans' DST (Hermans & Hermans-Konopka, 2010) posits an environment for the self that is somewhat different to previous positioning theories. His ideas provide a more gradual progression between the self- and other-positions which usefully enables theory building around how significant others relate to the self in learning and professional development. In Hermans' contemporary theorising (Hermans, 2013), the psychological views of self-categorisation and intrapersonal identity appear to merge or synergise with the sociological concept of identification through positioning construed in relation to social structures. Psychological and social theories were therefore combined in a generative way to provide an appropriate analytic framework for this study.

According to Hermans (Hermans & Hermans-Konopka, 2010), the self is not only positioned and repositioned by multiple (re)categorisations, but these positions are also seen to be in dialogic interaction with one another. In order to capture the essence of the dialogism inherent to DST, Hermans portrays the self as 'multivoiced' being inspired by Bakhtin's ideas of polyphony, and refers to a "society of the mind" (Hermans, 2012, pp. 2-3). The concept of I-positions is central to DST, where external and internal other-positions become incorporated in complicit or opposing ways within the self (Hermans, 2013). DST elaborates on previous positioning theory to give rise to the notion that identities, consisting of various I-positions, may be in (self-) agreement or (self-) conflict. Hence the concept of a person positioning themselves in dialogical relation applies not only to others but also to the (extended) self.

In more conventional positioning theories based on concepts such as categorisation as a group member or othering (Akkerman & Bakker, 2011), as ingroup or outgroup (Tajfel, 1981; Turner et al., 1987), there was a clearer distinction and separation between self- and other-positions. In DST, however, Hermans introduces the notion that other-positions may be internal or external and are continually being appropriated in the self in various ways. For

example, some I-positions might exert dominance over others or they might merge to give rise to new and more accommodating positions. Other-positions might become promoters or blockers of developing I-positions (Hermans, 2012). This more gradual progression between self-positions and other-positions results in a blurring of boundaries between internal and external positions. DST thereby allows greater explanatory potential for making meaning of various relationships with significant others in learning processes and identity construction.

In Hermans' theorising, the other when represented in the self may be "actual, remembered, imagined or anticipated" (Hermans, 2012, p. 9), and may take up "promoter" or "anti-promoter" positions with regards to the development of positive identities (Hermans, 2013, p. 87). Hermans also usefully hypothesises a 'personal position repertoire' (PPR) consisting of multiple other-positions available for appropriation in the self (Hermans, 2013). These ideas informed my theoretical suggestions regarding possibilities for positive identity constructions enabled by others present in clinical COPs (see section 7.3.1.3 Repertoire of possible I-positions p. 220).

3.4.1.1 *Link to Vygotsky and Bourdieu*

Incorporating DST (Hermans & Hermans-Konopka, 2010) as an analytic framework added a further useful dimension in that it enabled plausible explanations for how internalisation and ZPD described by Vygotsky (Vygotsky, 1978) might operate. At a micro-process level, internalisation and ZPD could also be viewed in terms of multiple and diverse self-positions that result from appropriating other-positions in the self.

Linking with Bourdieu's (1990) theory of *habitus*, capital and field, described in the previous section, made it possible to evaluate positionality as 'ways of being' in relation to others. In concluding this section I briefly discuss narrative identity in the broadest sense and argue that narrative inquiry serves as a window into all the theoretical domains discussed so far – learning, social practice and identity construction (see Figure 1 p. 53).

3.4.2 Self-representation in narrative form

According to Andrews et al. (2008, p. 29), personal identity is now conceptualised by many identity theorists as “the accumulation of stories we tell about ourselves”. Andrews et al. also argue that “dialogic approaches to the self and to narrative are brought together in many different ways in order to theorise their complex interrelationship” (Ibid.). Whatever genre a personal narrative might take – for example, anecdote, oral history communication, legal testimony or response to interview questions – it is always a narration of the self. In addition to personal narratives, social groups and organisations also construct identities for themselves through narratives that represent who they are, depending on how they want to be known (Riessman, 2008).

The purposes for which individuals engage in narrating their experiences are many and diverse. Riessman (2008) expounds on several functions that narratives can accomplish in social interaction, where narrating supersedes any other means of communicating. It is these accomplishments, or the ‘work’ done by narratives, that to my understanding achieves positioning, and in turn becomes the focus of narrative inquiry. The persons whose narratives they are may not necessarily be conscious of the work that is being achieved, as narrators themselves may be quite unaware of the accomplishments of their stories (Freeman, 2002). We engage in story-making and story-telling as the means by which we interpret our experiences and communicate them to others. Therefore, narrative is an exercise of retrospectively making meaning and a way to understand ourselves and others; recognising and connecting consequences of events and actions over time.

However, our narratives are not simply a reflection of our own individual views, because we collaborate with others in the co-creation and the analysis thereof. The shaping of a narrative, for instance, is always influenced by the intended audience and other possible readers as we imagine them to be (Riessman, 2008). The identities claimed by narrators (Mishler, 1986) might also include representations of particular personal, socio-cultural or political standpoints. Furthermore, organisations, professions and communities of practice similarly create and re-create narrative identities for themselves. The influence that such

collectively constructed identities have on individual member's identity constructions needs also to be taken into account when interpreting personal narratives. Therefore self-representation essentially occurs within social contexts, through interaction with others, whilst embedded in local institutional settings that have established organisational cultures and ideologies.

From the above argument, the self consists of the interpretation a person currently places on their life-history rather than a direct consequence of events; and their interpretations would be expected to change over time. As a way of conceptualising this form of self-identity in narratives, Giddens (1991) refers to a 'reflexive project of the self' in which (auto)biographical narratives, though revised continuously, still exhibit a coherence that is sustained, and therefore may be considered as partial representations of the self. In the next section I outline the analytic framing that informed my thinking regarding the role of interpersonal relationships, particularly in professional identity development.

3.4.3 Relationships and identity construction

As discussed in the previous chapter, informal learning and 'good' relationships in the workplace are acknowledged as important factors in early career learning across various professions (see section 2.4.2.1 A multi disciplinary theory of relationships p. 42). However, the nature and quality of these relationships are not well elaborated in the literature and remain indistinct. To add clarity in this area I draw on the work of Axel Honneth (2007), a critical theorist who philosophises the role of 'recognition' in identity development. He understands relations of recognition to mean the ascription, or granting of entitlement, to certain levels of consideration for the "needs, beliefs and abilities" of one another, as "worthy of articulation and pursuit in the public sphere" (Honneth, 2012, p. 46). For instance, it is the supposed links between recognition and identity that give rise to the urgent demands for recognition by 'subaltern' and minority groups in the politics of multiculturalism (C. Taylor, 1994).

In medical education, relationships with senior colleagues are said to be essential, and positive role modelling has been promoted as the crucial pedagogic strategy for the professional development of NQDs (Passi et al., 2013). There are also some persistent problems described in the literature associated with negative aspects of NQDs relating to senior colleagues. For example, there are reports of various abuses of power ranging from rudeness to outright bullying (Lamdin, 2006; Quine, 2002), and humiliation or shame being employed as a teaching strategy in clinical work settings (Witman, 2014). Medical internship is also perpetually described as overly stressful, and seeming to propagate a lack of patient-centredness (Brosnan & Turner, 2009); which are also causes for concern that remain inadequately addressed.

In this study, Bourdieu's (1990) theories of *habitus*, capital and field provided some useful tools for thinking about the influences of broader socio-cultural contexts on individual ways of being (and vice versa) and for explaining social reproduction. In addition, at a more intimate level of analysis, Hermans' (2010) DST proved helpful in understanding the role of relational influences in self-categorisation processes. For a theory that would speak to the quality of interpersonal relationships and agents' relationships with institutions, Honneth's (2007) contemporary philosophy of recognition and disrespect were incorporated to make meaning of these relational influences on identity construction.

Honneth (2012) makes the assumption that 'I-formation' takes place gradually through the internalisation of "social responses characterised by intersubjective recognition" (p. 204). In this view, human beings achieve autonomy as they learn to understand themselves as mirrored by the recognition received from others as beings whose needs, beliefs and abilities are worth being realised (Honneth, 2007, p. 41). Charles Taylor is acknowledged by Honneth (2012) as having made an invaluable contribution to contemporary social philosophy; and Taylor (1994) reasons that we negotiate our identities through "dialogical relations with others" (C. Taylor, 1994, p. 34). Honneth elaborates further by differentiating three forms or patterns of reciprocal recognition, that lead to self-confidence, self-respect and self-esteem respectively. The usefulness of this proposed schema lies directly in the increased potential for understanding how intersubjective recognition or disrespect (lack of recognition or misrecognition) impacts on the self. I have attempted to summarise

Honneth's ideas on recognition and disrespect in the table below (adapted from Fleming & Finnegan, 2011):

Table 1: Honneth's three forms of reciprocal recognition

Form of recognition	Relation to self	Corresponding form of disrespect
Acceptance, emotional concern (friendship, care, love)	Self-confidence	Neglect or abuse (physical or psychological)
Approval of legitimacy, rights-based recognition	Self-respect	Denial of rights or exclusion
Valuing / honouring contribution, social esteem	Self-esteem	Denigration / insult

In Honneth's view, this multi-layered concept of reciprocal recognition is a dynamic that operates both interpersonally and within the wider socio-cultural context. It should also be noted that these three forms of recognition can occur in parallel, with no set sequence. The first form, as listed in Table 1 above, is linked to primary care-takers, such as parents, who provide resources for early identity construction. However, to continue and expand a positive relation to the self requires belonging to social groups, being accepted and recognised within mutually respectful relationships. In Honneth's (2012) recent work, he expands usefully on this latter concept, stipulating that it is the group that allows adults to be re-affirmed in "their needs, judgements and various skills in direct interaction with others" (Ibid. p. 206). The implication of this, using Honneth's terms, is that processes of individuation and socialisation are intertwined, and it "allows inferences about the role of social groups in individual maturation" (Ibid. p. 205).

In this study combining Honneth's ideas with theories of learning, social practice and identity development, enabled theorising about the way identities of NQDs were intersubjectively shaped.

3.5 Summary

Vygotsky claimed that whatever we as individual human beings become able to do independently is as a result of our social experiences with other humans. Considering individual and social processes to be in dynamic interaction, enables a view of identity construction as performed in semiotic acts, and adds insight into this complex interrelationship. Accordingly, this study has been founded on a philosophy of social constructionism, as relationships were considered central to processes of learning and identity construction.

Situated learning and LPP in COPs are theories that pay particular attention to learning opportunities arising from social situations in practice. Bourdieu's theories enable a more socially determined view of the self and relationships as influenced by and influencing cultures and social structures. Analysis of narrative identity based on self- and other-positioning has the potential to inform interpretations about learning, the role of significant others and identity construction. In combination, these theoretical lenses allow for the meaningful tracing of trajectories of newcomers as they develop identities of mastery. The negotiated nature of the developmental journeys in COPs therefore places relationships, the *habitus* of individuals, organisational cultures, and social structures in a diffusely expanding matrix of contextual layers, in which this study of identity construction is embedded.

Rita Charon (2006), who is both a clinician and literary scholar, advocates "close reading" of patients' illness narratives, by attending to "all aspects of the literary apparatus of a text" (p. 113). Her aim is that doctors should develop greater narrative competence as a means to achieve greater patient-centredness, by strengthening their "cognitive and imaginative abilities that are required for one person to take in and appreciate the representation – and therefore the reality – of another" (Ibid.). The following chapter on research methodology could therefore be viewed as a detailed account of the way I went about paying such close attention to the accomplishments of NQD participants' narratives. By employing the methods described, I focused on how medical interns were positioned in relation to social groups in clinical practice, and what that positioning implied about their learning and identity.

Chapter 4: Research Methodology

4.1 Introduction

The term 'methodology' when applied to social and educational research includes underlying beliefs about reality, existence or being (ontology), the nature of knowledge (epistemology) and values (axiology). These beliefs give rise to sets of assumptions that shape the overall design of a study and the specific methods used to generate and analyse data. In this chapter on methodology I begin with an explanation of why I chose to locate this study within the interpretive paradigm. I then discuss the sampling and elaborate on how the narrative approach used in this study aligns with interpretivism; and I contrast the qualitative, case-centred orientation of this study with the positivist paradigm generally privileged in medical education research.

I go on to present in detail the actual methods I used to generate data and the thematic and structural narrative analyses conducted at various points of the study. I then summarise the phases of data generation and analysis, and the interpretive insight gained in the form of a table (see section 4.5 Summary of phases of data generation and analysis p. 99). Finally I highlight some of the ways in which the specific methodology contributed to eliciting rich data that enabled a deeper understanding of medical internship experiences.

4.2 Paradigmatic considerations

In the medical education literature 'methodology' and 'methods' are often used synonymously and research paradigms as understood in the social sciences are not commonly discussed. I therefore considered it necessary to explicitly position myself with regards to the assumptions behind this interpretive study design, which would be considered less than acceptable if judged by the standards of positivism. Although researchers may find that their ideas straddle the various research paradigms, there are some clear distinctions that may be made based on foundational ontological and

epistemological assumptions. Ontology refers to assumptions about the nature of what is 'out there' (Guba, 1990) and positivism aims to discover aspects of reality that are generalisable in ways that are replicable as demonstrated, for example, in experimental research conducted in the natural or physical sciences. This type of framing is indeed necessary for answering particular research questions, even involving human subjects, wherever rules and standards are important. For example, in clinical trials to determine physiological responses to various levels of therapeutic agents, quantitative methods and statistical analyses are mandatory. The nature of knowledge, or epistemology, of positivism is correspondingly based on valid and reliable measurements (of singular truth) being obtained from large enough samples, where investigator(s) must remain objective and impartial. By contrast, interpretive inquiry aims to understand multiple truths, where knowledge is assumed to be jointly constructed between subjects; here reality is contextually variable and socio-culturally mediated. The researcher is expected to play an active role and to disclose their opinions and biases that are an inevitable if not essential influence on the research process. Denzin and Lincoln (2008) aptly describe the role of a qualitative researcher as comparable to the work of a *bricoleur* who carefully pieces together various representations, such as in the art of quilt-making or montage (assembly of images in film-making) to create a new construction, which is also an emergent representation. As the qualitative researcher's work is essentially reflective, their biography, thought process and subjective choices, which may not be apparent in advance, should be acknowledged and made clear in reporting such research, so as to bring the reader along and enable them to draw conclusions for themselves (Ibid.).

Quantitative studies are therefore generally consistent with the positivist paradigm, whereas a qualitative orientation, implying an "emphasis on qualities of entities and on processes and meanings that are not experimentally examined or measured" (Denzin & Lincoln, 2008, p. 14) aligns with the interpretive paradigm. It is possible to analyse qualitative data guided by the ontological and epistemological assumptions of positivism, and researchers now increasingly adopt 'mixed methods' which draw on the strengths of both quantitative and qualitative orientations. However, interpretivism would typically attend to socio-cultural issues, situational factors that influence the study and the relationship between researcher and researched (Ibid.). As this qualitative research aimed

to interpret participants' meaning making and gain a better understanding of the experiences of NQDs, I positioned myself as a researcher within the interpretive paradigm. This paradigm is typically characterised by concern for the individual, and rejection of positivist emphases on objectivity, prediction and control. Its primary aim is to "understand the subjective world of human experience" (L. Cohen, Manion, & Morrison, 2007, p. 21). Manifestations of these characteristics are then three-fold: people are attributed with creativity and intentionality (Blumer, 1962) instead of being regarded as passive products of culture and circumstance; situations are not fixed and static but fluid and changing; and the social world is best studied in its natural state with minimal interference by the researcher (Hammersley & Atkinson, 1995).

I have previously emphasised the predominance of positivist methods and thinking in medical education research (see section 2.2 Methodological state of medical education research on internship p. 19). The propensity for using large samples in pursuit of generalisability in educational studies is somewhat paradoxical considering that the development of medical expertise often depends on particular patient cases. I have argued that there are some issues and research questions that require a different approach and different 'ways of knowing'; identity construction is one such issue.

The narrative approach I chose to adopt is detailed in the following section; however, I would first like to point out that narrative methods themselves are far from being a uniform process on which there is wide consensus. Rather, there is significant variability, depending on the researcher's conceptualisation of what narrative is, how to study it, and why it is important; for instance, narrative as material (data), method (analysis) or route to understanding psychological or social phenomena (approach); or all of the above (Andrews et al., 2008). However, what all narrative methods have in common is that they involve case-centred stories, in written, oral or visual forms; where the 'case' might be an individual, a group of individuals, community, organisation, or even a nation (Riessman, 2008). In anticipation of, and to counter, potential critics of research methods that use small numbers of select cases to examine the nature of a broad phenomenon, such as medical internship, I first present a point-form summary of Flyvbjerg's (2006) main arguments against five common 'misunderstandings' regarding case study research, which equally applies to case-centred narrative research.

- Context-dependent knowledge which is essential for the development of any field or discipline can only be accessed through numerous concrete case studies. Experts have been shown to achieve mastery, or the tacit skills and fluidity of performance of the 'virtuoso' (Bourdieu, 1997), from intensive and extensive experience with case-study rather than depending on general rules that are context-independent.
- Carefully chosen experiments and particular cases, coupled with critical reflexivity have historically been responsible for major developments in scientific knowledge. For example, Galileo's rejection of Aristotle's theory on gravity and his case for heliocentrism were verified by a single experiment. Newton's Laws of Physics and Einstein's related theories were also based on selected cases and experience.
- Atypical, extreme or paradigmatic cases are often necessary to extend a theory about a general problem. Flyvbjerg (2006) uses Popper's famous example of a single black swan that falsified the proposition that 'all swans are white'.
- By focusing on everyday situations, case studies can provide a test of how something occurs in social life, as they have the advantage of depth rather than breadth; they can force the revision of hypotheses.
- Through attention to narrative detail or the 'little things', important insights can unfold from the many sided, complex and sometimes conflicting stories of actors in the field. Cases reveal facets which readers can decide the meaning of and investigate for themselves the interpretations of narrators and actors in deciding what the case is about (Flyvbjerg, 2006).

The above arguments demonstrate how qualitative, case-based methods are central not only to the practice of science but to the evolution of general knowledge about the workings of the physical and social world. The aim of presenting these arguments is not to say that generalisability has no value; rule-based knowledge is arguably foundational in every discipline, and therefore both approaches are needed. However, generalisation is only one way of developing knowledge and should not be considered the ultimate goal of scientific knowledge. Particularly in research involving educational processes, case studies are a source of nuanced realities and are essential for meaningful understandings of human behaviour (Flyvbjerg, 2006).

Narrative research, while having a case-specific focus, also pays particular attention to the storytellers and their stories, how the telling of stories has a specific form and sequence, and how they represent the storyteller and his/her world. As Samuel (2009) points out, narratives record the storyteller's current view of their position in relation to the subject that is being discussed. Narrative research is thus particularly suited to investigating how people understand their own experiences and make meaning of their learning and identities. My study adopts the narrative approach for these reasons, as I elaborate in section 4.4 Narrative approach below.

4.3 Selection of participants

In line with a qualitative approach, I drew a purposive sample of doctors from whom I felt I could "learn the most" (Denzin & Lincoln, 2008, p. 130) about their internship experiences. All participants were graduates of a PBL curriculum innovation 'Curriculum 2001' and being the first cohort of students to experience this curriculum (see section 1.4 Introduction to study design p. 8), I could reasonably expect their awareness of meta-cognitive processes to be heightened. The doctors I invited to participate in the study were also personally known to me during their undergraduate years, mostly through a Christian Medical Fellowship mentorship group. The activities within this group included meeting together approximately once per month for prayer support, voluntary sharing of spiritual matters and biblical teachings. This provided an opportunity to build mutually trustful relationships in a small group setting, though personal knowledge of each individual was limited. After graduating, only a few of them had had occasional contact with me, usually to share some significant personal news. However, I viewed my pre-existing relationship of trust during their time at medical school as both a privilege and a strength of the study, due to which I could reasonably expect honest and fuller disclosure even of more sensitive details (Grinyer, 2005; Maydell, 2010; West, 2010) relating to their development as practitioners. Having listened to these individuals speak about their various curriculum experiences from their second year of undergraduate study until they graduated from medical school, I was also personally

motivated to find out how they had fared as NQDs and what kind of practitioners they had become. By engaging these participants, I anticipated opportunities to generate richer data and a greater depth of insight than from any other random or stratified sample of previously unknown individuals, with whom I would have had to build relationship prior to soliciting their narratives as NQDs.

Data generation and analysis took place in two distinct phases as summarised in Table 2 Phases of data generation and analysis p. 99. In the previous research that generated the data for Phase 1 of the study, twelve NQDs fulfilling the abovementioned criteria were invited to participate, of whom nine initially responded positively. Three of these respondents were unable to complete their written reflections for personal reasons and therefore six NQDs became participants in this study. Entirely incidentally these six participants included three male and three female NQDs who were also of diverse social and ethnic backgrounds. All six participants agreed to being interviewed in Phase 2 of the data generation process that followed up on their career trajectory and/or professional development. The interviews focused on their learning processes and identity constructions during internship from a more mature perspective and were the means to gain valuable insight into the influence of motivations, dispositions and aspirations on learning and identity construction. Examining the coherence of each participant's narrative as a whole, or when something appeared to be different to the way others had told their stories, clarity could be sought during interviews.

4.4 Narrative approach

Historically, narrative research emanated from two quite distinct but parallel academic traditions: firstly the holistic, person-centred individual case studies of biographies and life histories, especially post-war; and secondly the Russian structuralist and later French post-structuralist moves within the humanities. In current narrative research there are many convergences between these humanist and post-structural approaches, often because of a "shared tendency to treat narrative as modes of resistance to existing structures of power

..." (Andrews et al., 2008, p. 4). The use of narrative research methods in the human sciences during recent decades has undergone rapid expansion to the extent that authors refer to a 'narrative turn' which has been associated with 'moral intent' within postmodern social theory (Riessman, 2008). However, in medical education research, until recently, a generalised avoidance of narrative research methods has prevailed and this avoidance has been critiqued as being a form of "self-imposed institutional autism" (Bleakley, 2005, p. 534).

The narrative approach aims to address two primary questions: "what does the narrative or story reveal about the person and the world from which it came, and how can this narrative be interpreted so that it provides an understanding and illuminates the life and culture that created it?" (Slay & Smith, 2010, p. 7). Personal biographical details from the perspective of the one who lives them, as well as specific meanings attached to them, are best communicated to "attentive listeners" (Riessman, 2008, p. 26). It is however important to note that narratives "do not 'reveal the past', neither are they 'open to proof', but through interpretation they do reveal truths about narrators' experiences and how they want to be understood" (Personal Narratives Group, 1989, as cited in Andrews et al., 2008, p. 31). All narratives are considered fundamentally co-constructed between the author and the audience. The narrative researcher, whether physically present or not, would have an influence on what is said, how it is said, what can be taken for granted and what needs further explanation (Riessman, 2008). As narrative methods are always subjective, in the sense that narrative researchers are unavoidably part of the data generated, it is essential that researchers adequately account for themselves in their work and consider the possible influence of their positions, biases, and relationships to the participants. Pillay (2009) takes this idea a step further by arguing for the "I-visibility" (p. 56) of the researcher in research reports, detailing a far greater presence and involvement than the co-constructed nature of narratives and subsequent narrative knowing (Clandinin & Connelly, 2000). These ideas make space for "the 'me' of the researcher" (West, 2014, pp. 171-172) to explicitly participate in the research process as a biological and neurological reality, including 'critical conversations' they have with colleagues, friends and fellow PhD students, and the inspirational knowing that arises from these engagements (Pillay, 2009). Rather than attempting to 'wash away' the knowledge we bring as part of our being, or to limit our

contribution to matters of intellect, Pillay (Ibid.) advocates a more active inclusion of the embodied knowing of researchers, “with our social, cultural, and political Researcher-selves” (p. 40).

A comprehensive definition of ‘narrative’ is elusive as there are various understandings of the term depending on numerous traditions, academic disciplines and analytic strategies. Contemporary literature on the narrative approach often uses ‘story’ as synonymous with narrative, as I have done in this thesis, although strictly speaking the story might be considered to be only one kind of narrative (Riessman, 2008). Other kinds of narrative might include political, historical, documentary, hypothetical or habitual narratives, having their own distinctive forms. Reid (2010) uses fictive narrative as a means to display the researcher’s cumulative experiential knowledge of NQDs’ experiences in rural healthcare contexts of South Africa. Reissman (2008) highlights ‘contingency’ to be a fundamental characteristic of narratives of whatever form and whatever they are about, as they involve the linkage of events or ideas in some sequence or temporal arrangement.

In the human sciences narrative refers to texts generated by several overlapping layers or levels of an inquiry, such as the participants’ stories, investigators’ interpretive accounts and observations, which are stories about stories, as well as the narrative that readers construct having engaged with the previous texts (Riessman, 2008). In this study I used ‘narrative data’ from two sets of texts that were participants’ written reflections as well as oral interview accounts of their personal experiences (see section 4.4.2 Narrative data generation p. 89). By ‘narrative analysis’ I refer to both thematic and structural analyses of the narrative data that revealed narrative positioning as discussed below (see section 4.4.3 Narrative data analysis p. 95).

Narrative researchers appear to devote a great deal more attention in their written work to even fewer individuals than do other qualitative researchers; for example, entire books have been devoted to an individual’s life story by anthropologists, sociologists and psychologists. Other narrative researchers have based entire books, chapters or articles on a small number of narratives (Chase, 2010). Historically the question of representativeness has been debated, whether an individual or small group of narratives should be seen as representing the population being studied. However, such concerns have been refuted by contemporary

narrative researchers who highlight the particularity of each participant's narrative, but ensure that they somehow place their stories in a broader expanse of previously reported studies to demonstrate how the narrative they present is similar in some ways and unique in others. Chase (Ibid.) sums this up well as she concludes that narrative researchers regard:

... *any* narrative as an *instance* [original emphasis] of possible relationships between a narrator's active construction of the self, on the one hand, and the social cultural and historical circumstances that enable and constrain that narrative, on the other ... they do not claim that their studies exhaust the possibilities within that context ... any narrative is significant because it embodies – and gives insight into – what is possible and intelligible within a specific social context (p. 226).

Andrews, Squire, and Tamboukou (2008) have observed that it has become common practice in experience-centred research to gloss over language in order to get to narrative meaning or function. This practice is problematic in that the finer details of positioning and identification reflected in the linguistic choices of narrators would then not be given due consideration. Therefore the same authors recommend a much closer examination of the language used in the telling of narratives in addition to the content or what is being told. They do warn that “a fetishization of language in social research would not be a happy remedy” (Andrews et al., 2008, p. 9) but a slower and more attentive reading of narrative language might be. In this study I therefore chose to examine the ways in which participants positioned themselves in relation to others (persons, social groupings and institutions) throughout their written reflections and oral accounts. This approach is aligned with the idea of narrative positioning (Bamberg, 1997; Guerrero, 2011) where the participant is shown to construct their identity by multiple possible means in communicating their experiences. Narrative therefore becomes an invaluable resource that is used to display the self and identity, which can be analysed using various methods attending to the linguistic structure, content and socio-cultural context of the narrative (Guerrero, 2011). The narrative language used as well as the various discourses employed were carefully examined in this study, as discourse is recognised to be the mediating mechanism in the social construction of writer-identity (Ivanič, 1998). For the purposes of this study I defined ‘discourse’ as a collective conversation, debate or discussion representing a mutually

understood reality, determined by ideology and culture (see also 4.4.2.1 Written reflections p. 89).

In the following sections I consider narrative methods as a particular subset of qualitative research methods and highlight various aspects that made them particularly suited for use in this study.

4.4.1 Rationale for narrative research methods

When the aim of the research is an in-depth investigation of personal experiences, narrative methods have much to offer as detailed above. Despite the limitations of the methods discussed later on in this chapter, there are certain advantages that outweigh the drawbacks. Whether oral or written communications are employed, researchers who engage in narrative studies treat narrative as a special medium of communication that retrospectively makes meaning of actions and events, organising and linking consequences to these actions and events. Narratives also communicate points of view, unique evaluations and emotions associated with each action or event (Chase, 2010).

Furthermore, narrative methods have been recognised as particularly suited to the study of careers and professional identity; a career being a sequence of work experiences, and narratives about these experiences inform the professional self-concept (Slay & Smith, 2010). Identity construction is assumed to take place through the kind of narratives that are told, where individuals portray who they are, contextualised by interactions with persons and institutions in the work environment. Therefore I considered narrative research methods, in all their theoretical diversity and subjectivity, as offering the greatest potential for adding new meaning and insight to what is currently known about the learning and professional development of NQDs. Furthermore in clinical practice, autonomy, empathy, practical reasoning, self-evaluation and motivation towards further learning are valued traits of medical practitioners, which I considered difficult, if not impossible, to evaluate using any other methods.

Narrative research also resonates with broader issues of social justice, personal and systemic change. Chase (2010) addresses the importance of narrative inquiry to bring about social change, asking some critical questions as to the kinds of narratives that disrupt oppressive social processes. She insightfully considers how and when social justice and democratic processes might be promoted by researchers' representations of others' stories. The very act of self-narration is recognised to potentially lead to personal emancipation and positive change. However, narrators would often want their stories to be heard by others, and, in situations that involve social injustices (or forms of disrespect), there is likely to be a degree of urgency to command the attention of the audience by the 'I-who demands to be recognised'. Therefore narrative studies have claimed to 'give voice' to marginalised persons and 'name silenced lives' over many decades. By personalising issues, narratives can also promote empathy and create opportunities for dialogue. Readers who identify with the personal narratives presented in narrative research studies may also find resources in researchers' interpretations to understand and tell *their* stories differently. Furthermore, together with interpretive commentary of researchers who reveal "oppressive metanarratives" even hostile audiences might be "moved through empathetic listening to think and act in ways that benefit the narrator" (Chase, 2010, pp. 227-228).

I found the above arguments regarding the possibilities for social change through personal narratives resonated particularly well with my hopes and intentions in undertaking this study. Considering the need for change in medical internship experiences documented in the literature (see section 2.3 Experiences of medical internship p. 34), narrative methods seemed to be ideally suited. The underlying assumption of this study is that by personalising the experiences of NQDs, insight would be gained and possibilities of how to deal with various problematic issues relating to the early career learning of doctors would be brought into relief or focus.

4.4.1.1 *Limitations of narrative methods*

The question of how researcher(s) might 'get things wrong' needs to be considered in all research endeavours, not only in relation to narrative methods. Especially concerning issues

of validity and truth(s) in qualitative research, Bosk (1979, p. 193) is often quoted for having said “All fieldwork done by a single field-worker invites the question, Why should we believe it?” in reporting an ethnographic study of surgeons in training.

Maxwell (2010, p. 281) takes validity to mean, quite simply, ‘credibility’ or ‘correctness’, and explains how qualitative researchers should concentrate on how to “rule out *specific* plausible alternatives and threats to the interpretations and explanations” in their work. He warns against depending on abstract strategies such as ‘bracketing’, ‘member checks’ and ‘triangulation’ being invoked for their “magical charms that are intended to drive away evil” (Ibid.) However, he recommends attention to specific issues in a study related to researcher bias (in selecting data) and reactivity (how the researcher might affect participants). Validity threats in qualitative studies appear to be most commonly encompassed by these two broad areas.

There are no research methods or combination of techniques per se that can guarantee validity, as it is not a commodity ensured by methods. It is a goal that is relative, and concerns about validity can only be addressed by evidence – methods being the means of generating evidence (Maxwell, 2010). In studies employing narrative methods, validity concerns arise based on the very nature of personal narrative. As participants’ stories are composed of their reflections on events and experiences, there are inherent limits to historical (factual) truth and ‘correspondence’ – the degree to which they are consistent with accounts from other sources (Riessman, 2008). Even the way in which the same individual communicates a story, about the same events or experience, can vary from one telling to the next. Depending on their immediate present perspective, shaped in the moment by power flows and discourses in circulation, narrators will structure and restructure their stories in time and space. In addition, various “identity groups, communities, nations, governments, and organizations construct preferred narratives about themselves” (Riessman, 2008, p. 7), that in turn exert their influence on personal narratives.

As narratives are also purposeful, aimed at achieving a certain way of being seen by the self and others, they are used to “remember, argue, justify, persuade, engage, entertain and even mislead an audience” (Riessman, 2008, p. 8). Whether these intentions are conscious and deliberate or not, individuals use narrative to make sense of their past experiences and

therefore engage in 'memory work'. It is these same attributes of narrative that can add a depth of understanding to identity constructions, which also lead to validity concerns regarding narrative research. Therefore it becomes essential that the trustworthiness of the stories told by research participants and the interpretations or researcher's accounts of them are understood within the parameters of the epistemology and theoretical framing in which the research is situated. For instance, this study founded on principles of social constructionism, focused on the interactive meaning-making of participants rather than the accuracy of sequence and details as narrated. Verification of the facts was therefore not as relevant as within a realist framework which would attempt to match personal narratives with other reports of the same events and require correspondence with other kinds of evidence (Riessman, 2008).

Various authors on narrative methods have discussed ways in which the trustworthiness of narrative research might be evaluated (Elliott, 2005; Loh, 2013; Mishler, 1990). Types of coherence are amongst the most widely upheld criteria, checking for global, local and thematic coherence within participants' stories, and whether causality and continuity are traceable; or, if discontinuities are apparent, whether these have been adequately explained by the researcher. However, Riessman (2008, p. 190) warns that it could well be the "needful ears" of investigators and other parties who might otherwise be invested in finding continuity and meaning in the narratives that attempt to find coherence where at times there is none. For example, in the stories of survivors of some form of trauma, where meaning and order have been disrupted by events, it might be the incoherence in the stories that enables learning about and understandings of their experiences. Therefore, Riessman (2008) advocates that validity is more meaningfully established at the level of the investigator's analytic story that links data segments in a manner that makes them theoretically coherent. Data should be presented in a way that demonstrates that the stories are genuine, and researchers should endeavour to make the process of generating analytic accounts 'transparent' and convincing. Strategies that strengthen persuasion include the use of evidence from participants' accounts to support theoretical claims, the inclusion of negative cases in discussions of findings, and the consideration of alternative interpretations when documenting the researcher's reasoning.

4.4.2 Narrative data generation

4.4.2.1 Written reflections

This study initially made use of NQDs' written (auto)biographical reflections of internship experiences as a stimulus for conducting interviews with the same participants. The work of Ros Ivanič (1998) provides a basis for making inferences regarding identity from written texts. Ivanič (Ibid.) posits that identity construction is performed in all writing and other semiotic acts. In her seminal work on writer-identity, she draws on the ideas of several identity theorists to provide a framework within which the language used in written texts might be understood. She goes on to recommend that, although a 'process' approach has prevailed in writer-identity research, "a 'social' approach to the study of academic writing" (Ivanič, 1998, p. 75) is needed. This view of writing attends to the broader sociocultural contexts and recognises that all writing events are embedded in various social practices at various levels. In such a social view, both the writer and the reader are viewed as 'characters' engaged in co-creating, acting upon, and being represented in the text; a view which resonated well with the overall narrative approach of this study. Not only do writers portray themselves and readers interpret, but their relationship to one another, the writer's commitment to the ideational content, and their assessment of the reader's knowledge and beliefs, all play a role in generating written texts.

The written reflections that were re-analysed in this study were first generated by NQDs in response to my primary question: 'What prepared you for internship and community service?' (see Appendix A for a list of sub-questions). Although I was not physically present when the written accounts were generated, the assumption is that participants' responses, addressed as they were to me, would be mindful of the degree of intimate knowledge that I was likely to have. For example, my level of familiarity with the PBL undergraduate curriculum, as well as my knowledge of a participant's personal characteristics and how they might be expected to act in certain situations, would have been judged based on their relationship to me. The jointly constructed nature of the submissions was accordingly given due consideration.

On receiving the written narrative accounts, I recall being immediately impressed by the diverse styles of writing and language use that seemed characteristic of each individual. Although at the time I had no knowledge of how to interpret the 'structure or form' of narratives (see section 4.4.3.1 Structural analysis p. 95), I intuited that there was much insight to be gleaned from attending to these different ways of telling their stories. Ivanič (1998) usefully explains that writing makes a distinct contribution to a 'reflexive project of the self', with a three-way interplay between the writer's life experience, their sense of self and the reality they are constructing through their writing. The influence of timescales in individuals' writing adds yet another layer to the models previously proposed (Burgess & Ivanič, 2010). I considered timescales as being relevant in this study because data generation took place in two phases that were three years apart. To find out how doctors' views of their internship experiences might have changed over time and from a perspective of more mature practitioners, the timing of identity constructions needed to be considered. Timescales were also relevant to my own development as a researcher, to my growing experience and development particularly in the area of narrative research. As the written (auto)biographies presented in this thesis were jointly constructed, I was continually mindful of what I needed to learn, and my responsibility to 'do justice' to the participants' narratives in representing my understandings of their experiences.

Although much valuable insight may be gained from the interpretive analyses of the written texts by reader(s) and/or researcher(s), there are always implicit experiences and hidden meanings that are not accessible without detailed explanations by the authors themselves (Ivanič, 1998). This potential inadequacy of examining written texts alone was addressed in this study by interviewing participants to clarify interpretative meanings inferred from their writing and also to probe what seemed to be absent from the written texts. Therefore the interviews, as discussed in the next section, provided an opportunity to further investigate and to enrich the (auto)biographical narratives of the doctors and to check for coherence, development and/or discontinuities of identity constructions.

4.4.2.2 *Interviews*

In the second phase of data generation, I followed up participants with face-to-face, one-on-one, semi-structured interviews. Interviewing is widely acknowledged as a primary data collection method in narrative research (Greenhalgh, Russell, & Swinglehurst, 2005; Mishler, 1986; Roesler, 2006). Some of the interview questions aimed to clarify meanings behind writer identity constructions, as could be inferred from the previous thematic and structural analyses of written reflections. Interview questions were also designed to probe further regarding participants' aspirations and motivations, and which internship experiences had helped or hindered them in becoming the practitioners they aspired to be. As participants' aspirations were an unknown entity at the time of interview, various aspects such as career intentions as well as evaluations regarding what had enabled or constrained them were explored. I was also able to probe for ways in which participants might not have wanted to appear in their writing. The interviews helped me evaluate where there had been conscious or semi-conscious efforts made to resist being positioned in certain ways, even by particular discourses that seemed to have been avoided (Ivanič, 1998, p. 230).

The approach outlined above generally followed the philosophical tenets of narrative interviewing as authored by Reissman (2008), where the dialogical and co-constructed nature of interviews is emphasised. Consistent with the epistemology of social constructionism underpinning this study, the interaction between participant and researcher and the contexts in which interviews are embedded, are central to Reissman's methodology. Rather than the researcher simply attempting to elicit a story about the participant's experience, they actively engage in exploring and making meaning of the participant's experience, resulting in a unique and collaborative performance of narrative identity. In my understanding, the researcher's contribution to such an interview includes the preparation done beforehand, in thinking about the questions they would like to pose to the participants. In this study the entire Phase 1 data analysis (see Table 2 p. 99) could be considered as 'preparation' for interviews as described in the interview process and schedule outlined below.

4.4.2.2.1 *Interview process and schedule*

Prior to conducting each interview, I re-read previously analysed written reflections together with all accompanying notes appended and memos I had compiled on that particular participant. Based on these previous findings, I prepared specific questions I would like to ask during the interview in order to obtain clarity on events or actions that were written about (see also Appendix B). Some open-ended questions were also prepared inviting participants to elaborate on their experiences as NQDs, particularly when I had sensed that some aspects might have been left out of the written texts. The latter were extended mainly by an intuitive process as explained in the previous section, often prompted by a degree of surprise or unexpectedness in my response to what was contained in the original texts. I had therefore hoped that participants would add explanatory details during the interviews. However, I could not have anticipated the extent to which participants would reveal aspects of 'life and fate' or the profound effect that these factors had on internship experiences (see Chapter 5: The Narrative Data p. 106).

The overriding principles governing my approach to conducting the research interviews were trust and mutual respect, based on the recognition of the participants as experts in their own personal experiences. As such I wanted to create a safe space for them to share their experiences from which I hoped to learn about medical internship and identity constructions of NQDs. Therefore I allowed them more uninterrupted time to think and to speak than the typical 'turn taking' behaviour of an entirely naturally occurring conversation where my responses would have been spontaneous. Instead, I found myself continually thinking of prompts; anticipating how I might encourage participants to share their thoughts and evaluations more fully about situations they were reflecting on. I consciously refrained from expressing my own thinking and assumptions, deliberately using open-ended prompts instead. This process of being aware and over-thinking during interviews, as well as several other 'tensions' are amplified in Beuthin's (2014) reflexive deliberations on conducting narrative interviews based on Reissman's dialogical-performative methodology. For example, while the researcher should be actively engaged in co-constructing meaning, there is a tension created between leading and following, as the researcher should also refrain from interjecting in a manner that would overly influence in the traditional sense of asking

leading questions. Whenever I felt that further clarity was needed, or that something had been glossed over or left unsaid, I interjected with carefully worded searching questions until satisfied that the participant had shared as much as they were going to about a particular event or experience.

A specific Narrative Interview (NI) method is reputed to have been originally described in German by Schütze (1977, as cited in Jovchelovitch & Bauer, 2000) which has been translated into English and elaborated on by Jovchelovitch and Bauer (2000); and which comprises the following steps:

1. Preparation (exploring the field, formulating exmanent questions)
2. Initiation: present the initial topic and start recording
3. Main narration: no questioning, only non-verbal encouragement
4. Questioning phase: only immanent questions
5. Concluding talk: stop recording and continue the conversation (spontaneously)
6. Construct a memory protocol of 'concluding talk'

Although I very broadly used these steps as guidelines, in practice, I found that the interviews I conducted were more semi-structured than adhering to the phases and rules of the NI as set out above. There were several brief sequences of questions and answers, interspersed with longer periods of narration where I withheld comment except for brief interjections to indicate attentive listening or encouragement to proceed with narration until participants brought that segment of their narrative to a close. Some of the questions and prompts had been prepared prior to the interviews as described above. However, it was also necessary adapt to the particularity of each story, and formulate new questions and prompts as the interviews progressed, according to what was being communicated during the interviews (Chase, 2010).

Interviews were recorded using a digital recorder, and each interview was between 36 minutes and 52 minutes in duration, with a total recorded time of 257 minutes (four and a half hours). I began each interview with a brief introduction communicating a summary of work that had been completed thus far in the study. Information I communicated was based mostly on thematic findings I had presented in the form of a poster at a medical education conference. The gap in the existing literature regarding internship experiences was

highlighted and I re-iterated the aim of intended further study. The interviewee was then given an unmarked copy of their previous written reflection to read as a stimulus, an exercise that was often accompanied by signs of enjoyment such as smiling, comments of “Oh ja!” and occasional laughter (one participant, Juanita, even asked to keep her copy after the interview so she could share her story with a younger sibling). I had in hand another annotated copy of the same reflection containing my analytic comments and potential clarifying questions prepared prior to the interview. Permission was obtained to record the interviews. However, I appended a few additional notes during interviews, primarily to capture reactions or responses in the form of non-verbal gestures or facial expressions, or to clarify the spelling of place names that were unfamiliar to me. In the main, I tried to allow participants a greater degree of freedom to speak without interjecting, except for expressions of affirmation and agreement such as “mm” or “OK” to indicate that I was listening to what they were saying, until they seemed to have exhausted the point. This allowed participants to speak about whatever they felt was important or whatever they linked in some way to their reflections on what had shaped them as practitioners during internship. This process required me to deliberately suspend any judgement on what they were saying, unlike in an interpersonal communication at any other time, when I would have been free to express my opinion and/or critically question some of their actions or choices. In the context of the study, I felt this was a necessary part of encouraging a greater degree of reflexivity to deliberate why things had happened or unfolded in a certain way and what values and circumstances had led them to be as they currently were at the time of interview.

Participants were finally asked to comment on internship learning from their current perspective as more experienced and mature practitioners. I also raised some of the topical issues found in the medical education literature pertaining to internship experiences, such as the impact of hierarchical power structures, and the hegemony of a predominant biomedical approach being propagated by medical ideology. From the interviews I was therefore able to evaluate whether these issues were also relevant to internship experiences of NQDs in South Africa.

4.4.3 Narrative data analysis

4.4.3.1 Structural analysis

With the assumption that the structural analysis of narrative form would yield important insights into practitioners' identity constructions, the question arose as to how the recommended 'close reading' of narrative language (Charon, 2006) was to be conducted. Attention to language needed to be more iterative and meticulous than is commonly practiced in more holistic experience-centred studies. Linguistic devices such as metaphors, descriptive language (adjectives and nouns), archetypes, as well as unintentional choices of first or second person pronouns yielded insights into positioning strategies. In addition a modified Labovian classification of functional clauses and evaluative elements was applied to storied events in the data as presented below.

Two seminal essays by sociolinguists Labov and Waletzky are reputed to form the basis of much narrative work (J. Smith, 2006; Toolan, 2001). Possibilities of enabling the analyst to better examine "the narrator's perspective on the events being told" (Andrews et al., 2008, p. 26) and to better interpret "the relation between meaning and action" (Riessman, 2008, p. 89) were two compelling reasons to use Labov's classifications in this study. Labov and Waletzky had originally developed a linguistic model classifying the function of clauses in 1967 (J. Smith, 2006), which was subsequently adapted and further developed by Labov (Toolan, 2001). Although the model was originally intended for 'fully formed' oral accounts of personal experience in event-centred narratives, the Labovian method has also been applied to various kinds of written texts and literary works (Georgakopoulou & Goustos, 2004), and to audio-recorded data (Monrouxe, 2009). The analogy of a classical music score being broken down by musicians to analyse the component parts of each musical phrase and instrument helps describe the value of such analyses of personal stories to see how they are compiled into a coherent whole (Riessman, 2008).

In Labov's six-part model (Toolan, 2001), each functional clause is categorised as one of the following:

(A) abstract (what is the story about?)

(O) orientation (time, place, characters, situation: who, when, where?)

(CA) complicating action (the plot or sequence of events: what happened, and then what happened?)

(E) evaluation (so what? and how or why is this interesting?)

(R) resolution (outcome: what finally happened?)

(C) coda (ends off the story and brings back to the present)

Labov further identified three main types of evaluation (commenting on meaning and associated emotions):

- External (suspends CA to stand outside of the story and relate what the point is)
- Embedded (relates how the narrator felt at the time whilst preserving the dramatic continuity)
- Evaluative action (stays within the story, reports actions that reveal emotion without direct description of such, e.g. burst into tears)

These evaluative elements are then further categorised into one of four different types of devices: intensifiers, quantifiers, comparators or explicatives.

In this study the application of Labov's classic socio-linguistic model was limited to key storied events embedded in the data. I chose to analyse only these segments of the data primarily because other researchers have reported difficulty using a Labovian approach when the data are not in typical narrative form containing all six elements of Labov's model as listed above (Patterson, 2008). However, despite such restrictions, Labov's classification is still recognised as adding value and remains a foundational method in applied linguistics.

Using a Labovian approach as outlined above was helpful as a starting point, being a rigorous method for the analysis of personal experience that could easily be accessed without prior expertise in linguistics (Riessman, 2008). However, the point of the exercise in this study was not the accuracy of linguistic classification; it was a means to enable insight regarding the perspectives of participants on the events they chose to write about, without losing the richness and layered meanings of the narratives. In my view, Labov's classification enabled new insight through engagement with the text at a formal level by continually

having to ask the series of questions pertaining to each functional clause as listed above. With this type of structural analysis, some aspects of identification that even the narrators might possibly be unaware they are portraying, are made visible. Attending to the different types of evaluative clauses is useful for interpreting categorisations of the self and others that are not explicitly described in the texts, but are nevertheless inferred. I found the structural analysis also helped me discern (reflexively and intuitively) when further explanation needed to be sought by sensitive probing about some issue that did not seem to quite fit or sit comfortably in the original written text.

Structural analytic methods such as those employed at the commencement of this study are not suited to research questions that require the study of “large numbers of nameless, faceless subjects” (Riessman, 2008, p. 18). They are, however, particularly suited to detailed analyses of a limited number of case studies, and for cross-comparisons between cases such as conducted in this study. When attending to the nuanced and subtle nature of professional identity construction through narrative communications, I considered structural analytic methods would be likely to generate insight that might otherwise be overlooked. Socio-linguistic methods such as described here allow meanings to be generated that could easily be missed by assuming transparency of data as in thematic content analysis alone. In studies that give serious consideration to language, structural analytic methods provide researchers with the tools to interrogate various ways in which participants use written and oral communication to construct their histories and identities (Andrews et al., 2008; Bamberg, 1997; Charon, 2006; Chase, 2010; Guerrero, 2011; Monrouxe, 2009).

4.4.3.2 *Thematic analysis*

For the thematic analyses of both written and oral accounts, the data were examined as a whole, broadly following the tradition of holistic content analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998), rather than risk fragmenting the biographies or fracturing the stories of participants by separating out segments according to categories (Chase, 2010). Starting out more superficially, I recorded my understanding of the main points of the stories as annotations, and was careful not to overdo the data reduction process (Miles & Huberman,

1994). I moved back and forth between the data and my interpretations thereof, “in a classic hermeneutic circle using a combination of top-down and bottom-up interpretive procedures” (Andrews et al., 2008, p. 50). Compilations of analytic comments from the written reflections of each participant were developed and I labelled them ‘ID Memos’, which in essence formed part of an analytic proforma. This process began with the socio-linguistic analyses of written texts and continued throughout the analysis of the interview data.

Audio recordings of the interviews were transcribed verbatim by myself, as the researcher, which allowed me the opportunity to reflect more deeply on the participants’ experiences than at the time of interview. This ‘listening while transcribing’ therefore formed part of the thematic analytic process, as I began to filter the data through various theory lenses while transcribing them. Having conducted all the interviews myself, I found the audio-recordings a useful reminder of how the interviews had progressed in real time and was able to recall participants’ non-verbal expressions (see them in my mind’s eye as it were) during the interviews. I was also able to begin the process of continual checking for the development of themes both within cases as well as from case to case (Andrews et al., 2008).

The interview transcripts were then read repeatedly over several months and further analytic comments were manually appended to the texts classifying various discourses featured. My interpretations of the positionality that I perceived narrators to be expressing in their stories were noted throughout. These comments were then extracted into various tabulations and visual (concept) maps or displays of the data (Miles & Huberman, 1994) as aids in the process of interpretation and making inferences from the data.

The sets of interpretive findings on each participant were then further compared for intra- and inter-narrative coherence and/or variations in themes and identity constructions. In this study a series of influential learning relationships emerged from the various displays of personal experience narrative data. It became evident to me that almost the entire data set could be interpreted using such a schema of relational influences (see Chapter 6: Relationships, Figure 2: Relational influences p. 171). In the tradition of analysing qualitative data as described by Miles and Huberman (1994), I endeavoured to display a composite compilation of these relationships as represented in the narratives of each participant. The

nature and quality of these relationships were subsequently analysed through manually constructed visual mapping that allowed further interpretations regarding whether there were enabling or constraining factors for learning opportunities and positive identity constructions.

This level of analysis involving a combination of thematic and structural methods was found to be at a much deeper theoretical level than the previously conducted holistic thematic analysis of referential material alone. The methods were used in a complementary manner and yielded valuable new insight pertaining to learning processes and identity constructions of NQDs. Close attention to narrative language and form further revealed the various dispositions of participants and of significant others and their ways of being in the world (see section 7.3 Identity and ways of being in clinical practice p. 217). The way in which participants positioned themselves and others illuminated the quality of relationships, both interpersonal and with organisations. Consequently the influence of these relationships on learning and identity construction of NQDs could be inferred.

4.5 Summary of phases of data generation and analysis

The narrative methods of data generation and analysis detailed in the preceding sections and the interpretive insights enabled by these methods are summarised in the table below:

Table 2: Phases of data generation and analysis

	Data generation	Analytic approach	Interpretive focus
Phase 1	Solicited autobiographical reflections – written texts (at three years post-qualification).	Socio-linguistic analysis of narrative structure & form.	Positionality and writer-identity constructions; learning processes implied & clarifying questions for Phase 2.
Phase 2	Conducted one-on-one, face-to-face semi-structured interviews (at six years post-qualification).	Holistic analysis of narratives – thematic, discursal & positioning, generated proforma secondary narratives	Aspirations & motivations, enabling &/or constraining factors with regards to becoming doctors, influence of medical culture, ideology and power flows.

4.5.1 Phase 1 – socio-linguistic analysis of written reflections

To sum up, in the first instance, an existing data set from a previously completed study was re-examined using structural analytic methods for studying narrative form rather than attending to the referential content alone (Lieblich et al., 1998; Riessman, 2008). Through the use of socio-linguistic lenses, I specifically attended to narrative language and this enabled inferences of narrative positioning.

4.5.2 Phase 2 – interviews

Interviews were used to access meanings that could only be clarified by the participants themselves and to gain a fresh perspective for reflecting back on internship experiences as more mature practitioners. The role of aspirations and the *habitus* of doctors in relation to the socio-cultural contexts of clinical practice were amongst the insight gained.

4.6 Ethics of research

Traditionally there are a set of moral principles that have formed the basis of judgements between ‘right’ and ‘wrong’ conduct in scientific endeavours: non-maleficence, beneficence, autonomy, justice, utility, fidelity, honesty and privacy (Resnik, 1998). These principles are commonly applied to medical practice and universally guide ethical standards of research. Howe and Moses (1999) observe that medicine has historically led the way in debating ethical issues, although sociological and educational research has then built on these founding principles by reorganising them to refocus on aspects of greater relevance to research in these domains. Various ethical codes have also been developed to specifically suit educational research, for example, the Code of Ethics of the American Educational Research Association – AERA (2011). The five ethical principles undergirding the AERA Code

of Ethics are listed as: a) professional competence, b) integrity, c) professional, scientific and scholarly responsibility, d) respect for people's rights, dignity and diversity and e) social responsibility.

Howe and Moses (1999) further discuss ethical dilemmas under two broad headings relating to the 'protection of research participants' and 'research misconduct' that arise specifically from interpretative educational research. Compared with positivistic axiology, the same authors point out that interpretive methodology introduces ethical issues through two inherent features: 'intimacy' of relationship to participants and the 'open-endedness' of questions and sampling, for instance when conducting interviews and/or participant observations. Both these features are in stark contrast to research designed along the lines of experimental or quasi-experimental methods.

All research endeavours should adhere to general ethical principles which protect participants' rights, for example, their right to autonomy and privacy. In this study the autonomy of the participants was protected through the use of an information sheet (see Appendix C) that communicated the nature of the research, explained that participation in the study was voluntary and that participants were free to withdraw at any stage. Although participants might have felt a mild degree of obligation to me personally due to a previous mentorship relationship, there was no coercion involved. In fact, I was grateful to discover that NQDs were enthusiastic about telling their stories despite the regular pressure of work they faced in their current practices.

As the study of personal and professional identity construction of NQDs involved some issues of a sensitive nature, I reassured participants regarding the confidentiality of information and their anonymity in all reports of the research. Information pertaining to healthcare contacts described in the biographical narratives was handled in a manner that respected the privacy and anonymity of all persons throughout the research process. Where internship experiences involved other practitioners and/or patients, their identities were protected by not disclosing actual names of persons and any other potentially identifiable personal or contextual details such as the actual names of hospitals. The use of pseudonyms for the participants, together with a permissible degree of relevant personal detail, nevertheless allows the reader to nevertheless connect events and experiences being

reported with specific individuals in a personalised manner. This personalisation of stories facilitates the contextualisation of narrative data, while maintaining the anonymity of participants, and personally engages the reader in the events and experiences being reported, as appropriate in a narrative study.

For purely ethical reasons, as opposed to the notion of member checks for purposes of proving validity, it is advisable to allow participants the opportunity to provide feedback on the researcher's interpretations and secondary narratives (stories about stories). Whenever possible, participants would be thus afforded an opportunity to evaluate the adequacy of anonymity and confidentiality and provide better informed consent for the use of their narratives in the particular context of the research report. This is, however, not always possible and may not be meaningful in cases where participants have moved on considerably beyond the identities they constructed at the time of generating the data (Riessman 2008). In this study the participants were extensively consulted on my interpretations of their written reflections from Phase 1, which was also the process that generated much of the interview data in Phase 2. The final secondary narratives contained in this thesis were not sent back to the participants as I felt confident that their views on medical internship experiences had already been sufficiently captured and clarified. Furthermore, inferences using theoretical lenses, and findings based on comparisons of narrative positioning within and across cases, represented analytic work on diverse experiences. Individual participants would not necessarily be in a position to evaluate such findings incorporating narratives that might have been similar or very different to their own. I conceded that they might not necessarily even agree with my interpretations, especially where I found narratives to contain inconsistencies or ambiguities, or had reported some findings in a less than glowingly complimentary light. There is, therefore, an ethical responsibility on researchers to explicitly own and take responsibility for *their* views on the lives and identities of participants (Riessman 2008).

Written consent was obtained from participants prior to being interviewed via a consent form (see Appendix D). Degrees of voluntariness, particularly in situations where power differentials exist between the researcher and participant have been debated in the literature (Appelbaum, Lidz, & Klitzman, 2009; Fisher, 2013). In this study I would like to reiterate that the participants could be considered as being in a position of greater power

over me, as they were the experts in what I needed to learn about (medical internship experiences). Far from being a vulnerable group of people, qualified medical practitioners are also generally inclined to assume powerful positions in relation to non-clinicians. However, I found that the participants in this study were still inclined to treat me as a confidante due to the pre-existing bonds of trust and mutual respect.

Gatekeeper permission did not apply in this study, as participants were independent practitioners who were reflecting on their own experiences as NQDs, and the research did not involve my visiting or directly observing internship training sites.

Ethical clearance was obtained for the previous research that generated written autobiographical data (approval No. HSS/0296/09 – included as Appendix E) that were re-analysed in Phase 1 of this study (see section 4.5 Summary of phases of data generation and analysis p. 99). A further application for ethical approval was submitted on commencing the current study and updated ethical clearance obtained from the Humanities and Social Science Research Ethics Committee of the University of KwaZulu-Natal (approval No. HSS 1220/011D – included as Appendix F).

4.7 Limitations of the study

As the principal investigator in a study of medical internship it might have been advantageous to have first-hand experience of the clinical workplace. My lack of such experience and of the public healthcare sector was therefore a limitation of this study, especially as the participants tended to assume that I was more familiar with their contexts than I was. Therefore I was entirely dependent on the contextual details revealed by participants and had to seek clarity regarding the day-to-day organisation of internship work. However, this did mean that I could also not be tempted to superimpose my own experiences onto the participants' experiences of internship in my interpretations of the findings of the study. My lack of clinical work experience could therefore be construed as both a limitation and a strength of the study.

Participants being known to me (the researcher) might be considered problematic, especially by those holding positivist convictions of objectivism. However, my methods are intentionally subjective and acknowledge that there are advantages to relational ways of conducting research. As argued previously, there are always sensitive details about ourselves and our practices that we are unlikely to disclose, other than to someone we know and trust. In similar interpretive studies, for example Luke's (2003) study of Australian medical interns, a lengthy process of building relationships and trust was necessary prior to conducting interviews with participants. As an 'outsider' to medical practice, Luke judged that this was an essential step in gaining access not only to the clinical context, but also to NQDs' personal and professional lives. By the time the data were generated and analysed, there was reportedly a strong bond that had formed between researcher and researched, without which her study would not have been able to access the same degree of personal detail, depth and richness of the data.

Another limitation of my research study was that participants all professed the same belief system, consistent with Christian values, which undoubtedly would have influenced identity constructions and medical practice. I would argue, however, that as long as such matters are openly discussed and owned as part of the research, the reader would be able to judge where it had a bearing on particular research findings. I have accounted for the influence of primary identities, including an individual's gender and ethnicity as well as their beliefs, where these were pertinent to newly forming professional identities. Participants' specific values and beliefs also did not detract from the numerous experiences of internship that are common to NQDs of whatever socio-cultural background. For example, aspects pertaining to clinical practice environments, availability of support and supervision, encounters with diverse patient populations, disease profiles, other healthcare professionals and the healthcare system of South Africa, are likely to be consistent for interns of any belief system. Whatever an individual's primary identities might be, other clinicians would be able to identify with participants' stories on becoming doctors at the level of their collective experiences. Therefore, in discussions of the data, I have used descriptions that are sufficiently detailed for readers to judge for themselves whether the findings were influenced by the participants' beliefs and I have declared my own bias in this regard wherever I was aware of this.

4.8 Conclusion

In concluding this methodological foray, I return to the concepts introduced at the beginning of the chapter. The link that is maintained throughout the different methods used in this study is the underlying assumption that there are multiple possibilities for selfhood and that there is a fluidity to identity constructions. Therefore, in my view, there is a common dialogical thread that runs through contemporary identity theory and the methodological approach of narrative positioning, which encompasses a variety of academic domains.

An epistemology of social constructionism maintains that relationships with others are of paramount importance in learning, identity development and educational research. Within an axiology of valuing individuals, diversity is essential for clarity of insight; the learning potential of particularity being enhanced by combining thematic and structural analytic methods. This methodology aimed to explore how participants positioned themselves as NQDs and various others in relation to social groupings that were relevant to medical internship experiences in the clinical workplace.

The following chapters present the narrative data generated and analysed by the methods detailed in this chapter. Each participant negotiated their transformational journey of learning and becoming, within variously layered areas of congruence and divergence between their *habitus* and the socio-cultural contexts of internship.

Chapter 5: The Narrative Data

In this chapter the narrative data from the study are presented using a similar thematic arrangement for the structure of individual participants' narratives. It is understood that these are co-constructed secondary narratives, where I as the researcher have selected segments of narrative data for display and organised them in the way I perceived them to most meaningfully speak to the key research questions of the study. Each participant's narrative is titled with the pseudonym assigned to them and comprises an intra-case 'longitudinal view' of their story. I begin with introducing the participant to the reader, including some background contextual information based on my personal knowledge of the participants. Their stories are then presented in a semi-temporal and thematic arrangement according to the time-line of each participant. Commencing with the participants' internship experiences, as these were the primary focus of the study, I have included critical incidents, personal experiences and evaluative reflections to showcase internship journeys in terms of learning opportunities and identity constructions. Links to the undergraduate curriculum which were found included in the participants' narratives are then presented, followed by a retrospective view of internship from their current perspective and in light of their aspirations as shaped by internship.

In the tradition of presenting qualitative data, quotations from original texts are interspersed with interpretative commentary. I have deliberately used lengthy segments of original narrative data in the participants' own words to enable the reader to get a sense of their linguistic choices and resources, the unique styles of writing and speaking, as well as a sense of the person behind each story. This corresponds with the intention of the study to pay close attention not only to *what* was told but also *how* the narratives were told (see section 4.4.3.1 Structural analysis p. 95). In addition to the thematic analysis of the referential content of the narratives, such close attending to narrative language contributed to uncovering how participants positioned themselves in relation to others.

5.1 Ezera

5.1.1 Introduction

Ezera was originally from a North African country. His family had immigrated to KwaZulu-Natal when he was a child and he was therefore a naturalised citizen of South Africa.

Outwardly, Ezera always appeared calmly confident whenever I met him; he expressed himself well and was exceptionally personable. He had played an active role in student leadership while he was at medical school. In addition, I recalled that he had become involved from his first year of study in the rural health outreach clinic which was operated by clinicians and students from the medical school of UKZN.

Ezera was married at the end of internship, his wife being of the same nationality as himself, and he maintained close links with both his family of origin and his family in-law. He was the father of three young children at the time of interview. He was brought up in the Christian faith and attended a charismatic church. Although he spoke freely about God and his faith, this was more with regards to his family and personal life rather than to internship experiences or his career as a medical professional. For his internship Ezera was based at a Level II hospital in an urban area of KwaZulu-Natal responsible for providing a range of specialist services to the population from many informal settlements of the province and even some areas of the Eastern Cape.

At the time of interview Ezera was a Registrar in General Surgery at a Level III institution in the same urban area of KZN. However, he had been unsuccessful in his efforts at the qualifying examinations and was therefore in the process of renegotiating his options.

5.1.2 Internship experience / journey

The hospital where Ezera did his internship was an academic establishment with a full complement of structured disciplines accredited to provide postgraduate training for Registrars. Although it was a very busy environment, he started his rotations in Family Medicine and described being adequately supported there in the way interns were introduced to clinical work. He was able to spend some time observing senior colleagues,

following which he was encouraged to ask for assistance when assuming independent responsibility for patients whenever he felt it was necessary. He explained that at this institution interns were allocated to a particular Registrar for the duration of the rotation. I noted that Ezera had written about his transition from medical school to internship in a manner that generally portrayed more confidence than other NQDs expressed about the commencement of internship. For example he described it as an “exciting transition” where he “had no apprehensions of the upcoming challenges” and “looked forward to the learning curve”. When I probed this matter further during his interview, I found out that he had commenced work in the month of March instead of January, having first had to repeat a block in one of the final year disciplines. In retrospect, he realised even while I questioned him, that this might well have resulted in him feeling less overwhelmed than other NQDs who had commenced during an overly busy period of the New Year and while senior colleagues were usually in short supply. In Ezera’s case, he said that his confidence had to come down a notch as he realised the broad scope of the work involved, and he felt that “the day-to-day work” had “humbled” him.

Another point that I discussed with Ezera regarding his previous written reflection related to the lack of any mention made by him about his fellow intern colleagues. He explained that this was not due to any difficulty he had in relating to them – on the contrary. However, the way that clinical duties had been organised at his internship site enabled only minimal contact between interns in the course of their daily functioning:

P: ... the way it worked at [Hospital Name] ... you had your own cubicle, and er if ever you worked with somebody you worked with a senior person and not your colleague. And in the wards ... [in] Medicine ja, we’d sometimes do rounds ... We’d do calls, you were the one intern on call with a senior ... paired up, so you didn’t associate with [intern] colleagues that much.

But I stayed in Res, well at the DQ, the doctors quarters ... we got to meet and we got to interact with the other guys [intern colleagues] quite a bit. But it was mainly outside of work.

R: Did you find you still discussed your work with them? **[P:** work, of course], ja, compared notes?

P: Yes, and er battle scars as well ... (laughingly)

R: And senior Registrars and Consultants? (shared laughter)

P: Of course, and how we hated who, and this person was good or better (.) you talk about your work. – *Ezera, int.*

Ezera was cognisant of the fact that relationships with senior colleagues had a key influence on how interns experienced and progressed through a discipline. He admitted to therefore to actively identifying amenable Registrars with whom he could form strategic learning associations:

I suppose different places work differently, but at [Hospital Name] the guys that were allocated to you stayed with you for a period of between four to six months; which was generally your rotation in that block ... that's why I call them "My Registrars" [referring to his written reflection] because I would attach myself to someone and then make them almost responsible for teaching me. – *Ezera, int.*

Therefore Ezera described a situation where he was able to develop learning relationships that were similar to the form of teaching he was accustomed to as an undergraduate student. However, these attachments to senior colleagues were now in conjunction with his own responsibilities as an intern. He elaborated that learning opportunities had varied depending on the Registrars' preferred styles of supervision and with their inclination to be present (or not) with interns while they examined and managed patients.

... different Registrars had different ways of working, some guys would say alright, "you see the patients then call me and we'll assess the patients and manage them", others would say "if you think that they're stable then you can discharge [the patients], you can send them home, keep only the ones you want me to see". Some people would say "as soon as they call you call me and we'll both go down and see the patients" and I appreciated those that said "let's both go down and see the patient" – *Ezera, int.*

Ezera was candid enough to admit that at the outset interns were primarily concerned with the way they would be perceived by others and it was important for them to appear to have the adequate knowledge and skill even if this was not the case. Calling for assistance was therefore not always as straightforward or as easy as one might assume it to be:

As an intern, you want to appear like you know what you're doing, but you know you don't really. And um, in [Hospital Name] a lot of times you were left alone and you had to try and call some-, and they'd always say "you can call, you can call us", but the truth was not everybody was available ... if you don't get along with them, or you don't have that interaction, you tend to call them less. Which is what I did, that is if I had an issue and I knew the Registrar I was on call with didn't like to be disturbed at night, or didn't

like to be called, then um I wouldn't. You'd tend to just do the best you can, and sort of err on the side of being overcautious, I'd just admit the patient, and hope that when the Registrar does a round, if there's any problem, they'd pick it up then. – *Ezera, int.*

Despite his concern to 'save face' Ezera had therefore worked out a strategy to balance patient safety with his reluctance to call a Registrar if he knew them to generally express displeasure at being inconvenienced. By admitting the patients when he was unsure what course of action to follow, he hoped that they would receive adequate medical attention when a senior colleague was next available.

The Consultants were ... depending on the Block, they were a very supervisory (.) role, um, the most interaction I got with Consultants was in maybe Surgery, um, where they would do rounds with you every day. And maybe Obs & Gynae [Obstetrics and Gynaecology], because there'd be meetings and there was also specific rounds where you'd meet with the HOD actually ... But we didn't interact with them a whole lot outside of that. – *Ezera, int.*

The above excerpts illustrate the varying degrees of support and supervision within Ezera's COP, which depended on institutional, organisational and personal factors. At this particular establishment the Consultants had minimal contact with interns while the major part of educating NQDs in clinical practice was delegated to the Registrars.

5.1.2.1 *Critical incident – New Year at casualty*

An incident that stood out for Ezera took place at the beginning of his second year of internship when he started his rotation in Surgery. He was left on his own trying to manage an overwhelming number of trauma patients in Casualty:

I actually remember the scene so clearly, think they [the Registrar and another intern on call with him] were busy with a guy who had a stab heart, so they had to do an emergency thoracotomy, and um, so they couldn't come out of that because that was a life-and-death operation ... Casualty was chock-a-bloc, full, full, full (.) And you were there, you were on your own and you do the best you can. And you can phone the guy you could call, he would basically tell you what he can over the phone, whilst busy as well. – *Ezera, int.*

... patients with stab abdomen, polytrauma injuries, head injuries, multiple gunshots, not to mention intoxicated patients packed the casualty like peak hour traffic ... my mind felt just as congested. Informing my senior of the situation was returned with the not-so-reassuring response, “As soon as we’re done in theatre, we shall be right there to help you”. The only thing that helped me was the surprising amount of knowledge retained from the skills lab during BLS [Basic Life Support] training and skills training. That I believe helped me manage the ‘traffic’. – *Ezera, writ refl.*

He initially described this incident as his “most challenging yet most enjoyable experience yet”. However, comparing what had transpired to the way in which on-call duties were organised in his current context:

P: ... our interns still are the ‘first line’ [initial point of contact] in Casualty, so, but there’s two of them at least. And that environment allows, um two Registrars at least, minimum, and on-call at night. So you will, at any point, be able to have at least a call on one Registrar that can come down almost immediately so you’ve got that backup [**R:** if you call for backup]. Ja, right, and that is a much better system, um, usually you get at least three Registrars, so at any point if there’s two people in theatre you’ve got one out that’s available to cover emergencies, in Casualty, or in the wards, and you’ve got the intern as well. So yes you should be able to be the first line to build your confidence and to be exposed to what, um, it means to manage a trauma patient, but you should never be alone. You shouldn’t be in a position where you-, your Registrars are not able to come out of theatre and you [are] forced to manage your patients on your own. That should never happen. Granted that the technicality was that yes the Casualty Office was supposed to stay with the patient and continue the resus[-citation] until the Surgeon is available together with the intern, but of course with the number of patients that come through, it’s not always possible [**R:** it’s not practical?]. Ja, so you did end up with the patient and you did end up doing what you can until your Registrar came through. – *Ezera, int.*

Therefore Ezera reflexively concluded that interns should not be expected to handle the degree of responsibility that he had been expected to handle on his own and particularly without recourse to assistance. The above incident had taken place when he commenced his rotation in General Surgery and it was his first experience of an overly busy New Year season. Although he did not again experience being overwhelmed by patient numbers to quite the same magnitude, he found that he often had to make autonomous decisions regarding prioritising and managing patient cases:

... but it happened on a sort of a smaller scale ... I suppose anything in comparison was manageable. But, um, you’d still have patients, you’d still line them up, you’re talking

about, say a benchful, maybe eight to ten patients you'd see. Not all of them acute trauma, like a stab abdomen or whatever, um, some of them were 'cold cases' [non-emergencies] as well. But you would be left there, and then, as and when the Registrar could come through, he'd come.

That time particularly, I knew there was-, that we were short of Registrars, and I enjoyed the independence of being able to try and do something, and I think I learnt a lot more then, because you're forced to ... – *Ezera, int.*

The healthcare system and the shortages of medical personnel therefore were readily accommodated by Ezera in evaluating his internship learning. He judged that being compelled to make clinical decisions independently had likely resulted in him gaining more knowledgeable skill than if he had been in an environment where less was expected of interns.

5.1.2.2 *Medical Zulu Competence*

Considering that Ezera was not born in South African, I thought that he might have experienced difficulty communicating in isi-Zulu, but he had not mentioned a language barrier in his written reflection, so I questioned him further about that:

R: You also haven't mentioned any language issues [**P:** (laughter), yes] – were there any? (.) what happened with language?

P: Language, OK (.) [**R:** How did you cope?] – this being KZN, and my internship ... being in [Hospital Name] most people spoke Zulu, and I'm not Zulu-speaking by birth ... Zulu is definitely a third or fourth language for me, but I made a particular effort to try and learn it, [**R:** in medical school?], in medical school, and um, er, prior to that, sort of on and off, but it wasn't as important to me as it was in medical school. There was this Zulu Course they offered us as well ... that sort of helped a little bit, but I think what solidified it for me was that, if a patient came through, I'd definitely try in Zulu, I'd break it, I would you know, mispronounce words but I would try. And from-, by the time I'd finished Medicine my Zulu, at least my medical Zulu, was um comprehensible. ... my Zulu is not perfect, they would-, Zulu-speaking people would still pick it up immediately that I'm not Zulu-speaking, but they'd understand what I was trying to ask and be able to respond and I'd understand.

R: And so you didn't have to depend on anybody else to translate?

P: Translate er-, I felt sorry for the guys that did, because I did have friends that couldn't speak Zulu, and that was painful because sometimes a nurse is not available and they have-, they're stuck with the patient, so I knew, there were some problems there, but I didn't experience any of that, ja.

5.1.2.3 *Critical incident – patients uprising*

It has been established elsewhere in this thesis (see section 2.3.1 Hours of work p. 34) that the public healthcare system in South Africa relies heavily on NQDs to attend to the numerous patients presenting at various public hospitals. From the perspective of patients, which is rarely discussed in the medical education literature, this cannot be an ideal situation. An experience Ezera described, due to a situation that arose while he was a new intern, revealed some interesting situational dynamics from the patient perspective:

... the one afternoon patients began to bang on the doors demanding to be seen and at one point simply just barge into the room whilst another patient is being examined. The hundreds of patients intimidated the two security guards on duty and so they did nothing. – *Ezera, writ refl.*

Unpacking this incident at some length during his interview, Ezera provided his interpretation of the occurrence. He had been informed that it was not the first time patients had overtly demonstrated their discontent. Combining this information with his personal experience of having to initially engage in a deductive process of clinical reasoning, he suggested that most new interns would need considerably more time to arrive at a diagnosis compared to experienced senior colleagues who demonstrated a different approach:

The vast number of patients waiting to be seen in the MOPD [medical out-patients department] bench didn't allow you much time to spend with each patient. I remember during my first weeks working in MOPD, I took some 30-40min with each patient so did most other interns. Since the workforce in the MOPD was interns, this affected the turnaround time. – *Ezera, writ refl.*

... People come and you [are] trying to put together what they're complaining about into a manageable system. ... we [had] learned Medicine in a structured way, so, your symptoms were already put together in a way that, almost in a way that you could assume, OK, we [are] talking about diabetes say for instance ... in that Theme. ... I felt when I was seeing patients, particularly in the MOPD setting, 'cos patients don't come to you with all the symptoms ... they're supposed to come with ... I'd sit after interviewing a patient and I'd still not know what was wrong with the patient ... I thought, is it just me? Or is it something that I still have to go back and read? Or what's

the issue? ... [when] paired up with one of the senior guys, they'd immediately begin to talk to a patient and class them into a disease profile ... And their discussion would go along that. My interviews were usually very broad, you know, I'd ask about anything ... now I realise that I just ... tried to consider too many options ... so my interviews would take a whole lot longer typically. – *Ezera, int.*

Ezera surmised therefore that with each intake of new interns, NQDs took much longer to reach a diagnosis due to their lack of expertise, resulting in backlogs of patients waiting to be seen. He had also wanted to be thorough and patient-centred in his approach, although he soon discovered that this was not possible. He described his own discomfort with being forced to spend less time than he considered was adequate for patient consultations. He considered it impractical for doctors to be asked to see a patient for less than 15 to 20 minutes, as that was insufficient time to conduct a thorough examination. However, he described the pressure compelling him to do exactly that by using words he ascribed to hospital staff at the institution following the critical incident:

... that is what was being forced, 'cos that time 'twas, "you got patients, they're complaining outside, you have to be quick"...

... I felt it was horrible because you weren't relaxed to ... take your time, speak to them, go through your differentials, get a management plan, write good, neat notes ... explain to the patient your management plan as well ... speaking to the patient was now a luxury. Because you just asked the nurse to explain to the patient, [they] must go for an ECG, must go for this, must do that, and that's it. And you were now scribbling down some notes, and trying to get to the next patient ... it just highlighted how bad the system is.

... until you address that, the problem won't be solved, because interns-, as an intern ... you come out with the idea of, sort of, you're very idealistic about how you should approach the patient. You try do that, and you quickly get forced into ... a situation like this, you realise you can't do that, you have to just, [to] use the term "push the crowd". – *Ezera, int.*

The immediate need of patients to be attended to within a reasonable length of time therefore appeared to be in tension with NQDs' efforts to implement patient-centred care. Crowded waiting rooms compounded by novice doctors spending too much time with each patient, whatever the reason for the delay, led to patients expressing their frustration in a

manner that posed a threat to the safety of healthcare personnel, was inconsiderate of other patients, and in fact, would undermine their own medical care.

5.1.3 Links to the undergraduate medical curriculum

The abovementioned tardiness of novice doctors in the process of clinical reasoning was not due to any lack of knowing how to communicate with the patients in general:

I found no problem communicating with patients as I was familiar with the clinical setting. We were taught since first year the approach to history taking and examination. Even before I knew what questions to ask and how to link the relevance of the responses, I knew *how* to ask them. What I found challenging as I began internship was linking the symptoms into disease profiles quickly enough. – *Ezera, writ refl.*

Ezera admitted that he had felt that his knowledge of foundational sciences in particular areas was lacking, particularly when he was expected to teach medical students, however, he did not feel that this had hindered his clinical management of patients in any way.

... many a time that I felt I had to go back and read some basic principles. Especially in departments where students had been allocated, since as junior doctors we interacted more closely with the students (with whom, by the way, we shared a similar shoe not-so-long-ago!) ... Completion of tasks or managing patients within the working environment was never a problem for me ... however, it was when I was a Community Service Officer teaching students that I realised that some gaps existed ... [for example] what is the pathway of the nerves, arteries and veins in the chest? ... One remembers for the procedure that they run below the rib therefore insert the ICD [intercostal drain] just above the lower rib, but speaking to a student you need to start at the right ventricle and end at the left atrium. Or when you give a patient [name of a drug], what is the chemical pathway of its action? I know when and how and why I use it, but I remember having to re-look at the ... basic mechanism of action. – *Ezera, writ refl.*

In discussing the hierarchical structure of medicine, Ezera expressed appreciation for the early exposure to the clinical environment in the curriculum:

This reinforced the familiar conduct and professional etiquette between doctors and patients as well as between interns and other senior doctors that I had witnessed since my first year of training. – *Ezera, writ refl.*

P: ... from a student's perspective looking in ... on the interaction, we knew-, you saw that the Registrars spoke to-, told the interns this is what you must do, this is how you do it, and there's certain amount of teaching that went on. And um, the guys that were junior respected the guys that were senior ... the guys who were on call didn't leave the hospital until the Consultant has left, [when] the Consultant left, then maybe the Registrar could leave and then only after that maybe the intern could leave. If it was a good day then everybody left at the same time sort of thing; and that was just a small amount of respect that was shown to the person that was senior, not to just say "I've finished my work, nothing else to do in the ward, I'm going". You know, you respected the guys who were around you for their seniority, you waited and you stayed with them until-, even if they were talking about the soccer and it was nothing to do with work, but you stayed and you were there and you were present. And then, until two hours later you'd all walk out together.

R: And at that stage were you already thinking OK ... how did you feel about that kind of hierarchy?

P: Er I, I didn't have a problem with it as such ... 'twas good, it was um healthy, 'cos at least people knew, that's where you knew where you were. You knew where your boundaries should be as such.

Ezera explained further that the intern's responsibility was to be present and to inform their senior colleagues if they identified a problem; "as long as you spoke to your Senior Registrar or to the person who was senior to you, you were sort of covered". In this context, being 'covered' implied that the rigid hierarchical structure of medical practice was helpful for interns in that they knew the bounds of their responsibilities and that they were absolved from blame for any negative consequences. He elaborated using a particular patient he had encountered whose blood pressure remained low despite administering replacement fluids. Ezera recalled that he had spoken to 'his Senior' who instructed him to repeat the measurement of the patient's blood pressure in two hours. This had happened in the early hours of the morning, it had been a busy call and it was "one of those Registrars that didn't like to be called". Following his previously described strategy, Ezera admitted the patient to High Care, but the patient's blood pressure continued to drop and he died later that morning due to a significant intra-abdominal injury that he had failed to detect. In retrospect Ezera realised that "those are the type of things that you'd want to get sorted out earlier". He felt that, had he been proactive and called someone else, or if the Registrar in question had been more approachable and he had felt comfortable calling him a few more times while trying to decipher why the patient's blood pressure was not improving,

the outcome might have been different. However, when this patient case was discussed at the 'morning meeting', Ezera said "they uh didn't come back to me ... then the hierarchy or the order of responsibility fell on the Registrar ... and not me as an intern".

Ezera came to appreciate that the 'protective' function within the hierarchy of medicine could only be effective if senior colleagues were available and approachable in their supervision of interns:

I know that I'm quite outspoken, and I was even at that time. And I'd always try and talk about whatever issue I had ... [But] I did remember being cautious with the people that weren't [approachable], ... you'd get shouted at, you'd get like "how come you don't know this?" or you get comments about "Ah! he was asking me about this or that"; you don't want to get that the next day. – *Ezera, int.*

Whilst being accepting of the existing power flows and declaring the hierarchy to be beneficial in a sense for NQDs, when it came to his own current practice Ezera chose to blur these same boundaries:

The way I speak to my interns now, I empathise ... maybe they don't know um, certain things about how to manage a patient, they might not want to ask if I'm not approachable ... I try and make the lines of hierarchy a little bit more fluid. – *Ezera, int.*

5.1.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)

Regarding Ezera's aspirations to specialise and the kind of practitioner he wanted to become, his choices were far from fixed during internship:

P: ... I was really just out there to try an' investigate what it is that I'd love to do. I honestly just didn't know. My internship years [are] what shaped ... what I'm doing now ... my interaction with the Registrars and Consultants in that block.

R: But apart from a specialty, did you see yourself as a sort of physician, practitioner of a certain nature?

P: Ja, as in qualities of myself as an individual? (.) Mm! I- (.) I think I saw-, I saw what I'd like to be in others ... I'd interact with a Registrar I really respected, the way they approached patients or the type of practitioner they were, I'd pick out qualities that I'd

want from that, and in that way that shaped who I aspired to be, or the practitioner that I aspired to be. – *Ezera, int.*

He went on to name a particular medical practitioner from Obstetrics and Gynaecology who had inspired him “for his dedication to his patients and the way he approached each patient as an individual”:

This has stayed with me and I continue to glean from great men and women in medicine that I’m privileged to meet. – *Ezera, writ refl.*

With reference to the above statement I gently chided Ezera asking if medical professionals were really all that “great” and whether he had no negative experiences of them. He replied in a serious tone that he had deliberately “tried to become more of an optimist than anything else”; explaining that it is “far more common to see the wrong” and “far easier to buckle under the many pressures [of] *time*, family stress, exams [and] all of that”. But he had seen people who rose above it all, even if he hadn’t interacted with them on a personal level, and always tried to think about “*those* people rather than the many others that “became frustrated with the nurse that’s not doing this or that, again!” or “made the other interns cry”:

... the environment doesn’t change, even now [as a Registrar] ... little has changed, when you go and walk along the corridors, and it’s the doctors that are there and that dedication, or that effort that they put into it, for that patient they are seeing ... that’s the kind of doctor I wanna be ... I guess the PBL system ... introduces you early on to it [the healthcare system], so you get to recognise patterns from early on. And your experience starts as a student, um see-, looking into the whole system, and it slowly, once you get to enter it, and you start to have more responsibility in the system, you realise that even as a student, you could do a whole lot more, and I guess that’s what I didn’t realise [back then as a] student and as an intern, is that your influence on the same system ... you don’t have to be a Senior, you don’t have to be a Head of Dept. or whatever to influence it, you can do your part on sort of your circle. – *Ezera, int.*

From his currently more mature perspective, when I asked if he would change anything in his written reflection or tell it differently, he admitted that it “would have been a bit more honest” to elaborate on some of the negative aspects. Admitting that his optimism might have obscured “some of the other stories that happened in the wards ... Because it builds you as a person to remember them as well”, which he now conceded that “it’s not being

negative to tell, even just to say it". Therefore, Ezera's thoughts about being able to effect change on the system through one's sphere of influence at whatever level of the hierarchy, combined with his deliberate optimism revealed a strategy towards constructing a positive identity as a clinician. He clearly wanted to convey in his narrative that he embodied the dedicated, approachable and humanitarian professional that he had witnessed or imagined he had witnessed. He had embraced the magnanimous side of the medical profession and tried to turn a blind eye towards the flawed elements, particularly regarding any associated abuse of power. However, he presently appeared prepared to re-evaluate this strategy, considering that he might benefit from a more balanced perspective, particularly in the light of some difficult decisions that were confronting him about the future of his career as a surgeon.

5.2 Gillian

5.2.1 Introduction

Since writing her story on internship three years previously, Gillian had emigrated to a French speaking African Nation (which I will refer to as FANA). She was on a brief personal visit to Durban when she made time for me to interview her. I was grateful for the opportunity to meet her face-to-face rather than rely on Skype, which was the alternative medium I had considered might be necessary for purposes of interviewing her.

Gillian had been a paramedic before entering medical school, and I recalled her outspoken and confident manner as a medical student, often representing her class mates to voice issues about the PBL curriculum or the administration thereof. Being slightly more mature than most of her class, and being part of a very limited intake of white medical students at UKZN, she was already distinctive. She had been brought up by a single mother and I discovered during her interview that she had learned German as a second language in school. I recalled that she had belonged to a charismatic church when she lived in Durban.

However, in her responses about internship experiences she was generally less vocal about her beliefs and faith. I felt that she might have held back from discussing her beliefs during the interview as she considered these to be personal matters not directly related to my research.

Gillian was initially situated at a Level II district hospital in an urban area of KZN for the first four months of internship. This time was followed by two months at a Level III hospital and two months at yet another Level II hospital in the same urban area of KZN. Gillian chose to get married towards the end of her first year of internship and moved back to Durban for the second year of internship to be closer to her husband who was in the process of completing his tertiary education in Engineering. She was then based at another Level III hospital in Durban. Gillian was therefore in an unusual position in that she was able to compare her experience of being an intern in four different healthcare institutions. This enabled insight into various contextual factors and different ways of organising work relating to interns, and the way these variations had affected Gillian's internship experience. At the time of interview she had one child, a toddler who had accompanied her on her journey to Durban, and she was pregnant with her second child. She had become a devoted wife and mother, determined to prioritise caring for her family before considerations of advancing her career as a medical practitioner.

5.2.2 Internship experience / journey

The first day of internship was "daunting and overwhelming" for Gillian due to an exceptional shortage of senior medical staff at the site where she was based. At this Level II hospital, the doctors had refused to report to work because of a dispute concerning remuneration for overtime. Gillian made it clear to me that this was not an organised strike action, but it was an *ad hoc* stay away due to ongoing "hospital politics"; particularly over the New Year period this situation impacted negatively on her transition to internship:

I had two Surgical Wards to oversee, two paediatric wards, and the neonatal ward where I had a resus[citation to perform on] the first day. Thankfully there was senior cover in Neonatal Ward, but [for] the rest we were left on our own. I didn't enjoy it and

I found it very overwhelming due to the numbers of patients I was responsible for. – *Gillian writ refl.*

... some of those memories, and where you realise that had you been more efficient-, if you'd been a more experienced doctor and you could have been more efficient, or you could have judged a clinical case more effectively ... you probably could have, maybe even saved a life. And it-, it-, [is] those experiences that are negative, [and] can scar you as a doctor ... in the early formative years, it's kind of like learning to ride a bike, if you fall hard the first time, you [are] more reluctant to get back on the bike than if you just bounce and get up ... those situations can definitely scar *new* doctors. And, I mean, I think that I had an advantage because I was a paramedic, so- – *Gillian int.*

Despite these initially challenging circumstances, Gillian described Family Medicine to be an ideal discipline in which to begin her internship:

I was glad I started there [Family Medicine], because ... my first month was in Casualty, so you get to see everything. And so it gave you a good overview of ... medical practice and how to cope – *Gillian int.*

Comparing herself to other interns, she felt that her prior experience as a paramedic had given her an advantage when it came to emergency situations. However, this advantage did not extend to clinical reasoning and medical management of patients:

... for example the Cape Town students, and Bloemfontein, came through a lot stronger, but they had been given a lot more responsibility in their wards, in their decision making, and er so, that's why I differentiate from my experience as a paramedic to a medical student, I think they're two different (.) fields almost. Just because you're a good doctor doesn't mean you can resus[-cite] well, 'cos you might not see it all the time. So that's why-, a lot of people say "Oh like the paramedics are really good at their job", but you can't put them into a doctor's position, 'cos then they don't know about general medicine. – *Gillian int.*

5.2.2.1 Contextual factors and organisation of work

Gillian was very aware through her experience of internship at multiple sites, that contextual factors had a significant impact on her day-to-day work experience; for example the way interns' rotations had been organised, and how communal spaces such as tea

rooms were made available or not. Also her learning experiences within a discipline had much to do with the staff members and her interactions with them:

... first of all [transitioning to a new rotation] you've got a new department Head and new staff to work with ... your working enjoyment can be very dependent on the staff that you're working with, and how well they teach you or how they, how they treat you.
– *Gillian int.*

The other interns in the cohort were also important in her setting, as they were required to work together in groups:

... your rotation tends to be with the same interns, so-, and that can also make or break your experience because, if you're with other interns who are doing the bare minimum, and you doing more, that can also affect you. – *Gillian int.*

Gillian raised the matter of a social life being important as NQDs, which she felt needed to be addressed when planning space allocations for internship programmes:

[There were] other more superficial reasons as to why you would enjoy a block, and at [Level III hospital] I stayed in the 'doctors' quarters' (with humour) ... but you know, saying that, er things that were not as enjoyable, for example if you had to compare [Level II hospital], and that was quite a rough time [work-wise], but the social time ... was so much better because we had a common tea room, where we could all get together, we could moan and complain as much as you wanted, go back to work, but at least we had our own space, and there was more of a camaraderie than ... where we were dispersed. Now you go to [another Level II district hospital], and there's a common tea room again ... I think the social aspect shouldn't be ignored in training. – *Gillian int.*

The category of hospital also had an impact on the interns' duties, as they were expected to make arrangements to transfer patients requiring more specialised medical attention from Level II to Level III institutions:

[at] the referral hospital, so, you wouldn't have to spend hours on the phone trying to refer ... so you wouldn't have that battle ... at [Level II hospital] you'd have the problem of waiting for hours trying to refer a patient ... and that really affected your day ... – *Gillian int.*

Gillian considered the excessive workload she had to contend with across all internship sites a hindrance to adopting a biopsychosocial approach to patient care. She expressed regret in this regard using a specific incident as an example of when she might have acted differently if she was not stretched to the limit:

because it's so busy, and you have very little time, to-, I know it sounds awful, but very little time to be empathetic with patients ... you can be as polite and pleasant to a patient as possible, but some patients I think could benefit from a little bit more time and you don't have that time to get through, otherwise you'd never get home. Um, I remember one case ... the girl was conscious, and she was a young girl, I think she was HIV positive, and she kept on asking for her family ... I said "I'll go and call them just now" ... in the same ward I was taking bloods, and I went back 20 minutes later and she'd died ... I think she died alone, she died with the curtains closed around her, because she was struggling to breathe ... many of the patients have breathing difficulties ... didn't see it for what it was then. And you look back on yourself and you think (hiss), if that had been me, I would have wanted my family and if no-one could have got my family and I died alone ... how much of good person am I? ... There's no time for it. That's-, there's too many patients. – *Gillian int.*

About the Registrars from various disciplines she had encountered in her internship COPs:

Unfortunately the majority of ... Registrars saw the interns as 'blood takers', and so there was not much teaching going on ... they'd go and do a ward round, and [instructing us] "do this and this and this" (speaking very rapidly), so you'd end up with a list of bloods, but with not much teaching. There were some dedicated ones [Registrars] ... it was actually some departments-related; Paediatric Department – these guys were very dedicated, Surgery – dedicated and enjoyed teaching, and Internal Medicine (negative facial expression and gesture). 'Cos I mean you can take 11 bloods in a patient at one time, there's a lot of ward work to get through and they need to get home and they need to study. All the Registrars do actually, and so the quicker they get their ward work done, the quicker they can go home and study and do their thing. Maybe we also just hit it [a discipline] at a bad time where it was just before exams (questioningly).

... I mean it's a general statement, some of the Registrars were very good, and again it comes down to the dedication of the person I think. – *Gillian int.*

Therefore the personal dispositions of Registrars as well as the general organisational culture within a discipline were seen to play a crucial role in the learning opportunities that were available to interns.

5.2.2.2 *Critical incident – poor supervision*

Gillian said that she generally enjoyed being left on her own to manage patients as long as she knew that she could call for assistance if there was a difficult case and she felt out of her depth. She described an interaction with a particular senior casualty officer who refused to render assistance when she needed it. This particular person apparently had a reputation amongst the interns for being unhelpful. On this occasion Gillian was having difficulty intubating (inserting an airway for) a female patient who had taken an overdose of drugs. She described a scene where the senior colleague sat watching her, but would not help; eventually she had to call for a Community Service Officer (CSO) and they managed to secure the patient's airway. The patient was subsequently referred to a Level III regional hospital but later died and Gillian was left wondering whether this patient's death might have been avoided had she immediately received more pro-active assistance.

She was made to feel inadequate and powerless in this situation where a patient's life was at stake, despite a senior colleague being present at the time. The conduct of the senior colleague in this instance constituted ethically unacceptable behavior both towards the patient and towards the NQD. Gillian offered the following pertinent explanation as to how such overtly abusive behaviour might arise:

It was a lack of-, lack of empathy, er I think too long in the Government system, er just possibly there to get a pay cheque, and, and nothing more. And unfortunately we did find those people [R: in the system] in the system, ja. Whichever hospital you went to ... the worst case ... where there are ... senior doctors with private practices outside the Government system, and they are paid to work full-time, or part-time for the Government services, and [to] teach students. And they would pop in for two hours a day, and leave again, [R: 'sessions'?] and they wouldn't have time-, 'sessions' ja, so they wouldn't be honouring their contract in the Government, 'cos they wouldn't be fulfilling their hours, the mandatory hours, and the students didn't benefit, or the interns didn't benefit 'cos we didn't get that training they were supposed to give us and for me, I think the whole of medicine is based on mentorship, you can't get around it. And so it's, it's just-, it's unfair. But I don't know how to- (.) – *Gillian int.*

Gillian's evaluative comments referring to this critical incident gave me insight into possible conflicting interests between some doctors employed in the healthcare system in South Africa, the provision of adequate care for patients, and clinical teaching for interns as expected by the state. Interestingly she also described developing a defiant attitude in time towards such senior colleagues. Such attitudes were, she observed, particularly prevalent in her group of interns who were the first to undergo a two-year internship. They had become more outspoken than previous interns about various issues they encountered:

I think by the time we got to the second year of internship we were finished! I mean we're-, the-, our fight was out of us, hehe, (deep inhale) we lost- (stuttering) and also I think we took a lot less (.) er flack, rubbish, from-, from people around us. By the end of the second year of internship we were just like "take us or leave us! We can't get out of the system, so you just gonna have to put up with us, and we don't like what you're doing, and we'll tell you we don't like what you doing 'cos you actually can't fire us!" And so I think we became-, a lot of us became a lot more brazen in our second year of internship. Whereas I think if you do one year of internship, it's only one year, then you get out [into] community service and then you [are] almost out ... there's no point in fighting systems or fighting people, you just quietly get on with your work and just do it to get by.

... so if this particular Senior would sit there and do nothing, we would actually get quite cheeky and disrespectful, because I think you've had one year, huh, where you've just felt downtrodden and by the second year you actually-, you not going to take it anymore. – *Gillian int.*

When questioned about how NQDs might deal with unhelpful seniors, Gillian personally identified closely with the CSOs and described her strategy which had been to enlist their assistance instead. She reminded me that her cohort of interns were not far behind the CSOs present in the establishment at the time, who had done only one year of internship:

I think as interns you develop close relations with-, working relations with the Community Service doctors and anyone who had more experience. And so certainly if you knew that you were going to be working with notorious doctors who were very unhelpful, um, I think in a way there was a lot of camaraderie ... If you worked hard as an intern, then the Comm. Serve. doctors would enjoy working with you, and when you called them for help, then they would know that it was not because you were trying to be lazy but that you actually needed help. And, um, so that was how I dealt with it.

Like the Comm. Serve. doctors, I think we were all in the same boat, we were in the system that we didn't want to be in, and we were just trying to get through and survive ... where they would really be, if not dedicated, they at least had a sense of work

purpose. And they would get through the work, even if they didn't enjoy the work, even if they didn't enjoy the Department, most of the Comm. Servers that I found had a dedicated work ethic. – *Gillian int.*

Her use of language therefore conveyed a sense of 'you and me against the world', positioning herself and the CSOs as having to plough ahead to survive the healthcare system to which they were subjected. Furthermore, she revealed that her own struggle with the Department of Health continued after internship on the issue of a placement for her community service:

P: I got third rounded [**R:** what does that mean?] er, when you go for your community service post you put in your first selection, and if you don't get your first selection you can put in your second selection, and if you don't get your second selection you have to put in a third selection. And they third rounded me, and didn't-, would not accept that I was already married at the time ... and wouldn't keep me in the Province. They said it was acceptable to travel a 100km, but I mean Limpopo's not a 100km. And so I refused to put in my third round application. I just didn't. And, um, they eventually phoned me in December and said 'what am I doing?', and I said 'well I'm not doing my community service (tone conveying irony) if I have to live away from my husband'. Um, and they found me a post in [name of Level III hospital in Durban]. So [**R:** OK, so that's how come-] and I mean that came with fighting. So I mean by the time you finished with your internship, and you've fought a whole system there, now you've got to fight for a position just to-, and I mean I know there were students that just lied about it-, that they had aunties and uncles that were very sick or frail or whatever, but I mean there were genuine cases of marriage and things that were not given priority. And, um, I don't think it was a system that was conducive to happy-, happy home lives, huh.

R: Or that took your, your situation [**P:** ja] into any consideration? [**P:** ja].

P: And I wasn't-, I mean I don't know of any of the 'marrieds' that were, were willing to live apart for a couple of months at a time from their spouses [**R:** no, that's-], so I mean it was just fight after fight after fight, uh-uh (negative expression). – *Gillian int.*

5.2.3 Links to the undergraduate medical curriculum

Regarding preparedness for practice Gillian drew attention to the contrasting expectations and roles of medical students compared to interns:

I think the transition would have been easier if we had had more responsibility as medical students. As medical students we were never expected to take care of patients on our own, so all of a sudden being responsible for four wards of patients felt

impossible. As medical students we attended ward rounds, took some bloods, attended teaching sessions, and learned what we had to [in order] to pass the next test or exam. Talking with interns from other medical schools, their medical school programmes seemed to prepare them better for the transition to internship. For the last two years of their medical degree they were responsible for patients. I could tell the difference because they were a lot more confident in making decisions and taking responsibility for a ward full of patients. – *Gillian writ refl.*

Therefore Gillian had actually felt somewhat inferior to intern colleagues from some other universities. Whether the other interns had actually been given more opportunities to manage patients or not, it seemed to Gillian that the curriculum at UKZN had not afforded her sufficient experience to prepare her for making clinical decisions with the same degree of confidence.

When asked about the perceived lack of foundational sciences in the PBL curriculum (see section 2.2.1 Problem-based learning in medical education p. 19), Gillian responded with an often used truism or cliché about Medicine being ‘both art and science’ to infer that her communication skills were stronger than her knowledge of the sciences:

... funny story, when I was going for my [admissions] interview at med school, they asked me about the new curriculum. I had no idea there was a new curriculum! Pha! I didn’t know that I was going on to a new curriculum, I just said-, they said “how do you feel about it?” and I said “yes I’m very supportive”, not knowing what it was about or that there was something new. But, um, if I had had to go through the old system, with the proper sciences, I think I would have failed. ... it didn’t really interest me, to be honest, and I don’t think it makes you a good doctor. But yes, for understanding, absolutely, and so, were there instances when I felt I need to fill the gaps? Now more so, because (speaking slowly) I’m finding, the teaching role has changed. Now you are trying to teach and the younger medical field people want to know ‘why?’ “Why can I pick up- ... why?” And you have to kind of understand those. And you realise it makes you a better doctor academically, but I don’t-, I don’t claim to be an ‘academic doctor’. I divide ... medicine into art and sciences and I’m the artist, you know, I’m not the scientist. I can always explain-, I can sit the patient down, or the family down, and tell them that their loved one is dying. I’m not the kind of person who enjoys taking tutoring groups ... – *Gillian int.*

Gillian had much to say on issues of language and language barriers being a hindrance to effective communication with patients. Specifically about the undergraduate curriculum she opined that Zulu should have featured more prominently later on in the curriculum rather

than in the first and second years when it was taught to her cohort. She realised that the usefulness of learning Zulu depended on the province in which one was placed for internship. Interestingly she felt that having learned some German in school and now more recently some French; this might predispose her to learning Zulu more quickly, implying that there might be some transferable generic skill to learning other languages.

There were several senior colleagues that Gillian admired and who became her role-models and mentors; she mentioned one of the clinicians she encountered during her time at medical school:

I did my undergraduate surgical rotation with Ms B ... one of her patients being so grateful he hugged her. She returned his hug with genuine empathy. Witnessing that one moment between a highly skilled doctor whom I respect, and her patient, taught me more than any textbook will ever teach me about being empathetic and compassionate. – *Gillian writ refl.*

5.2.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)

At the time of the interview Gillian practiced part-time as the doctor of a mining company in FANA and she had recently opened her own private practice. She employed a nurse practitioner at her clinic who spoke both French and the local African language of FANA. When I asked her about the way language affected doctoring she revealed how important it is for her to understand the patient and vice versa:

P: ... because there's always going to be those cases that you need more clarification on that-, your language skills ... I mean unless you're going to really immerse yourself in it for four years and learn the detailed language of a 90yr old person (.). Because, you know, er, there's sometimes a deep cultural root behind the language that you need to-, come to grips with.

P: ... writing is a language, even if you write in English, if no one can read your English writing, uh, how're they going to understand your prescription? ... I've got referral letters from doctors that I can't read! ... it makes it null and void. Um, so it comes down to being understood, in your own language or someone else's language so-.

R: But do you find you rely on maybe the non-verbal-?

P: The non-verbal, yes, yes, yes. And I, er, I draw pictures, um, for example, I ask them to tell me in their language because quite often I can understand their language better than I can explain myself in a language ... how often they should be taking it, at what times. So I'll draw on the box, medication 1 tablet 3 times a day, and you can put there sunrise, sunset, you know? – *Gillian int.*

When considering future aspirations, Gillian said that with each new rotation during internship she had thought about specialising in that discipline, indicating that she had definitely not made a decision by the time of graduating. Even at the time of interview, she laughingly said she had still not decided on an area of specialisation, if in fact she was to ever specialize:

What motivates my choice of ... [not specializing] for the next 18 to 20 years is my family. Um, I just don't think that you can get that back again. And I think as a woman, in medicine ... I've not met one female consultant who's happily married with children. They're either married with no children, or they're divorced, [**R:** they're single?], they're single, ja, and then they've got issues on their own ... that makes me stop and think about specialising. Because, I mean, like the people that I admire, have completely dedicated their life to medicine. And I mean ... I'm not there ... [during] internship it was gonna be all the specialties ... – *Gillian int.*

Gillian was therefore deterred by observing women's difficulties in balancing family life with specialisation. However, she mentioned two specific (male) Family Medicine practitioners she had admired for their empathy and expertise during her internship. Despite her not having had the opportunity to interact closely with them, encountering them in her COP had a lasting influence on her, as she had been inspired to consider Family Medicine as an option if she were to specialise. Furthermore she reasoned that Family Medicine would allow her that variation in practice that she would find stimulating:

... just to be able to walk into an operating room and do a caesarean section and then go and set a fracture and go into casualty and do resuscitation and just be ... a really good generalist ... there's two I've met [recalling the names of two doctors] ... they were really inspiring. – *Gillian int.*

However, Gillian unexpectedly announced that she might also like to pursue Paediatric Orthopaedics as an area of specialisation. The rationale behind this divergent option was

expressed in terms of wishful thinking that she might get to deal with patients who were, otherwise healthy children and free from duplicity:

Now I think I would like to do Paediatric Orthopaedics ... generally you [are] working with well kids, and well kids are not going to lie to you ... if they're sore they'll tell you ... once they're better they're gonna go back and play. You know, whereas the other disciplines ... specially the adult disciplines, there's a lot of-, Orthopaedics (.) they're like back-aches and they're like grants [referring to some government grant applications that require medical certificates and other paperwork to be completed by attending doctors] and (with laughter), like you have to deal with those [R: so you don't want the geriatrics, you want the paediatric orthopaedics!] I want the paediatric orthopaedics.

Family Medicine also, ah I ... look at them and think, shew! – I want their ability, and then you look at other people and think Oh! – I want their knowledge, ... I guess there's different aspects to it, ja. – *Gillian int.*

For the time being, however, Gillian was content to be a General Practitioner as she was capable of dedicating a good deal of her time to caring for her family.

5.3 Ian

5.3.1 Introduction

As a medical student, Ian was reticent in the extreme. He called it “being shy”; however, as he appeared attentive and almost pensive most of the time, he drew attention to himself with his silence. I recalled that people in general, and particularly educators (me included) would want to know what he was thinking. When pressed for comment, Ian demonstrated that he was in fact deeply thoughtful and often communicated his feelings with unexpectedly descriptive language.

In response to my invitation to the participants to tell their internship stories, Ian's was the first written reflection I received, and again his follow up interview was the first one to be scheduled. He made time to meet me on a brief family visit to Durban from the Western

Cape, where he was a Registrar in Paediatrics at the time. Furthermore, he made his way to my office at the medical school for our meeting, surprising me by bringing his wife along with him. This indicated to me that he was eager to communicate his experiences and that he considered sharing these through my study to be somehow a worthwhile exercise.

Ian grew up in Durban, was of mixed race-group lineage, termed 'Coloured' in South Africa. Prior to studying medicine, he had completed a Bachelor's degree in Biomedical Science and enrolled for a Master's degree in Anatomy (which he had not completed). He felt "a little bit older" and that he had "missed out on the life experiences and the social development" when compared to his peers. In his opinion he had a domineering father who he said "always had this control over us" and therefore his choice of internship site was influenced by wanting to "get away from home ... as far away from home as possible". Consequently Ian was, of his own volition, based in the Western Cape, which happened to be at a Level II hospital in a semi-urban setting, and where almost everyone spoke only Afrikaans.

5.3.2 Internship experience / journey

On transitioning from medical school to internship, Ian had felt an acute disruption to his identity for various reasons. From having been a respected senior student at medical school in Durban, he had to contend with being a new intern who saw himself as more of a nuisance than a help to the senior colleagues in his COP:

I overheard a group of senior medical officers discussing interns and how we are more a hindrance rather than an aid to them. This then made me reluctant to ask for assistance, only if desperately necessary (I soon learnt where and when I was out of my depth) and had to fast learn and make myself familiar with the hospital protocols. – *Ian, writ refl.*

Ian was to encounter many challenges in his internship environment. He was able to respond with determination to adapt and overcome some of these. However, others posed a severe threat to his professional identity formation.

5.3.2.1 *Language barrier*

Finding himself in a hospital where Afrikaans was the prevalent language was Ian's primary challenge in transitioning to internship:

... that was my biggest issue, I mean the last time I did Afrikaans was in school, that was at school level, and I walked into a hospital which was Afrikaans speaking, and people, I mean, actually refused to speak English to you, even though they could speak it, I mean they could understand, but they wouldn't, they wouldn't (.) and of course a lot of the patient profile is from also the poorer farms and the wine vineyards around and things like that, where a lot of them didn't speak much English ... I had to learn to communicate with them.

... Afrikaans people (.) in general, I wouldn't say everyone, but here and there, they can be very critical of, of English speaking people speaking Afrikaans, they would then laugh at you, make jokes of you ... or ja, "you don't speak the language properly" and things, which made things also a bit more difficult for me. – *Ian, int.*

Ian was determined from the outset to overcome this initial obstacle, describing how he had eventually attained not only a degree of proficiency in the language to communicate with patients, but Afrikaans had become part of who he was:

... it took time, and um, um, the thing is I was exposed to it all the time, it's all I heard, er at the end I'd-, if I was speaking to English speaking people I'd speak to them in Afrikaans. – *Ian, int.*

5.3.2.2 *Critical incident – failed vacuum assisted delivery*

The following incident was a defining moment in Ian's life which he said was always at the back of his mind and he would never forget:

One night on call I get called up to the labour ward, the sister informs me of a patient in labour with a prolonged second stage of labour. The mother was physically exhausted and could no longer bear down. On arrival I assessed the situation and clinically decided that the appropriate course forward was to attempt a vacuum assisted delivery (VAD), having no practical experience with the procedure I remember panic setting in, the baby was in distress and the mother could not assist me. I phone the consultant on call

who happened to be at the clinic about 20min away, he said this to me “you are a doctor start acting like one; what do you expect me to do? I am busy at the clinic, you need to get the baby out” After three failed attempts at vacuum delivery, I decided to take the patient for a caesarean section, phoned the theatre only to be told that all three theatres are busy and the soonest we can do the C-section is in 30mins, now what?? With that, one of the senior Medical Officers walked in, he was informed by the Consultant to come and have a look as to what was going on. He arrived, and attempted the vacuum delivery, which also failed, “we have to wait on theatre” he said. Subsequently the baby was delivered dead after C-section.

I ran out of the theatre with tears rolling down my cheeks, filled with anger and resentment for the Consultant and the Obstetric department at medical school for failing to equip me with the practical skill. I felt completely helpless and at the same time guilty and responsible for the death of that precious new life. – *Ian, writ refl.*

His use of language in writing this narrative aimed to preserve a sense of drama for the reader, where he positioned himself as the central actor and a victim of circumstance. While mourning the loss of the neonate, he does not mention the mother, who was his patient, other than that she was exhausted in labour and unable to help him in the delivery of her baby. His reflective comments about this incident include several evaluative clauses in which he positions the intern as a fallible conduit through whom assistance was rendered while undergoing a process of self-discovery. The process could make or break them; however, he also alluded to a higher power deciding on which patients’ lives they were able to save:

Internship was a period filled with lots of learning curves, growing, and lots of self-evaluation, learning your strengths and weaknesses, your overall ability. This either made you a strong decision making person or broke your spirit. You soon realised that you are not in control of peoples destinies you are merely an instrument there to aid them and help when applicable, you cannot save all. – *Ian writ refl.*

Ian had avoided performing obstetric procedures for some time following this incident, saying he was “terrified of obstetrics after that” and had attended numerous skills courses to try and be better equipped for medical emergencies in this field. A senior colleague had observed Ian’s avoidance behaviour and stopped him from attending further courses and compelled him to perform C-sections to overcome his anxiety:

I think what happened to me was that I was using all these courses as a crutch (.) and er I couldn’t get enough, “I needed to get more experience”, “I needed to be trained more”, “I needed to get better”, which wasn’t really the case, because I had learnt what I needed to learn, I just needed to have the confidence now to be on my own. [R: OK,

that's important, so you didn't feel the Consultant was being unfair?] No he wasn't at all (.) because I became afraid of doing caesarean sections, I mean in internship you had to do a minimum of ten to be signed off, um, in your block, and I became then-, I withdrew, whenever there was a caesar I would then get whoever was assisting to do the caesar and then I'd assist. Till it reached a point when he said to me "No, come, you have to cut", from there, once the first one was done, then it went much easier. So I think it was just initially getting over the hurdle of initially doing the caesar yourself, and then it being a success and things and from there I never had a problem, and then in community service I did over a 100 caesars. – *Ian, int.*

It was interesting to note that the Consultant here played a remedial role to restore Ian's confidence, and in a sense to repair the damage sustained to his identity. To achieve this, his mentoring support took the form of a further positive challenge to Ian, possibly having gauged his capability and assessing that Ian was in fact capable of successfully executing the procedure.

5.3.3 Links to the undergraduate medical curriculum

I was mildly surprised to note that Ian had partially blamed the Department of Obstetrics and Gynaecology at the medical school for the critical incident with a failed VAD related above, when there were numerous confounding circumstances involved. I questioned him regarding whether a VAD was in fact a procedure he was supposed to have learned as an undergraduate student and if an NQD was expected to be able to perform one. I was surprised at what this line of questioning revealed, as Ian then related an experience of being humiliated as a medical student by a clinical educator in Obstetrics and Gynaecology:

Maybe it was my own fault, I mean I don't want to mention names and things but (speaking quickly) but I was in [Name of clinical educator]'s group at [Hospital Name] and it wasn't the best group to be in, I mean he wasn't the most pleasant person at that time to be with (.) um, for some reason or other he had-, I don't know if it was my own-, er== whether I just imagined- (.) but he had something personally against me. For some reason or the other he used to pick on me all the time (.) day in and day out (.) and once he even asked me in front of the [clinical tutorial] group, the entire group, "Are you on drugs or what? What's going on with you?" and I mean (.) I was just quiet, minding my own business (.) [R: but that's now going back to student days?] student [days] yes, and then I didn't much focus on obstetrics and gynae[-cology] because I shied away from

everything. And then when I got to internship, and now suddenly I was faced with this situation (.) now I'm way out of depth, I didn't even know what's going on. – *Ian, int.*

His experience of being disrespected as an undergraduate student was clearly still an unpleasant memory for Ian. He was still unsure whether his reaction of avoiding obstetrics and gynaecology as an undergraduate student had contributed to the death of an infant. Even six years post-graduation, this previously identity-damaging incident appeared to have left a residual effect on him as a medical practitioner.

5.3.3.1 *Communicating bad news*

Having to communicate bad news, usually about a patient who was dead or dying to family members of the patient, was something that Ian found particularly difficult:

One of the biggest tasks which no medical school in the country could equip you to deal with, and even to this day I struggle with it, that is breaking bad news or informing the family on the passing of a loved one. I have subsequently learned just to do it and get out of there as soon as possible and console myself by the fact that there are just some things that I just have to do, it comes with the job. – *Ian, writ refl.*

... on one or two occasions people have come to me and said, “why have you become so cold?” (.) so it's almost as though emotionally I've got no connection to what's happened, but I've felt that I have to do that, otherwise I wouldn't survive, personally from an emotional point of view. Um, it just depends on the case, the circumstance or the situation surrounding the whole death of the family or, or now it's even more difficult 'cos I'm in Paediatrics, and it's more difficult now to go and say “Eh I'm sorry ... your baby's passed away” (in a low voice) or “your child didn't make it” and things (.) so it is difficult and I think it will (.) still be an issue for me, but I'm slowly, slowly learning to deal with it. – *Ian, int.*

It was therefore interesting to note that this was a part of medical practice that Ian did not feel the undergraduate curriculum could address adequately and an area he might always struggle with.

5.3.3.2 *Foundational sciences vs developing a social life*

P: I was the only one from here from the new curriculum that went there as an intern, there was a guy there from the old curriculum who was also there as an intern with me, [Name of colleague] ... there's always been this comparison between the two curricula, from the day we started ... when we got to internship ... we'd compare because, it so happened that in one of our rotations, in surgery, we were together, and the Consultants would also compare now the two of us we were both from Natal [UKZN] Medical School. ... But I can tell you from a personal point of view, that when I looked at him [Name of colleague], we had more practical experience, I'd go in there and do what I needed to do and shew! the Consultants would ask you, "do you want to assist with an amputation?" and I'd be like "yeah sure". He on the other hand would be (.) no, he'll have to watch one first and then, and then do it. So I think we were more prepared practically, as in because, I mean, we started from Day One in the clinics and hospitals, while they theoretically (.) he could give like ten thousand lists of anaemia while I could only give like one or two (.) OK, it might be an individual thing, but I mean ... they had the theoretical grounding which unfortunately we lacked.

R: And were you then, during internship learning that?

P: Unfortunately not (softly laughing, expressing embarrassment) ... I should have, but (.) then as I said [**R:** time wise?] not really time- (.) I mean it was a new life, and it was a new experience, and being away from home, it was almost like the 'prodigal son' (shared laughter) ... I think my social life-, the development in my social life took over ... [**R:** so being withdrawn was a thing of the past?] ... it slowly became a thing of the past. But then it was strange, because at work I'd still have this whole façade, and OK this is [Ian], this is how I am, but outside of work ... ja, it was different. – *Ian, int.*

5.3.4 *Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)*

P: ... being at [Hospital Name]... now that I look back I don't regret being there at all (.) er, it actually made me, forced me to become the doctor that I was when I got into community service. Um, you know it gave me the grounding for everything I needed, it also gave me a bit of confidence when I walked out of there, being a secondary level hospital, you then had to *function* and you were expected to perform. While (.) I mean in medicine you can only compare yourself to others ... if I look at people who went to Tertiary hospitals, for example [Name of training hospital in KZN] is a Tertiary hospital, they (.) I wouldn't say I was far superior (speaking quickly) but, I would get in- my confidence level was much greater. I was more confident and more willing to do things and to try things as well, while they will be more (.) reserved, more careful, more cautious, more "OK no, I can't do this, I need to first observe" and that type of thing.

R: Is that because you were expected to do a broader range of things?

P: Mmm it was, it was, I mean if you running around with X-rays and to the Blood Bank and things all day and you know not really getting to do stuff, when you get to

community service you need to get that -... I ended up in a small hospital, out in the Platteland, the farm area in the Western Cape, where it was the Medical Super, another MO and myself, the Medical Super is always busy with his administration and all this, so it is basically just the two of us. [R: And you have to handle everything] Ja (.) if there's a resusc[itation], if there's a caesar[ian section], if there's an appendix that needs-, one has to give the anaesthetic, one has to do the caesar, or one has to operate one has to-, ... if I didn't go to [Hospital Name], I would never have coped; (.) ... because I'd gained what I needed to from the hospital, and that helped me move forward in community service.

R: And you spent your whole two years there? [speaking over me, P: two years there, ja], that's interesting.

P: So it's an excellent teaching, teaching hospital, ja ... it is.

R: And, but ... from an under- or well-resourced [perspective]?

P: Not really, they're well resourced, well now they've renovated, they've got a CT Scan and they've got an MR- no, they don't have an MR, but they've got CT Scans now, and they've got Consultants, two Consultants in every department; all their clinics are there; so, it's a poor socio-economic- in terms of area- surrounding area around the hospital and things, but the hospital itself is quite well resourced (.)

R: When I say 'resourced' I mean the number of people as well (.)

P: No, no, they're fine, ja. In fact I would suggest that hospital for anyone who is looking for an internship, ja. – *Ian, int.*

I noted that Ian had therefore become increasingly appreciative of his internship site as he reflected back on how even the challenges and difficulties at the time he was there had shaped him as a practitioner:

P: ... fortunately for me it was a two-year internship programme so by the time I got to my second year, er== you were [R: it was easier?] it was much easier than the first year. And then the new interns were there, and then you'd be helping them along and telling them "ja, OK, do this", "don't do this", "this Consultant likes this and that", you know, that type of thing.

R: And does that also contribute to your learning?

P: It does ... it does because um, it makes you're, your knowledge and ground- ... solidifies it basically because then you helping others with what you've learned in the Dept. and things – so it does make it easier; and then of course you build relationships with them, because it's easier for interns to build relationships amongst each other than with the MO or the Comm. Serve. [Officer] ... and so you grow slowly as an individual. – *Ian, int.*

5.3.4.1 *Developmental continuum metamorphosis*

I think that's where [referring to a small Level I hospital in the 'Platteland' of the Western Cape, where Ian did his community service] I came out of my cocoon basically. In internship I was in this cocoon and in community service I came out and blossomed. I became a lot more confident with people and learnt how to, you know, build relationships with them and talk to them, and far those relationships would go (.) because there were many, uh-uh. For me internship was learning and then Comm. Serve. was developing other-, what I had learnt as an intern. And it helped you to become more independent, and to find your way basically. So if internship wasn't there I wouldn't have been able to make the decisions that I did make, and be where I am now. – *Ian, int.*

Ian explained that he had not seen things in this way during his internship, when there were many times he had thought "... it's so unfair ... why must they do this to me? I'm being abused 'cos I'm an intern". In retrospect he felt that he had learned more by being exposed to the environment that required NQDs to take action, even if it was possibly beyond the usual level of responsibility and workload recommended for interns in general.

He described how his interactions with patients during internship had been hampered by time constraints and he had therefore adopted a rather mechanical and strictly biomedical approach to patient consultations.

I think internship for me was, wasn't really-, yew! I don't want this to sound bad now ... You know at times there was like 20 patients at this clinic to get done and go in and boom, boom, boom gone ... there was no time to build relationships with the patients or to sit down and, and speak to them, and talk about their family life and this and any other issues or problems or anything. It was more like, OK you here, you got a cough, how long? when? any associated- ...? OK take this, thank you, good bye; come back in 2 weeks; finished. – *Ian, int.*

In his community service setting, however, he was able to spend more time discussing issues more holistically relating to other aspects of patients' lives. For Ian this led to quite another novel and rewarding way of relating to patients:

... the old grannies subsequently basically used to follow me around (shared laughter) and bring you things and ja (.)
... you walk in the streets and the people go out their way to come and greet you, "Hello doctor, so how you doing?" ... and that is what made you enjoy your job more, not just

Och! where you [are] just a doctor, you [are] just seeing numbers and that's it. That you learn to build relationships with them and they actually did appreciate you. – *Ian, int.*

Ian thus expressed his satisfaction that he had become a respected member of the community.

Whilst his connectedness to patients in general had increased, he recognised that his time in the Western Cape had eroded his empathy for a particular category of gender-based violence prevalent in the region:

... in the Western Cape we'd deal with a lot of- , and thank God I don't have to deal with it any more, sexual assaults. In the end, you'd be on a weekend and see three women being brought in for sexual assault. And you've got to take a detailed history and 99% of them are drunk, as in *drunk* and they put themselves in situations. I can't say OK now it's their own fault, but no, you can't blame them, but why put yourself at risk? in that situation? And then at the end of the day, you've seen a couple, and it always came in after 12 o'clock, after midnight 12 o'clock, 2 o'clock, 3 o'clock in the morning when you at that time trying to get a few hours sleep, and they phone you. So, you became frustrated with it, with the system and how society was and that, and you also became so cold towards them, it's like, OK, you just doing an examination, OK, come, take off your clothes, put this gown on (.) there, and continue. You never once thought that this woman has now been through this great trauma, she's been emotionally, physically-, you need to be a bit more sensitive. No, you didn't, after all, well after doing 10 or 15 of them you lose that [empathy]. – *Ian, int.*

Ian's comments concerning his choice of specialisation revealed his indecision at the time of graduation, how his internship experiences had completely revised his evaluation of a particular discipline, and shaped his present aspirations:

P: Well ... yeah... a little bit difficult because at that stage ... I didn't really know where I was going to- what I was going to, you know, to do and things.

R: Yes, did you have any intentions to specialise right from the beginning or?

P: Well, when I was at Med School, well I mean I had numerous options, well basically two – Forensics was one of them, and Anaesthetics was the other er, and actually internship helped a lot, and I hated, I hated, totally hated Paediatrics as a student, I stayed far away from it, (emphatic but expressing amusement) I hated it. But internship actually changed all that, because, well, No. 1, I had no forensic experience or exposure to forensics as an intern, so I lost interest in that. Um, Anaesthetics doing my two months of Anaesthetics I found it to be the most boring field in medicine, and I fell in

love with Paediatrics. I just loved the way it was done and the procedures and everything that was there and, and from then on, at the end of my Paediatric rotation I decided that that was what I wanted to do; which changed when I got to community service but it was always what I wanted to do ...

R: That's really helpful, so that answers my question as to whether you are where you wanted to be? after internship now?

P: Yes, it's taken me a bit longer than I expected, but I am now. – *Ian, int.*

Ian shared some further personal details about memories he had of family gatherings while he was a teenager, at which he seemed to be surrounded by younger children rather than spending time in the company of his peers. Therefore he appeared have a natural disposition towards working with children, and was currently very satisfied in his position as a Registrar in Paediatrics.

5.4 Juanita

5.4.1 Introduction

As I met with Juanita for her interview, she explained that she was weary from what she referred to as being 'post-call' (directly following a lengthy stint of being the responsible doctor on ward duty); and yet I was once again impressed by her uncompromising dedication to her profession. I recalled her capacity as an undergraduate student to sacrifice any social activity in order to pursue her studies towards becoming a doctor, firmly believing it to be her calling in life. Her passion for learning medicine and her single-mindedness in that pursuit had paid dividends as she had recently been successful at completing her specialist examinations in Internal Medicine; one of the first in her graduating cohort (if not *the* first) to achieve this distinction.

Born and raised in Durban, Juanita maintained close links to her family of origin, making mention of her parents and siblings in our conversation. Having been brought up in the Christian faith, she held firm Biblical convictions and had dedicated her life to serving God's purposes from a very young age. She had been a Sunday-school teacher as a medical

student, and I remembered her taking a guitar to the Children's' Ward on occasion to sing choruses with the young in-patients at the main teaching hospital attached to the medical school.

Juanita's current position which was about to be terminated was at a Specialist Clinic that was part of a Level III hospital in an urban area of KwaZulu-Natal. She was, at the time of interview, an attractive, youthful, female of South African Indian ethnicity; unmarried, and eagerly anticipating the commencement of her career as a Consultant Physician at a yet to be decided location, though she would be content to remain in the same region.

5.4.2 Internship experience / journey

As an internship site Juanita had chosen a Level II rural hospital in KZN, relatively smaller but busier than most urban hospitals. She described her experiences of the 'community of practice' there in considerable detail, enabling valuable insight into the possible differences in internship learning processes based on environmental or organisational factors. For example, she referred to the way in which the 'on-call' duties (rostered hours of work outside of the regular working day) were divided at this hospital:

What happened is the way [Hospital Name] worked, 'cos it's a small hospital, you work in Paediatrics, but your calls weren't in Paediatrics, 'cos it was such a small hospital, so you did two types of call-, it changed towards the end of my internship, but you basically did two types of calls, either the 'Casualty call' or a 'RU', Resuscitation Unit call. So when you did Resuscitation Unit calls, you had the 'Minor OT' [operating theatre] list. So that's how it worked ...” – *Juanita, int.*

Towards the end like when I did Internal Medicine in [my] second year of internship, I did Internal Medicine call. It wasn't a proper-, I was basically Internal Medicine. So the only person that I phoned was my Consultant, we didn't have MOs [Medical Officers] or Registrars [postgraduate students in training to become specialists].

... for me I think it was good, because you didn't have er, you didn't have many um people to, to depend on – I don't know if it's good or bad, heh! – but a lot of responsibility came to you, and then== you learned. It's the only way you really learn? ... So I learned so much just from that because, that's how you are when you are a Registrar, the only person you call is a Consultant. – *Juanita, int.*

It was interesting to note that, due to the absence of a structured department of Internal Medicine at this particular hospital at the time, a second year intern such as Juanita had felt that she had to represent the discipline in its entirety during her rotation. This was not likely to happen outside of a rural context. There were also no Registrars at her internship site, resulting in a 'missing level' of the usual hierarchy of medical personnel in academic medical establishments; which meant that the Consultant had been her direct supervisor. Therefore comparing her internship site to her current practice context, where she was a Senior Registrar supervising interns, Juanita was aware that she had had more direct access to guidance from Consultants during her internship than the interns she supervised:

Whereas my interns, they'd call me, I will speak to my Consultant or answer their questions, so it's sort of second-hand information.

I missed a level, they basically treated us like-, [R: more experienced] as Registrars, so- And I think that's why a lot of doctors go there [internship site] because if they come here [current context] as MOs, to do Orthopaedics ... they may not get a chance to operate, because there are Registrars who are trying to get their procedures done and things like that. So they all went there, to learn how to do procedures, so that when they come-, and they are Registrars, they're not clamouring to get experience ... –
Juanita int.

The hours of work she described were extremely demanding during her internship years. However, she reflected that she had been better able to cope and even enjoy the work back then, as everything was a novelty and she had opportunities to engage in more complex procedures and take on greater levels of responsibility than usual for interns in other environments:

P: In [Hospital Name], most of the time you worked the whole night, I mean it wasn't uncommon, but that-, I don't think that got to me during internship. It gets to me now, working the whole night without sleeping, but at that time I honestly enjoyed my calls. I-, it was really I think an adventure, you know, I'd get excited when things came in. When I think about it now, I just wish no one would come so I can sleep (humourously).

R: Because you've learned already?

P: Ja I suppose ... probably now it's like, OK, I've seen this before. That's probably right, because when I get an interesting patient at two in the morning, I get excited about it still (laughing) so ja, maybe it's that.

R: But was that all the time? I mean, you were finding new interesting cases?

P: Yes, and I think it's because of the varied call. It wasn't like er you did the same thing over and over again. And a lot of the things that you didn't really get to do at med school, it was your responsibility to do in internship. I got really good at skills, which

probably helped me out during my Reg. time, because I didn't have much experience in-between internship, Comm. Service and then I started the Reg. programme. But like dialysis, I knew about it because I'd done it at [Hospital Name]; which normally an intern wouldn't get the opportunity to do. – *Juanita int.*

When I asked about her written description of her colleagues as “other young doctors who were aspiring towards specialising”, questioning whether she had perhaps transferred her own affect onto them in presenting her narrative, she defended:

That's because-, *but they were!* (emphatic, raised pitch), the staff at [Hospital Name], I'm not sure [how it is] now, but at that time, it was *young*. Your seniors were a few years out of comm. service, and the only people who were ... like 'middle aged' were the Consultants ... because [Hospital Name] is a bit of er a rural area [context], people don't tend to raise families there, they wanna be in the city, so only people who are unattached and young would choose to work in a place like that ... a lot of the Orthopaedics guys who'd just wanted 'cutting time' or Surgery people, would go there. So Seniors were really very young and they were all doing exams or something like that – *Juanita, int.*

5.4.2.1 *Learning processes, strategies and dispositions*

Juanita generally did not describe in great detail any critical incidents or defining moments during her internship journey. She chose, however, to reflect at a metacognitive level on the processes that had been involved in her learning to become a professional:

Experience is the best teacher and I think it became easier to 'make differentials' as I saw more patients and learnt from colleagues and consultants as they managed patients. Medical school lays down the foundation so that one has a frame in which to think; and as one experiences different presentations of different diseases in different patients, one fills pieces into the frame and the frame gets bigger, more complex, has more detail, and starts overlapping with other frames – *Juanita writ refl.*

... when you're at Med School, because you don't-, you've never really managed the patient, so you know about the disease from the textbook and you know what patients present with, and what you expect. But patients don't always present like that. And patients are different. So I think when you-, you've got this kind of-, you know what it's supposed to be like, and you know the shape, but then when you get into it you start filling it in and probably gets more complicated [R: and messy] ja, *exactly!* People are messy they don't [R: in real life] follow the text book, they don't um, and they don't have one problem you know, like when you read it in the text book they just have a

heart attack. But when you actually managing the patient, they have a heart attack, but they also have gastric ulcers, so how do you manage the patient? do you give them, you know they bleed from the ulcer if you give them aspirin, and you know it-, it's not the kind of thing that you get taught, but obviously as you get more experience, then those questions come up and there's literature that you will read. But, you don't think that it's that complicated. But most things, when you get-, that little knowledge is-, what, what do they say? – little knowledge (laughing) is, is dangerous or something? – *Juanita int.*

Hence she elaborated in considerable depth how she perceived medical knowledge to be structured along the lines of a continuum from being an undergraduate student at medical school and afterwards during internship. Essentially, she was describing in her own words, as well as using some familiar clinical terminology, the difference between propositional knowing, compared to practical and experiential knowing, detailing how the latter are often of a much more complex nature. She also highlighted the uncertainty in medicine that prevails in actual patient cases, and is the subject of much discussion in the field of medical education, regarding how to better prepare graduates to deal with uncertainty.

Considering how internship contributed to her knowledge, she insightfully articulated a relative decrease in propositional knowing that occurs with time after graduation and as internship progresses, again demonstrating an intuitive awareness of the different types or ways of knowing:

I think in terms of numbers, learning how to cope under pressure, um, (.) I think ja, that kind of thing it [internship] helped me. In terms of theory, no, internship doesn't help you with theory, Comm. Service doesn't help you. In fact you *lose*! 'cos you not reading, you just like doing work and you like enjoying yourself 'cos you out of med school, so your knowledge just dwindles. Practically you get much better, but in terms of theoretical knowledge, it goes down [decreases]. – *Juanita int.*

Many of the above quotes demonstrate how Juanita also paid careful attention to the underlying physiological mechanisms in various patient cases she encountered. A statement she made about what it is that “truly makes one a medical doctor and not just a medical technician” further emphasised this point:

“Like people who work in the lab for example, they learn a lot of Physiology and I'm sure when they study-, but when it comes down to actually looking at the lab-, doing the lab test, they don't have to use it. Whereas with *us*, if you see a lab result, it needs to ring a certain bell.” – *Juanita, int.*

Furthermore, in explaining the above difference she was ‘othering’ medical technicians or technologists who she viewed as possibly having the scientific knowledge but not having to act on that knowledge in their laboratory-based practice. She thus distinguished basic scientists and laboratory technologists from medical practitioners, such as herself, who do need to recognise various test results as indicators of physiological processes and need to apply them in the management of patients.

However, Juanita recognised that during internship, despite her being a novice who lacked the necessary knowledge, she had been compelled to perform certain clinical procedures by adopting a superficial, technician approach. The following self-critique of her work at that stage also shows the value she placed on mastering knowledge of the foundational sciences as well as other discipline-specific knowledge, and the importance of integrating them into her practical knowing:

But the truth is a lot of the procedures anyone can do it. [R: OK, that’s what you mean] I mean, when I was doing Caesars when I shouldn’t have been really doing Caesars. And as an intern, I didn’t know enough, I don’t know enough Gynae and Anatomy to do Caesars, and yet we were doing it. So, those kind of operations I think anyone can learn to do. – *Juanita, int.*

Once mastery had been achieved, however:

... because everything becomes routine in the end. But actually, that’s probably ki-, why I don’t want to leave the academic set-up, ‘cos everything ... becomes routine, you lose the- (.) ... [*je ne se quoi*]” – *Juanita, int.*

Thus she also revealed a disposition to remain in an academic medicine environment in order to prevent her work from becoming merely routine. Again this demonstrates that her motivation stemmed from new learning, even above attaining mastery of clinical skills that would eventually cease to be a source of excitement for her.

5.4.3 Links to the undergraduate medical curriculum

On her transition to internship, Juanita had initially felt somewhat overwhelmed by some unfamiliar practical and organisational aspects of the clinical work environment, especially

as she commenced work in an operating theatre attending to minor surgical procedures. She stated emphatically that the curriculum had not adequately prepared her to understand how the various medical disciplines interacted:

And on the first night I had millions of questions, like: where to find things, how to do procedures, how the different disciplines worked; and *no!* medical school did *not* prepare me for that. Although one adjusts fairly quickly to these situations, an awareness during training may have helped” – *Juanita writ refl.*

However, she made brief references indicating that she had been well-prepared for communicating with patients in the ‘clinic-setting’ when dealing mostly with non-emergency situations. She felt competent conducting clinical interviews and engaging in the process of clinical reasoning:

Medical school did prepare me for the clinic set-up. There, one has time to think and ponder over one’s diagnosis and plan of management” – *Juanita, writ refl.*

We were taught very well to do clinical interviews, so those were easy” – *Juanita int.*

Regarding her choice of specialisation, she recalled that she had first been impressed by Internal Medicine as a clinical discipline in her fourth and fifth year of undergraduate study when she encountered the practicalities of how this discipline functioned. She had been cautioned at the time, by other medical professionals and colleagues who possibly knew of her propensity for new learning, that the current disease profile in South Africa predominantly involved HIV and TB, which might have caused her to become bored or discontented. However, Juanita’s personal experience was one of a progressively deepening absorption with Internal Medicine, finding herself increasingly drawn to the patients encountered in and the practices forming part of this discipline as she continued in her postgraduate clinical work:

At Med School ... by my 4th year, I did Internal Medicine and I really loved it, and then in 5th year I did it and loved it. But like a lot of friends I had who were like-, had done a few years of being a doctor, they all like, “no, it’s just like HIV, you won’t like it”. So I kept an open mind, even when I did internship, but then when I went to internship I spent two months in the Peritoneal Dialysis Unit, which was the best thing ever for me. Patients got better (expressing wonder), and I spent a month or two in the ward. But I

still enjoyed that, and then I knew I think this is for me, then I-, when I did Comm. Service I found that the only patients I enjoyed seeing were the Medicine patients. And we had some contact with the Medicine Dept ... then I realized, no, [R: that was-] this is the only thing, ja ... – *Juanita, int.*

5.4.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)

Juanita valued her internship experience as having enabled her to cope with the pressures of clinical practice. However, she expressed regret at some errors that she felt were due to her lack of experience, complicated by excessive workloads, inadequate supervision and a shortage of senior medical staff available to provide adequate and safe healthcare to a multitude of presenting patients:

It helped me cope, with large numbers of patients, uh. Because [Hospital Name] is busy, busy, very busy, with fewer doctors than like here [referring to her current practice context] is busy, but we've got staff and we've got Consultants and it's a properly run department. There you [are] just functioning with a few MOs, lots of interns and then a few Consultants and, and so you learn how to be quick, and you know who's sick, but you make a lot of mistakes. Like now when I think back on some patients like I would have done so much more-, I would have done it differently, things I didn't know, and just because I didn't have a Consultant around. I think *Aaah!* You know, like I had a patient who had a low pulse, and like he died. He was well, but he died the next day and he had had this low pulse for a while. And I just keep thinking, *man!* He probably had a complete heart block and I didn't transfer him to [Name of Specialist Hospital] for a pacemaker and things like that, but it's just that (.) you just didn't have a Consultant doing the round with you and you didn't know any better. – *Juanita, int.*

It appeared that Juanita realised, even while reflecting back during her interview, when she compared various practices that existed at her internship site and at her current institution, the way things were done at her internship site had been far from ideal:

... for Obs & Gynae, by my second or third week I was doing Caesars on my own ... not for any other reason [than] that they needed me to do Caesars ... They needed us, because the way they split the call was, probably wrong, now in retrospect I think about so many things *are just so wrong!* (raised volume and tone, expressing emotion). They split the call – it was an intern and then two senior people, or one MO and-, or basically more senior than me, and they split the call into three. So you either do 'Gynae Outpatient', you do 'Caesarian or Theatre', or you do 'Labour Ward'. So when it was

your turn in Theatre, you were the only one in Theatre (sounding amazed) and you had to do the Caesars, but it's probably wrong, it *is* wrong, but that's the way it was ... we were excited because we loved to do exciting stuff. So ja, now that I think about it I realise probably it was really wrong (low pitch). Thank God nothing happened (softly).

Like in [Hospital Name of internship site], you'd just-, in MOPD there'd just be benches of patients, and there's two doctors in one room, so they're seeing two different patients. So there isn't privacy, you don't have a lot of time, and (.) you may not be able to follow the patient up because of the way the system is.

But in like [Hospital Name of current context] we have Specialist Clinics, and it's easier to get to know your patients, like there are patients that I've been seeing for years, since I've been here, and they see you in the cafeteria and things like that, and you really know them, the whole Registrar body knows that this patient has this, this, this. When the patient comes in we all know the problem, so, I think it's easier, but [Hospital Name of current context] accepts few patients, I mean the clinic has like 30 patients and there are five doctors so you can know the patient, but in a set up like [Hospital Name of a Level II hospital in the same town] where there are so many patients, it's difficult to connect with the patient um the way you would probably want to (in a soft voice). – *Juanita, int.*

The practical experience gained in performing various medical procedures and especially those required in emergency medicine were for Juanita the crux of her internship learning:

Mm, I think it was what made specialising easy for me. I think the hardest thing you have is-, when you [are] training is doing things. You want to know-, when your Consultant says "put in a central line", you know how to do it. And the worst thing is not knowing how to do it, 'cos you've got to say "I don't know how to do it, can you show me?" or, something like that. Especially emergency procedures like putting in that peritoneal dialysis and things like that. So because I-, they made us do it, and taught us how to do it, none of those procedures were a problem – *Juanita, int.*

5.4.4.1 *Power flows in medical internship*

Juanita briefly discussed the hierarchical power structures in medicine in general and more specifically relating to internship:

... they're like crazy (laughs), like power (loudly, demonstrative gesture) ... fortunately, I think God is on my side ... I've never had problems, even with the incredibly difficult ones ...

I've had one bad incident in my entire training ... I think that's fairly OK huh, it's with someone who's difficult, but in the end we actually got along ... to this day ... I'll tell her what I think. I mean I resisted things, her opinions of managing our patients ... because I thought what we were doing was wrong. And I think she actually respects me (raised pitch) for that.

P: Consultants treating Registrars; Registrars treating interns badly; it does happen, sometimes, but I just, I think ... treating the interns badly, it's just laziness, so you just give them too much work because you don't wanna do the work (questioningly) Something-, but the hierarchy thing is an issue. Fortunately in [current situation] it's not such a big problem, I think people don't have such big egos here. But I mean wherever you go you hear about it, it's a big problem. But here it's not so bad ... everyone's pleasant and-, in all the departments, even Surgery. You know usually surgeons have quite a reputation, but here ... they're really nice to work with, even the Consultants ... an 'all round happy place' (with humourous cynicism, shared laughter).

R: Especially now at this phase of your-

P: Yes! I know! it's such a nice like-, they're trying to figure out what I should do, we're all trying to figure it out. But ja, it's such a nice time in your life, the exams are done, you [are] not-, and you're doing something that you're comfortable doing, because I've been doing it for the last 3 ½ years, so you [are] in a comfortable spot, but you don't have the pressure to study, it's like just the nicest feeling ever. Next year will probably be a bit more stressful because it's a new job- , but this is my old job without the normal pressures. Ja. – *Juanita, int.*

Juanita therefore seemed determined to paint what appeared to be a deliberately 'rosy' picture of the space she was in at the time. I understood her sentiments in this regard as she was finally able to cease driving herself and relax to an extent while awaiting an appointment as a Consultant Physician in the not too distant future.

5.5 Lana

5.5.1 Introduction

When meeting Lana, a petite, almost fragile-looking South African Indian female, one cannot help but be taken in by her openly personable, kind and gentle demeanor. From my recollection of her as a student, whatever the undertaking, Lana could be relied on to give it

her best effort; her love and concern for family and friends was expressed often and without reservation.

I was able to interview her at my office, because she had returned to UKZN after completing her community service, and her work at the time involved planning and operationalising HIV-related research projects and being one of the attending doctors at an HIV Clinic.

From her past, Lana revealed that she had personal experience of being a patient in a public healthcare facility, as she had contracted Guillain–Barré Syndrome while she was still at high school and had been unable to walk for some time. This illness, which had partially paralysed her albeit temporarily, had stirred in her a keen interest to study Virology at an exceptionally early stage of her education. Furthermore, she said that the experience had also motivated her to enter the medical professions with the express goal of effecting change in whatever capacity she was able, and she believed that “to change the system you have to be in the system ... there’s no other way to impact the system ... you can’t do it from the outside”.

At the time of interview Lana was the mother of two young children. She had been married to a medical practitioner who was one year her senior soon after she graduated and her first child was born during her second year of internship. There was no reprieve from the rigorous duties of internship during her pregnancy, nor from the contractual overtime, which meant that she had to ‘pay back’ her on-call duty hours after her maternity leave had ended. Her story was therefore intriguing, as she offered a perspective of internship not only as a NQD but also as a ‘newly qualified mother’ so to speak. In addition, being another doctor’s wife, she also offered a gendered glimpse of how their career interests were being negotiated.

5.5.2 Internship experience / journey

For Lana’s internship she was situated at a Level II hospital in Durban with an overtly Christian ethos. It was traditionally a ‘Mission Hospital’ and even during her internship was only partly subsidised by the DoH. For this institution and the COP she encountered there, Lana had only praise and admiration. She held in high esteem the values, dedication and

other positive attributes of senior medical colleagues and nurse practitioners who had provided a supportive environment in which she could grow as a NQD:

On my first call, just three days into internship, I found myself in theatre doing an appendicectomy [sic] from start to finish under the guidance of my Surgical Consultant. It astounded me that such opportunities were given to newly qualified doctors, and for the first time in my medical training, I felt like a valuable part of the team. He reflected the value system of the hospital as a whole – i.e. they placed much attention on teaching and training doctors, interns in particular were a fundamental part of their staff – and they constantly reminded us of this. All these factors helped me in my transition from medical student to intern. – *Lana, writ refl.*

... there were times where learning/skill didn't really matter – the life and death issues, in particular, were tough. I always found myself crying when I lost a patient, and it was pretty extreme to then compose myself and walk out to break the news to the waiting family. At those times you could say zero confidence (me), met zero tolerance (the grieving family). Thankfully we're a part of a team! The nurses, especially those who were working with me at that time, would reassure me and reaffirm their confidence in me; and this, together with much prayer, would give me courage to go out and face the grieving family. – *Lana, writ refl.*

P: ... it was um in terms of the values, the, the value that I felt, I think every doctor-, every um clinician that I came into contact with ... well they carried the ... theme of the hospital. So when I saw-, when I met any individual it was like I was meeting the hospital, 'cos wherever you went, it was like the staff were handpicked for that hospital.

R: Were there non-Christians that worked there?

P: There were non-Christian interns, there were Christians of all races, all cultures that worked there, but they all-, I think many of them felt the same way. They felt that they were 'covered'; that's the important thing. They felt that they were covered, they felt that they were not in any way exposed to any danger, they were not exposed to any sort of malpractice, they were taught accurately, and also, um, it's like the doctors and the clinicians went the extra mile that you became not just a, um, good practitioner, but one that genuinely cared about the patients. So ja, I think the hospital had a lot to do with it as well. – *Lana, int.*

Being approachable and flexible was particularly important to Lana, who considered good communication with patients to be an essential trait of every medical practitioner:

I think as a doctor, you are the face that your patient is seeing when he is-, he or she is at their lowest point. And if you're not approachable, you may most likely be in the wrong field. Doctors have to be approachable, there has to be this relationship, although not existing at that point in time, but it's always like there, you know um,

between the patient and the doctor. Where they can ask you about anything, because asking connects people, I can as a doctor either shut that person down, or I can respond. And I can respond with hope, or I can respond in a very cruel manner ... Yeah and I'm very flexible, I, I um I try not to stick to a job description, because I believe that we are supposed to help each other. – *Lana, int.*

In addition to what she had to say, Lana's use of language also positioned her as someone who was accustomed to reflecting on her development and she enjoyed the opportunity to précis her thoughts and ideas:

So I would say that character, charisma, colleagues and curricula are all crucial criteria for effective communication. – *Lana, writ refl.*

Lana's already considerable relational capacity came to the fore when learning to break bad news to family members of patients:

Eventually, as internship progressed, I found myself finding comfort in comforting others – I enjoyed talking to patients' families, regardless of the situation. My colleague realised this also, so we split our ward duties according to our expertise – after our ward rounds, she did the paperwork and I spoke to the families! I don't think we've changed too much since then – currently she's doing Microbiology and I'm doing clinics! – *Lana, writ refl.*

From what Lana described, I realised that it was in her nature to go beyond most medical practitioners in her level of connectedness to patients and to their families, especially as early on in practice as internship. Motivated by her faith, she admired senior colleagues with similar motivation and dedication to hers, who made a difference in the lives of patients despite being part of an understaffed system, where the overwhelming majority of practitioners found it difficult, if not impossible, to be empathetic towards patients due to the overburden of disease:

... one of our Medical Officers ... she was amazing because she not only had the skill, she *cared*. And, um, I knew that she had the patient's best interests at heart, no matter how hard she had to work, through the night, she would still do her part ... She was the doctor who would *counsel* patients, she would sit down and explain, that when a patient has vaginal candidiasis, you're not just gonna take the pessaries and give it to the patient. She would explain the process, for the entire seven days how they would do it, in detail (raised pitch of voice, showing emotion)." – *Lana, int.*

. I believe that life is sacred – to be valued always, from the unborn to the aged. I’ve been taught about the nature of Christ, how He values people and loves them one person at a time. I try to see patients through His eyes ... – *Lana, writ refl.*

[Also referring to her Community Service]

... people would come ... from far and wide ... people would wait in queues to see her. And she was my Supervisor in the clinic ... and I would watch her, she would go and take 5 minutes, a 5-minute tea break, literally and get back to work. Her lunch break wouldn’t be more than like 10 minutes, and she’d get back to work. And I would do the same thing. It was so busy, but it was so fulfilling. It was so rewarding to actually be able to care for the community in such a way ... with the right person covering you, you can do so much. [She was also] of the Christian faith and she, she was really an amazing person and character. So that’s why in terms of the “character and charisma” it has to be there for the patients. – *Lana, int.*

Therefore, whatever the situational challenges or limitations there might be, Lana fundamentally believed that it was the doctor’s duty to fully expend themselves for the wellbeing of patients; appearing to have genuinely internalised the essence of patient-centred medical care. However, in responding to the question of a perceived lack of foundational science knowledge in the PBL curriculum, she admitted that there were possibly many instances during her internship where she may have rendered less than the best medical treatment. There was a particular once-off incident she described, which further demonstrated to me how compelling the motivation to ‘save face’ was, even for someone as committed to patients’ interests in general as Lana was:

Because of the gaps in my basic sciences knowledge, it is most likely that I provided suboptimal care to some patients – I recall giving one patient an intra-articular cortisone injection (Right knee) and praying afterwards that I had done it accurately. The Orthopaedic Surgeon was away and I was the Orthopaedic intern on duty. To my knowledge she didn’t develop any complications ... – *Lana, writ refl.*

I asked her about this incident at her interview, wanting to know whether it had been reasonable to expect that an intern would be competent at performing the procedure and whether she had had the option to call a senior colleague for assistance:

... the easiest thing to do would have been to call the ... the Surgical Consultant. Because he would be the next best-, if Orthopaedics is not around ... I think this happened-, this happened in my second year of internship, so I think that is the reason I didn't call anyone; because I felt that I was um, I should have been able-, you know, be able to do this by now, although it wasn't required, but I felt like I should be able to do it. – *Lana, int.*

The above incident further revealed to me the kind of tension that NQDs face when they are placed in situations where they are expected to, or they feel that they are expected to perform functions in which they have not yet acquired adequate mastery. If the parameters of Lana's duties had been more clearly articulated, even as a second year intern she might have been more comfortable with calling an experienced senior colleague for assistance, rather than attempting the procedure herself.

5.5.2.1 *Balancing family responsibilities and internship*

Although some NQDs are able to suspend their personal desires or goals to get married and/or to start a family for the sake of progressing with their professional development, this is not always possible. It is an issue that seems to be more problematic for females than males, perhaps more so in particular cultures, because of prevalent societal expectations regarding childbearing and motherhood. When I asked Lana to elaborate on a particular statement she made: "But, um, a lot changes when you become a mum", she provided the following detailed account of the way she had juggled her family concerns with the requirements of internship:

"... well the one issue was you know I fell pregnant with my first child during internship. That was crazy (softly) huh ... I wouldn't recommend it to anybody. Um, it's difficult because HPCSA doesn't, um, give you any concession to stop your calls. [R: No maternity leave?] There is maternity leave ... but you have to keep working right up to and including-, there's no stopping calls even if you're like 38 weeks pregnant or 40 weeks. You have to try and swap around with your colleagues, but you still have to complete the expected amount of hours of overtime, for that sched-, for that month. So, that was difficult, um, I had a lot of interns around me though, who were very helpful, and they were happy to swap calls with me so that I would-. But what did happen was that by 35th week I was having Braxton-Hicks Contractions; and that's because I was running up and down doing calls, and up to the fifth floor and doing Medicine calls. And often the lifts wouldn't be working and you'd be struggling, and I

mean there's emergencies, you're not going to wait for a lift, you'd run up the stairs. So at 35 weeks I had to take maternity leave, I could have stretched it all to the end, but unfortunately I couldn't at that stage because of the contractions. So from 35 weeks I went on maternity leave and that unfortunately gave me one month less with my, my newborn baby. Um, so, I stayed at home, and surprisingly the child came on the expected date of delivery (with emotion, expressing consternation). I stayed at home for three weeks doing nothing, bored out of my mind, heh, trying to go into labour (laughingly). And, um, I had full pay for my maternity leave, and when I got back though, I had to pay back those four months of maternity leave, as an extra four months of internship. So I was the only intern, hehe, [R: still an intern-] still an intern after two years. I had two years and four months of internship because of my pregnancy. So those four-, the four months subsequent to that um, I was put into er one of the er different rotations, but I still had to pay back my calls and all of that. So I was breastfeeding, huh! (expression of desperation), and my Mum-in-law used to come with me. The hospital made a concession for me, they um said I could pay back my calls, but I was allowed to bring my baby. And they would give-, there are rooms provided for interns, but they said they would make the one room available throughout the day. So my Mum-in-law used to come and stay in the room with my baby. And I used to go and do my work, and then go on call, and in-between go and breastfeed. And it (.) was (.) crazy, because I lived-, at that time I still lived in [place name remote to Durban], I would travel-. It would be like-, we'd be like we were packing up for a one-day trip. We'd be packing up everything, come down to Durban and then spend 28 hours, 'cos the call is a 28 hour shift; so spend 28 hours in the hospital, then at 12 o' clock we'd leave back home. And my mother-in-law still recalls that I-, on certain days I would be sleepy and she would tell me "pull over", and just you know "throw some water on your face because you are-, you're falling asleep at the wheel". So it was difficult. And you know with baby it was like a very tiring- [undertaking], so that was the other strain on my internship.

R: What did Mum-in-law do?

P: She was *amazing* (raised pitch of voice) she just sat there with the baby, the whole day. [R: TV or anything?] Nothing, there's nothing in the room. It's just a room. I think (.) I, I can't even begin to count my blessings, because she was just amazing (laughingly). Ja, we still recall-, we still talk about that today. Ja, so that was my first baby, and when I went to [Community Service site], I was-, I mean, my first day I was put in Trauma, huh! So there was no time to think "Oh, I'm back from maternity leave – do I remember or do I not remember?" I was just thrown into the middle of it, so I went through that, I became very confident in my Community Service, I was very happy with treating patients in [an] ARV Clinic" – *Lana, int.*

5.5.3 *Links to the undergraduate medical curriculum*

Lana had a deep appreciation for the learning opportunities she had experienced both during her undergraduate education and during internship which enabled her to engage in

her current work. She admitted that she had not always been so appreciative, because whilst going through a situation, the learning aspects of it may not be as evident as later on when reflecting back on the experiences. For example at the beginning of internship she had felt “pulled in different directions” when required to transition between two different disciplines, one that was her rotation and another for on-call duties. Her perception at the time had been that she was ill-equipped to be a generalist because her undergraduate learning had been organised into Themes that dealt with particular systems of the human body. However, from her current perspective where her work involved a multi-systemic approach and a high degree of proficiency to manage the complications of HIV, she said:

... in an ARV Clinic and I see patients with HIV and TB who are *complicated* ... now when I’m sitting and thinking about it, I’m being exactly that – I’m being a generalist! (expressing surprise and satisfaction). So I think the curriculum and I think internship did prepare me, but I, just at that point in time, couldn’t see it. – *Lana, int.*

From the above statement Lana indicated to me that it had taken some time for her to become aware that her learning had been cumulative. With greater maturity as a medical professional she appreciated the continuum of medical education that had equipped and shaped her for her current practice. Although she had previously gone along with prevailing trends to criticise the undergraduate curriculum, she now felt that perhaps for her personally, especially from a research orientation, there had been certain advantages:

... the curriculum was an opening door for everything else that was to come. Um, you know sometimes I’ve had guilt in the sense that I’ve had negative things to say, because um, my friends ... people in my class [were critical of the curriculum]... and yet I still am satisfied. So I think it was um enough for me ... our curriculum, may have had a lot of flaws, but um one thing that it did er carry forth with much enthusiasm and vigour was research. We were the first lot. Um, they started introducing all these electives and the research electives in a much more vigorous manner. We actually got involved, I still remember going to [place name] as a student to go and interview patients and fill out this huge data collection form and thought “Woh! this thing is so long!” And, you know, and getting informed consent ... all these new concepts. Now I’m sitting and doing them comfortably, and if the curriculum didn’t focus on it, I don’t think I may have had any inclination towards research. So maybe the curriculum wasn’t the best for everybody, but I think, for me, it was. – *Lana, int.*

She also appreciated the early clinical contact which had been part of the undergraduate curriculum enabling students to communicate with patients from the outset:

Our PBL curriculum gave us excellent exposure to patients from first to fifth year. We were communicating with patients from Theme 1.1, so even if we weren't born extroverts, we learned quickly! – *Lana, writ refl.*

In retrospect, therefore, Lana was grateful for learning opportunities that were part of the curriculum even though they had seemed tedious or challenging to her at the time she encountered them. This study therefore gave me added understanding of how particular learning experiences of innovative curricula may not be well received by medical students, who may complain vociferously when evaluating the interventions, only to realise later the value or significance of those learning experiences towards their development as medical professionals.

5.5.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)

Lana's desire to specialise in Virology, influenced by her experience of a previous viral illness, had persisted. She said she had discussed these intentions as far back as at her interview for admission into medical school. Up to the time of my interview with her, however, she had not acted on her early aspirations. I had the impression while she was speaking to me that, for various reasons, she was attempting to convince herself that it was not really necessary for her to pursue specialisation in the discipline of Virology after all:

... the Virology idea, I can't say that it's gone away completely, because I'm still being called from Virology to ask me when am I coming to specialise (laughing) ... I think it depends on who you want your audience to be (raised pitch and volume of voice). See um, if I want to be an academic and want to be a Virologist I can do that. I can go and do that. But then I don't know if I want my audience to be academia. Sometimes I think I just want to help people. So I think it just depends, if you want your audience to be community, then you can be exactly where you are and still reach out, you don't have to be a specialised, like a specialist in a specialist field to do that. And ja, Virology is like, it's weird, because it's such a-, it's so lab-based, you hardly see patients. And for me, I

love interacting with patients, so I think I'm more of a Public Health person (vocal tone expressing high level of emotion) rather than I am-, I am a Virology person!
... at the moment ... I know this is something that is what I wanna do ... it's where the need is (voice back to normal-low pitch). HIV and TB it's where the burden in this country-, it's where the need is and I'm doing a lot of Research.

P: I think my personal aspirations have changed. I don't think it's about me anymore (softly).

R: Say a bit more about that?

P: Well I think that um I don't need to fulfil any sort of-, you know to do some further degree to help somebody ... Because I'm in a place-, in a posi-, I'm a Medical Officer, it probably means that my salary may well never change (with humour), and I might be sitting in this position for ever and ever, but I believe that I'm making a change, because I can see it ... And now I see that with research you can really touch more people. Physi-, maybe not physically, but you can impact-, in terms of a Public Health [R: the bigger picture] ... in Virology, if I was specialising towards Virology, it would be my own personal aspirations, trying to get to be a Virologist so I can have a good sort of job, maybe *then* do research, and then get involved. Now I'm already in research, but just without the degree. And I'm happy, I'm finally happy because I think people struggle with that, you know because people ask you-, you know specially if you're surrounded with Academia they keep asking you, "So what you doing now?" he-he. – *Lana, int.*

Lana then briefly turned to discuss her close friend and colleague who had recently specialised in Internal Medicine [participant Juanita in this research study]:

I celebrated with her because I felt like a part of my aspiration had been fulfilled in her, in her dream. I kind of like, sort of, at that point in time-, it sounds weird but I sort of released whatever personal fight I was having, personal struggle I was having inside of myself. Because it's not about the degree ... but I don't think specialising is for everyone.

In the main, however, specifically relating to her internship, Lana made special mention of the subculture of research activity that she had been exposed to. Practitioners in Internal Medicine at her internship site had modeled what was most likely to be an extraordinary degree of engagement in research productivity. Their commitment to scholarly activity combined with Lana's caring nature appeared to have shaped her in a distinctive manner:

... my biggest motivation was the patient. And, er, always facing the incurable HIV and the monstrous TB, which never goes away, and just becomes MDR and XDR and everything else, um I think it just um prompted me towards Research.

... the clinicians there were very passionate people and the hospital that I worked at was extremely research-orientated ... they were pushing out papers on a monthly basis. They had collaborators from the US, they had so many people involved in research. And we were attending Academic Medicine meetings where researchers would present their work ... In fact now that I'm thinking about it more and more, I remember we had a Thursday meeting that was dedicated purely to research. And it was HIV research, and they would talk about HIV resistance and they would talk about all of these different things ... some of them [were concepts that] I could grasp and some of them I couldn't. And now ... I find myself joining those same meetings, as a Medical Officer and finding them so interesting. And the whole conference that we used to attend as interns, I do remember those were very, very interesting and I still attend them now. – *Lana, int.*

Lana returned to discussing her roles of being a wife and a mother, and how prioritising her family commitments had affected her aspirations. She also disclosed that there were financial implications involved in making such choices, especially as her husband was currently busy specialising:

... that whole point of coming back from having these-, my two kids and, and just not knowing what to do, and just wanting to run back home every day to them, it really changes. And even my, you know even the whole idea of ... I don't do calls. Um, so I don't see overtime at all. So it is, it is a basic salary, and with [husband's name] being a Registrar you know, it would be like the same salary for him for the next four years so to speak. But we are happy. And just like this whole thing with Mum, being a Mum, you don't want to spend more time away from your child than is needed. And I think that was also one of the key reasons why I just decided not to specialise. Because um that would mean me spending time-, even if it was something like Virology, like a seven to five or seven to four job, where there are no calls, it still requires study time, it still requires a lot of stren-, er strenuous um er, er exercises, on the mind. And so you imagine being a nervous wreck with your child, trying to spend quality time thinking about the project that you need to do or the presentation that you need to give to the Third Year students or this or that. Because there's so many requirements in being a Registrar. So, now [R: you're free of that] I'm free of all of that ... still be able to serve the cause that I wanted to ... so finally, finally very happy. – *Lana, int.*

My impression of her deliberations was that, although declaring her deep satisfaction with her current position, Lana would in fact continue to be strongly motivated by her early aspirations. I also felt that perhaps as a researcher, I might well have been at least partially responsible for having reminded Lana of her early dream that she had tried to suppress without much success.

5.6 Philip

5.6.1 Introduction

Philip was born in a North African country; however, his parents had relocated to a country neighbouring South Africa when he was eight years of age. As this country where Philip was residing belongs to the Southern African Development Community (SADC) conglomeration of nations, he was permitted to enter university in South Africa as a 'foreign student'. He would later be regarded as a 'foreign doctor' resident in South Africa, a determining factor in Philip subsequently leaving clinical practice to become an Economic Advisor or Consultant such as he was at the time of interview. He nevertheless continued to use his medical knowledge in a broader, more systemic way to improve healthcare in Africa.

Having graduated *cum laude* Philip was very confident of his capabilities as a NQD. He was also strongly disposed to being relational, personable by nature, building rapport easily and getting people to confide in him. However, despite all his innate ability in this area, he faced considerable cultural and organisational challenges at his internship site which was a Level III hospital in the Western Cape.

Philip's family of origin held fundamental Christian beliefs and he re-affirmed his own commitment to Christian values during his interview, expressing unwavering faith that God was ultimately in charge of his destiny.

5.6.2 Internship experience / journey

5.6.2.1 Language barrier

The overriding ordeal that Philip faced during his internship was in his efforts to negotiate around a predominantly Afrikaans-speaking environment as a first language English speaker:

P: ... the first challenge in my working career, had nothing to do with my [medical] profession, nothing to do with medicine, had nothing to do with my competence or not, it had to do with the means of communication with my colleagues, and with my patients (.)

R: And how was that overcome [Philip]?

P: How did I, did I ever overcome it? No (.) no (.) this was the short answer [**R:** you didn't learn the language...] I didn't learn the language; I learned to cope. [**R:** so how was that?] The nice thing is with internship you know there is an end date (shared laughter) in that rotation, so I wasn't there to make a life of my time in [Hospital Name]. I was there to pass this rotation, have a sign-off so that I can actually go and do the real thing that I came to do, which is live a life as a doctor. U==m, so there were some rotations that were very biased, towards Afrikaans, I inevitably did worse in those rotations, there were some rotations like Internal Medicine that was an English rotation, and at the end of that rotation I got an invitation to apply for a Registrar position

... so earlier on I made a point, a==h! (.) to articulate the challenge, but as time went on, frustration took over, and there were some rotations that I, probably would just not go for certain meetings, so I remember Obstetrics and Gynaecology specifically, specifically the Obstetrics part, we had a weekly departmental meeting, where we discussed the difficult cases, it was done in Afrikaans. All the Registrars were there, the interns, the Medical Officers, the Professors, it was done in Afrikaans. I went for the first one, thereafter I stopped going. I would rather go and sleep in my flat during those (expressing disgruntlement). – *Philip, int.*

Philip had received some assistance with translations from Afrikaans into English, however, he was aware of the disadvantages of having colleagues translate instructions given by superiors, or patient files, as opposed to getting the information first-hand. He clarified that his angst primarily stemmed from the work-based teaching and learning platform and was not related to patient interactions per se:

... I think the thing of interacting with patients in another language I was used to, I mean I studied in KwaZulu-Natal where the patients spoke Zulu; I didn't necessarily learn Zulu either (.) So I was used to getting aid in communicating with patients and I think the patients have patience ... and you have patience as well to be able to go through the rigmarole ... (demonstrating how he might greet a patient in Zulu and in Afrikaans). You show an interest in them, you know, and the truth is, a big part of your diagnosis also comes from your physical examination, you know, which is your hands, observation and things like that (.) So I got help in interacting with patients, I definitely did – *Philip, int.*

5.6.2.2 *Critical incident – racial prejudice*

Philip identified himself as being someone who had not previously experienced racial prejudice directed against him personally. He had not grown up in South Africa, therefore he felt unencumbered by “preconceived ideas” about people from other race groups. He had witnessed racial discrimination and prejudice “all around” him. However, his own studies had not been hampered by any racial issues, although he briefly mentioned an unpleasant administrative incident in his final year which he had thought at the time to be racially motivated, but in retrospect felt that it was explainable solely by excessive bureaucracy. As evidence that he was able to relate freely across racial boundaries he pointed out that a number of his closest friendships as an undergraduate student, enduring to the present time, were with colleagues of other race groups. Therefore, while he was working as an intern in Paediatrics, an experience of overt racial prejudice directed against him by the mother of a young patient (of Coloured race group) caught Philip off-guard:

... having to now deal with a patient shouting at me (.) a child is critically ill, it's in the middle of the night, so it's not like there's [too many] doctors roamin' about, and the mother tells me I can't touch her child.

... she refused for me to touch her child, she refused for me to take care of this child, and I'm the doctor on call, and insisted that she wants to see a White doctor.

... I can't remember the wording, but she actually explicitly said so, and it was on that basis I could lay an official complaint ... but I did not follow it up, because ... it was part of the baggage that I was having to [deal with] ... it definitely sensitised me to this other dynamic, and I've had to live with that baggage by the way thereafter ... I'm having to work to reverse all that, um even a couple of years later, so yeah, it was a major issue. – Philip, int.

I persisted in questioning Philip about any possible mitigating circumstances relating to the above incident, such as the possibility of the mother being overanxious and might therefore have been worried about her child being attended to by a junior doctor. However, Philip insisted that he would be the first to look for alternate explanations. He reasoned that the patient's mother could not have known that he was an intern, as his appearance had never been overly youthful. She had also explicitly used the terms 'Black' and 'White doctor' therefore there was no doubt in his mind that this was an incident which arose due to preconceived perceptions based on race. Philip had written previously that the way he had

responded to this slur was a “thing of shame” to him, and when I probed this further, he explained:

S==o I mean, I think, I think, er== we have a responsibility as doctors, um, and as people in some place of authority, um to take control of the situation. Which means, in a situation like that I could have been wiser (.) in my response, but I lashed out at the mother. So I mean I lashed out at her, she shouted at me, and that’s the only time in my career that I’ve raised my voice at a patient, and I did raise my voice at the patient, I said “well it’s your child” (in a low, soft voice) and I must have said something to the tune of “if you want your child to die, good” (.) whatever, I mean I literally lashed out.

All the experiences thereafter, and even before that, [if] I feel there might be some racial barrier, not necessarily racism, but some racial barrier, you know, I mean, [for example] an old White lady, and you see this Black male doctor, there’s obviously the sex barrier, but there’s also the racial-, possible racial barrier. Um, I typically was very good at taking time to (.) get the patient comfortable with me. You know either by joking with the lady, spendin’ time with her, sitting next to her bed, you know, tryin’ [to] speak Afrikaans n’ she laughin’, you know, just to get that comfort, you know, because you *do* do invasive things to these patients ... to establish a rapport, but I didn’t- (.) I didn’t try with this patient because I think she was very vocal, it wasn’t just an unease, so that’s what I mean I could have managed that better. – *Philip, int.*

5.6.2.3 *Time / resource constraints and biopsychosocial approach*

When asked about his approach to patients during internship, Philip confirmed some disturbing trends to which NQDs might resort in order to get through the numerous patients they are expected to attend to:

... if you have 40 patients waiting to see you, you can’t necessarily spend the half an hour you need with this patient, when you’ve made sure you’ve helped the patient. Sometimes I would start writing the prescription before the patient sat down and told me what their problem was. Because I knew she’s an old lady she probably has arthritis and hypertension. Thereafter, if we get time, I would invest in one or two patients a day, so I couldn’t necessarily invest this holistic approach to all my patients every day. Funny enough the wa-, hospital settin’ helps better with the biopsychosocial approach, because you get to see the patients multiple times, um they are in the ward, so when you are next free you can chat to them. You know, you see them multiple times in the day, over many days. So you didn’t need to cram everything you needed to do at that point in time. When you’re pressed you could just do the ‘bio’ part, then at less busy times you could be more holistic. So ‘in-patient’ was a very good time for that. – *Philip, int.*

5.6.2.4 *Learning strategies and dispositions*

Philip found that senior colleagues had been his primary source of learning, whether “a Registrar, a Consultant or a Senior Medical Officer”. He made special mention of a Consultant who had visited him and provided “invaluable” advice while he had singlehandedly managed a psychiatric unit during his Community Service. Furthermore, his professional development as a clinician was attributed to experiential learning whilst working besides experienced colleagues who had taught him various clinical skills, and in turn he was able to teach others.

Furthermore, Philip had spent time reflecting on what motivated him as an individual, and he identified his pursuit of excellence and his relational capacity which had been noted even in evaluations of his current work:

... there are 2 strong elements that I've been aware of and I've managed, there's the strongly academic element, the fact that I actually wanted to be a 'renowned doctor' (.) um, I get a lot of energy from being *good* you know academically and scientifically. So there was that element, I definitely wasn't practicing that in those years (expressing humour). That wasn't what I was trying to achieve. But there's a strong element of people (.) you know, even now that I'm not practicing medicine, you know, whenever they do appraisals of me, it's clearly written that “[Philip] gets energised by people”. You know, therefore, I had clearly in my mind that I wanted to bond with people and this was the perfect opportunity. In my internship I did have opportunities and it did show that I bonded with certain patients, personally ... that I had clearly in my mind, not because I thought of it in a formal structured way, but just because of the way I am and have developed as a person. Um, and I still use it now, I still bond with my clients (laughing softly), you know. Not necessarily [that I am] ... the best technically, I'm not a banker for example, but I will bond with the clients. – *Philip, int.*

5.6.2.5 *Additional qualification Master of Business Administration (MBA)*

Philip made time during his second year of internship to obtain an additional qualification in order to gain management and business skills, as he felt that opportunities to learn these had been lacking in the medical undergraduate curriculum:

This is key in a world that revolves around money and cost containment. To improve my skills in this area, I enrolled for an MBA ... This has been one of the best decisions that I have made because I have had the experience of interacting with non-medics, I have

learnt numerous skills that I intend to bring back into clinical practice such as process management and cost management. – *Philip, writ. refl.*

... it was actually doable, I dunno, I mean (laughing) it wasn't too bad I must say [**R:** this is one special person] Uh? No, I think-, think number one the choice of the MBA I did, was a modular programme, which meant, during my classes I would actually take leave off work, so during classes, in-between, I mean we work, typically we work eight to five or eight to six, the days you're on call, we balance out with days you're post-call, I mean we finish earlier, then we did some work in the evenin's, so that was- (.) I found it doable, I was a single man, I mean- (.) – *Philip, int.*

5.6.3 Links to the undergraduate medical curriculum

Philip referred back to his journey through medical school when two curricula, both traditional and PBL curriculum were in operation and were continually compared:

... over the years in the medical school, I came to understand that the discourse regarding the merits of the old versus new curriculum was more political than anything else. People tend to criticise what they do not know and what they are not a part of. I began to understand that my studies ... are what I make of them. I was encouraged by the fact that in the last year of my studies, students from the old curriculum were paired with students from the new curriculum and students [from both curricula] fared well academically in these circumstances. As such, it gave some assurance that new curriculum students were not necessarily behind the old curriculum students. ... the criticism that students of the new curriculum had received over the years drove us to be a close knit group and an extremely determined set of students. ... Though we could not compete using microbiology or anatomy, we believed that we could compete by our humanity and awareness of and empathy towards each individual patient – *Philip, writ. refl.*

Referring to the claims of a biopsychosocial approach being promoted by the undergraduate curriculum, Philip noted that there was little evidence of this approach being demonstrated practically by clinician educators encountered by students:

So I must say upfront, that in medical school there's a big disconnect between what you learn in the lecture halls and what you see the doctors perform in the wards ... So we learn all this 'biopsychosocial' stuff, but number one, when we are examined, we are examined on the 'bio' part (curt laugh), and not the 'psychosocial' part ... "did you pick

up the massive liver?" "did you pick up the murmur?" – you know, not "how was your rapport with the patient?", nothing like that ...
... you saw your professors go in and treat patients like thin's [things]. There were some professors that were very good and I remember Prof [Name] in Medical School that was very mean to students, but would (h)allow little children to play with his beard ... he was that type of doctor, at least to his patients, but many doctors [only cared] about the 'bio' part.

Part of what helped me was the way I was socialised during medical school, through the group of friends I had, um, they were very conscious of the 'psychosocial' part, and we talked about it and we discussed at length, mixed with our faith. And I mentioned it there as well [referring to his written reflection] I think that was what made me the most conscious of the biopsychosocial approach to medicine ... these are patients, this is life, this is eternity. I think that is important to mention. It made you a better doctor when you were out there, it didn't mean you were able to see the number of patients; it actually made me a slower doctor (laugh), because you do have 40 patients you need to go through. It made you a slower doctor, so that was a big issue. – *Philip, int.*

5.6.3.1 *Critical incident – acting (role-playing) doctors*

During the final year of medical school, Philip was involved in an incident while he and a colleague were based at a severely understaffed rural hospital:

... we took a patient to theatre to do [a specified procedure]; I was the surgeon and [Name of Colleague] the anaesthetist. There was no other doctor in the theatre. [Name of Colleague] gave the patient the anaesthetic agent as we had been told; he called out to me saying that the patient's saturation was going down. Before long, we had to get help to resuscitate the patient (we did not know how to). The end result was a patient that needed three hours of intensive resuscitation. I knew at that point that my medical career almost finished before even starting. Armed with this experience, I had already learnt not to take chances with the life of a patient. – *Philip, writ. refl.*

Philip and his friend had slipped into a deplorable practice of speaking and attending to patients as he said "with confidence beyond our experience, taking the issues as a script from a Broadway show". They further decided to undertake a procedure for which they were not adequately skilled, whilst acting as doctors although they were not qualified to do so. When I asked him about the significance of this incident from his current perspective, Philip replied that students might well be tempted to act; however, their lack of knowledge had nearly resulted in them losing the patient, which was "highly scary".

He proceeded to advocate the need for role-models in what is essentially an apprenticeship within the medical profession:

... if possible, the apprenticeship model of medicine is critical ... where you're experienced, I get to learn from you. And as I gain experience, I develop, and as I develop, I get increasing responsibilities, and after a while I start teaching others. You know, the challenge is that in Africa, South Africa is actually better than most African countries, but the reality is [R: there's not enough-] that the apprenticeship model is tough, there are too many people that are sick, too few doctors (curt laugh) for that. I mean in that hospital the reason we had the opportunity to do that was because, in the whole hospital in the middle of nowhere, there were like two or three doctors, and they were short and decided, OK we got senior medical students, let these guys go and run this ward. It wasn't because of carelessness or callousness on their part, it was because ehe-he, there were not enough people. So what's my-, what's my advice? My advice is we still-, we all need to be responsible and we need to know where our knowledge ends. I think that's, that's where we need help. We need to be clear about that, and where we need to cross that boundary, we need to be clear that we are crossing that boundary. But there's a bigger question that needs to be solved around human resources for health [R: the need], yes.

He also qualified his previous statement about not taking chances with patients' lives, saying that he had subsequently learned that calculated risks were necessary when it is in the best interests of the patients:

... so there're times when, if you don't take a chance it's better off for the patient, because the patient still has time for you to consult and for you to get help. But there are times where if you don't take a chance, then the patient is gone. But that's based on knowledge, based on experience; *that* [referring to the previous irresponsible behavior as a student] was just based on a lot of immaturity ... – *Philip, int.*

5.6.4 Retrospective view of internship, in light of current practice and future aspirations (as shaped by internship)

When questioned about how he had come to leave medical practice and become an executive in a firm of Economic Advisors, Philip's explanation was based on a combination of his faith as well as his personal circumstances:

So (.) there are two elements right, I think the one element is I believe in-, I believe in God and there's the whole Divine order, you know whether- (.) my fundamental belief is that God orders our steps. So I mean I'll place that out there (.) If I look at it practically in terms of what happened and led me to the position I am in now, n' how I see the future (.) What essentially happened is just the fact that I'm a foreigner in South Africa, and I was not willing to leave South Africa. That's why I'm out; I'm not practicing Medicine. So the regulations limited my choices, meant that I would be a rural doctor for five years. I was thinking of getting married at that point in time, and I wasn't stimulated by just sitting in a rural place taking care of the patients in rural areas. There's some people who are energised by that; I would be more energised in a big tertiary hospital, where we have academic compositions. So that's the context and I made a choice at that point in time, and that I wasn't going to go and sit five years in the bush, I was going to go and find some work ...

... the policy basically comes from the fact that South Africa does not want to poach other African doctors (.), so that already puts some bureaucracy right, in terms of getting a foreign doctor registered in South Africa. They looked at my case, and they said "well we can see that you've lived in [Country of residence] nine years before coming to South Africa", plus I left [Country of birth] when I was eight years old (laugh) ... "we'll let you practice, but for foreign doctors, they must first serve time in the rural areas, which is five years before we now let them write exams to now be fully registered in South Africa". So this year my 5yrs is over, so I've done 5yrs, I actually didn't work in the rural areas, I did other things. The big question is, at this point in time, do I see myself going back to practice? – that doesn't excite me anymore. Um (.) so life happened, basically. – *Philip, int.*

Therefore a dichotomy of his reasoning from a spiritual and a practical perspective was apparent in Philip making sense of how he came to be doing what he was doing at that point of his career. His vision to improve healthcare for various people groups on the African continent had persisted:

I'm highly passionate, highly motivated, more than medicine, more than anythin', about the continent, I have always been. I've expressed this to some of my friends, ... from day one in medicine, that I'm passionate about how we're gonna turn the fortunes of this continent around. I always saw my avenue towards doing that as medicine, you know, so I'd be this renowned doctor, that I would build specialist hospitals across the continent, help people, helicopter the best specialists into some countries ... that's how I saw it happening. Have I lost that vision? No. I basically help people, I help organisations, sometimes some organisations I don't really care about, like *banks*, uh, I help them, but I'm in an organisation that fundamentally says we're developing people that can probably change the world, and they equip you to do that. ... I'm actually working with some of the leaders of the organisation to build a healthcare practice, where we'll now start helpin' Ministers of Health across various African countries, start really changin' things. So that's my core-, the core part of my

work, the problem is that we don't have enough clients right now, so I must do other things. ... I did six months in [a SADEC nation], helping with turnin' around the HIV – AIDS financing system.

I like to qualify my success not by how much money we've helped the client make or how much money our organisation has made from fees, but how many lives [have been] saved and things like that ... that's what still drives me ... this evenin' I'm talking to a lady in the US, that's very passionate about helpin' people in Sierra Leone, Sierra Leone has 20% of the world's amputees ... she's very passionate about that, she's been doing that for a while, so to see if there's an opportunity to get involved (.) to help them. You know, I don't know what that means, but I'm still highly driven by helpin' people on the Continent, specifically in the area of health care ... still very, very specific in the area of health care. Over time I've developed interest in OK economic development ... – *Philip, int.*

He had reflected on how he would approach his current work differently to other economic consultants who had done degrees that were more related to their field of finance:

... the medical training I don't-, I don't regret, right? – even if I don't see myself practicing again, because it does a couple of things for you ... the first is ... it still gives me a lot of credibility ... the second element is, fine, I don't use "there's a pain here, there's a pain there" but I understand a system, and I understand people. Um, the way I relate to people is ten times different from my colleagues that studied Actuarial Science, [**R:** very interesting], yes, from my day one ... clients would seek to retain me as a Consultant, and I can tell you it's not because of the output, because the Actuarial person will come probably to funny financial models and all of that, but it's because of the way I'm able to relate to them as people. And once you can relate to people, right? Then you've already created a conduit to pass any message on, you know, be messages good, messages bad, the message is that "I'm here to support you, serve you". – *Philip, int.*

Finally on the point of whether Philip saw himself ever returning to clinical practice:

P: Maybe, but I mean it's still a journey, right? So I just spent the last two weeks, really thinking about my career, and reflecting on what my past aspirations are, trying to identify what I should be looking at doing in the future (.) I don't have answers right now, ... I can't tell you now that I will not go back to just being a clinician, I can't say that confidently, I know it's not energising for me at the moment, um, and that's because of the series of bad experiences and just because I think I've gotten to a place where I see myself influencin' the bigger picture quicker er than just that ... but ... who knows right? I might just be able to-, just spend 100% of my time helping to improve hospitals, helping to improve health departments. I don't know (softly), or I might just completely leave that and help-, spend my time helping banks (laughing) make more money!

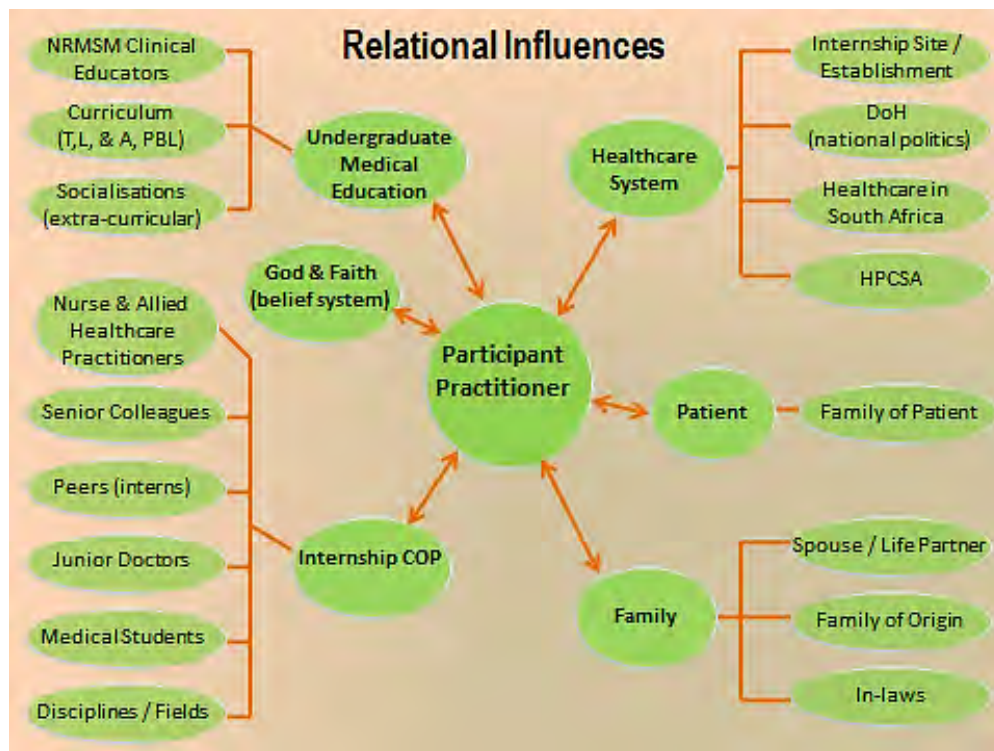
R: I'll call you a 'Bank Doctor'? (with humour) – *Philip, int.*

Chapter 6: Relationships

6.1 Introduction

The previous chapter established that identity construction is an integral part of learning to be doctors. As a person's identity is founded on how they see themselves and others, relationships to self and others, especially within the clinical environment; as well as the nature, extent and quality of those relationships became central to my study of medical internship. Although this point may seem obvious to some, it was when I began to map out the relational influences in the narrative data from my study that I realised that the interviews with participants referred almost entirely to a series of crucial relationships as experienced by NQDs. Whether these relationships were explicitly described by participants in what was 'told', or were inferred by their ways of 'telling', NQDs positioning of self and others (persons and organisations), was elicited from the narratives. I have therefore structured this chapter according to a composite set of relationships which emerged from the data, arranging them according to a schema of the various categories of relationships as depicted below (Figure 2: Relational influences). My discussion of findings that follows therefore consists of inferences and interpretations of these relationships as I found them to influence NQDs' learning processes and identity construction.

Figure 2: Relational influences



It is understood that the different categories in the above schema would relate to one another at multiple levels, and there would be complex power flows between them which are not depicted in the above diagram. For example, all healthcare personnel in the COPs would be employed by the Department of Health (DoH) and would have to be registered with the Health Professionals Council of South Africa (HPCSA) in order to practise their profession within South Africa. It is worth noting that the influence of each category on NQDs, as the focus of this chapter, would be determined by the various interests represented in that category. A mix of enabling and constraining influences would therefore emanate from most categories and it was expected that the relationships between categories would be multi-layered and far from straightforward. The relational influences on NQDs may be complementary or conflict with other relational influences both within and between categories as discussed throughout this chapter. The sources of greatest influence on NQDs' learning were, not surprisingly, found to emanate from the internship COP category. Encounters with various senior medical practitioners offered potential opportunities or possibilities for the development of promoter positions as well as anti-

promoters or blockers (Hermans, 2012) in the identity construction of NQDs (see section 6.3 In relation to internship COPs p. 189).

I commence by presenting a comprehensive exposition of the ways in which participants in my study related to patients both in particular encounters and more generally. Some of the ways that NQDs viewed themselves and how they wanted to be understood in their narratives are presented as identity claims that are relevant to patient care. The identities of persons who were the available role-models within COPs are discussed next, as they were a central theme in the personal experiences of medical internship. I have therefore grouped the various identities of senior colleagues into a synthesis of several contrasting models of clinician as portrayed in the narrative data. The practice environment and a multitude of other contextual factors relating to the healthcare system in South Africa and the organisation thereof also impacted on internship experiences; therefore these have been discussed in conjunction with COPs. Finally, the participants' personal aspirations, dispositions, belief systems and family relationships were a source of additional new insight contributed by this study; and references to them were found in themes that were continually evolving during the development of NQDs. Therefore, wherever participants disclosed these personal aspects in their narratives, as to how their transformative journeys had been shaped by these influences, I have endeavoured to capture and discuss the insight gained.

6.2 In relation to patients

The PBL undergraduate curriculum experienced by the participants in my study explicitly aimed to develop doctors who would have empathy for patients. It is noted, however, that this ethos may not have been demonstrated by all clinician educators in hospital teaching environments to which students were concurrently exposed as part of the curriculum. As highlighted by Philip, there were some clinicians who practiced the values being taught to students and others who treated patients "like things". He also noted that the assessments had focused on biomedical knowledge of students and therefore were not aligned with

developing patient-centredness. Having empathy for patients, as an outcome of education, is difficult to evaluate because of the complex and nuanced nature of doctor-patient encounters. It is also influenced largely by the tacit or implicit curriculum, by socialisations and personal dispositions which cannot be articulated in the formal curriculum. Meaningful evaluation of practitioner empathy also requires engagement with a continuous process of developing professionalism, as NQDs assume increased responsibility for patients and progress towards unsupervised, autonomous practice, to a stage when they in turn might become supervisors of other NQDs. The longitudinal element introduced in this study of internship offered a window of opportunity to track what became of empathy towards patients immediately after graduation, later during internship, and beyond.

6.2.1 Positioning of patients by referential narrative content (what was 'told' by participants)

Based on participants' descriptions of their internship experiences at different healthcare facilities in South Africa, internship learning environments were found to vary considerably. Viewed through situated learning lenses, patient-centred practice for instance was found to be promoted (or disregarded) to various degrees by the system, by organisations and by individual senior practitioners who were present at the institutions. However, the overarching finding concerning how participants related to patients was that NQDs were expected to attend to far too many patients to enable practising the principles of adequate patient-centred care:

... there was no time to build relationships with the patients or to sit down and, and speak to them, and talk about their family life ... and any other issues or problems or anything. – *Ian*

... if you have 40 patients waiting to see you, you can't necessarily spend the half an hour you need with this patient, when you've made sure you've [medically] helped the patient. – *Philip*

... because it's so busy, and you have very little time, to-, I know it sounds awful, but very little time to be empathetic with patients ... there's too many patients – *Gillian*

... as an intern ... you're very idealistic about how you should approach the patient. You try do that, and you quickly get forced into this situation ... you have to just ... "push the crowd".

... the Department [referring to the discipline he was rotating through] ... wanted to know how they can improve their times and wanted to do an audit ... they started now counting, How many patients do you see? How long do you take seeing these patients? ... I don't think it was (.) practical ... to see ... one patient for less than say 15-20 minutes, but sometimes that is exactly what you needed to do to get through the line. Because you don't examine a patient properly, but that is what was being forced ... "you got patients, they're complaining outside, you have to be quick" – *Ezera*

Like in [Hospital Name of internship site] ... in MOPD there'd just be benches of patients, and there's two doctors in one room, so they're seeing two different patients. So there isn't privacy, you don't have a lot of time, and (.) you may not be able to follow the patient up because of the way the system is. – *Juanita*

These time constraints and pressures of excessive workloads were found to hinder empathy and thoroughness of examination. In addition, Juanita discussed spatial constraints in her environment (two patient consultations taking place in the same room) and the organisation of clinical work which had also hindered the doctor-patient relationship.

6.2.1.1 *Biomedical vs biopsychosocial approach*

Regardless of participants' diverse capabilities, their various innate dispositions towards being relational in general, across different ethnic backgrounds and gender, they all felt that excessive workloads had compelled them to adopt a biomedical approach. This traditional biomedical focus privileges the doctor's scientific knowledge of human bodily functions over other ways of knowing about the patient's health or illness, and involves a lack of attention to the patient's life world (Geist & Dreyer, 1993; Waitzkin, 1979). Even having resorted to a biomedical approach, participants generally felt too rushed to be thorough or duly considerate of patients' needs. Paradoxically, numerous patients growing frustrated in overcrowded waiting rooms became a source of added pressure on NQDs to dispense with each consultation quicker than they were comfortable to do. In some settings even the physical spaces in which patient consultations took place did not allow adequate privacy, making it questionable whether the basic right of patients to confidentiality of medical

information was possible. Expressions of dissonance and regret accompanied reflections of having had to compromise the values of patient-centred communication and a genuinely biopsychosocial approach to clinical encounters:

... I felt it was horrible because you weren't relaxed to ... take your time ... explain to the patient your management plan ... speaking to the patient was now a luxury. – *Ezera*

During internship, better opportunities were said to be available for interacting with patients in the wards following admission to hospital rather than in casualty and outpatient clinics:

[The] hospital settin' helps better with the biopsychosocial approach ... you see them multiple times in the day, over many days ... When you're pressed you could just do the 'bio' part, then at less busy times you could be more holistic. So 'in-patient' was a very good time for that. – *Philip*

Some participants alluded to being more patient-centred after internship:

[during Community Service]... the old grannies ... used to follow me around and bring you things ... you walk in the streets and the people go out their way to come and greet you ... and that is what made you enjoy your job more, not ... just seeing numbers and that's it. That you learn to build relationships with them and they actually did appreciate you. – *Ian*

... we have Specialist Clinics [referring to current practice context], and it's easier to get to know your patients ... When the patient comes in we all know the problem ... but in a set up like [Hospital Name of a Level II hospital in the same town] where there are so many patients, it's difficult to connect with the patient um the way you would probably want to (in a soft voice). – *Juanita*

I would dig deeper into the problem and ask about family members an' other things that might bother the patient. This usually ended up in tears (both mine and the patient's), and promises which were not always fulfilled, but this interaction inevitably provided hope beyond what pharmaceuticals and surgery could provide. I was called out by the nurse in charge who told me that patients had begun to request for me as their doctor. They would tell friends and family members about me. This was an extremely gratifying and rewarding experience. – *Philip*

NQDs had subsequently been able to change their approach during community service placements when they were immersed in typically smaller communities in rural areas or in specialised clinics attending to limited numbers of patients. Patient-centredness was therefore described as being an important part of most participants' current practice,

indicating that the intent to empathise with patients was present even when circumstances had prevented them from practising what they knew to be a holistic approach to medicine.

6.2.1.2 *Culpability*

In assuming responsibility for patient's lives, NQDs also had to deal with feelings of culpability in the death of patients whenever they had been unable to save a life, whether they had misdiagnosed or misjudged the seriousness of an illness at the time, or had done everything they could do but circumstances beyond their control were unlikely to have allowed the patient to live:

... some of those memories, ... had you been more efficient-, if you'd been a more experienced doctor ... you could have judged a clinical case more effectively ... maybe even saved a life. ... those situations can definitely scar *new* doctors. – *Gillian*

I think *Aaah!* ... I had a patient who had a low pulse ... He was well, but he died the next day ... And I just keep thinking, *man!* He probably had a complete heart block and I didn't transfer him to [Name of Specialist Hospital] for a pacemaker ... you just didn't have a Consultant doing the round with you and you didn't know any better. – *Juanita*

I ran out of the theatre with tears rolling down my cheeks, filled with anger and resentment ... I felt completely helpless and at the same time guilty and responsible for the death of that precious new life. – *Ian*

In an ideal world, such situations where patients' deaths are attributed to NQDs' inexperience should not happen. However, participants in my study communicated these experiences as inevitable, which is cause for concern. The language use in the above quotations is interesting in that it reflects the NQDs' relation to self in times of crisis, precipitated by them being expected to manage medical emergencies before they felt capable. In phrases such as "had you been more efficient", "been more experienced", "judged more effectively" NQDs were positioned as 'I-as-inefficient / inexperienced / ineffective'; and 'I-as-ignorant' in "didn't know any better". Ian positioned himself in the final quotation as being 'I-as-helpless / guilty / responsible'. It is also interesting to note that Gillian and Juanita used the second person pronoun "if you'd been ..."; "you didn't know any better" signalling that they were not only referring to the individual self but to a collective

self of new interns. This further reflected a relation among NQDs of negative experience that they held in common. In the second quotation above, Juanita started recounting a personal incident “I had a patient ...”, then subsequently reverted to “you just didn’t have a Consultant” confirming that individual voices are not only private but speak for the collective “through the mouth of the individual speaker” (Hermans & Hermans-Konopka, 2010, p. 7). Gillian made this point more explicit in her phrase “... can definitely scar new doctors”, referring to interns in general, who should have been working interdependently and with adequate supervision from senior colleagues, but for various contextual reasons had been left to independently manage emergency situations. Therefore it could also be inferred that the absence of relationship with the more experienced other in these situations became a negative relationship with the self.

The identity claims of participants in my study projected motivation and dedication in their work as NQDs overall, as they aimed to make a difference in the lives of patients. Whether this meant serving the objectives of healthcare delivery to the best of their ability in as patient-centred a manner as they could, or whether they described going above and beyond the call of duty. They portrayed having faced the task of caring for numerous sick people with a self-sacrificing work ethic that was admirable. I must declare my bias, however, as a previous mentor of theirs from a Christian faith-based mentorship programme, I was motivated to search for high standards of caring and was inclined to be somewhat disappointed at the way the healthcare system and the regular demands of NQDs’ work had shaped the participants.

6.2.2 Communicating with patients

Other sociocultural contextual factors were also described as having hindered the quality of patient consultations; these were related to several interrelated aspects. Language barriers, for example, were influenced by personal dispositions towards learning new languages. Emotional distancing because of the nature of medical practice or from prevalent societal ills such as substance abuse and gender-based violence in certain populations also led to a

lack of empathy and poor communication. An incident of overt prejudice expressed by a family member of a patient towards one of the participants led to an uncharacteristic outburst and wounded identity, leaving persistent negative emotions to contend with. I discuss these issues briefly below and conclude this section with a summary of the factors that I found to have influenced patient consultations either positively or negatively.

6.2.2.1 *Issues of language*

The language of clinical practice and the language of teaching and learning during internship were problematic for some of the participants. All participants in my study communicated confidently and fluently in English, although two of them may have considered their 'mother tongue' to be African languages of the countries in which they were born. English was the language of teaching and learning in the undergraduate curriculum and the language that all participants usually spoke in their home environment. Therefore the participants in this study could be viewed as first language English speakers. While they had learned, or it was hoped that they had learned, sufficient Zulu at Medical School to converse with patients, it was evident that not all of them had achieved this goal. All participants had taken a course of basic medical Zulu taught in the early years of study. However, I discovered that even then they had responded quite differently towards learning another language depending on their personal dispositions.

A further complication arose for Ian and Philip whose internship sites were in the Western Cape, where the Zulu they had learned was of no practical use to them, as they encountered great difficulty communicating with patients and with colleagues in Afrikaans. Ian was determined to overcome this challenge by learning to communicate in Afrikaans. He described being immersed in his Afrikaans-speaking environment until he found it natural to speak and think in Afrikaans. Philip on the other hand found the language (and associated cultural) barrier between him and his colleagues to be insurmountable for him in many of his internship rotations and consequently ended up with a substandard experience of those disciplines.

Of the four participants based in KZN, where all healthcare professionals were able to communicate in English, some mentioned having to revise the Zulu they had learned previously or having to get help with translations for patient consultations. Others made no mention of a language barrier in their original written reflections and it was clarified at interview that this was because they had either dealt with patients who were capable of communicating in English, or they had achieved a degree of proficiency in Zulu. For example, Ezera was proud of the fact that he had achieved his personal objective of having learned sufficient Zulu to independently cope with patient consultations without relying on nurse practitioners. All participants considered competence in basic (medical) Zulu to be a distinct advantage for clinical practice as NQDs in KZN. There was, however, an element of doubt introduced from a more mature perspective; for example Gillian questioned the depth of knowledge required for understanding some complex issues patients might present with, such as psychiatric conditions. She reflected at length about the various languages she had encountered during her lifetime and felt that, as she had learned a number of different languages, it had become easier for her to attain a degree of proficiency in yet another new language. However, she noted that such superficial engagement in a language was not always adequate:

... unless you're going to really immerse yourself in it [the patient's language] for four years and learn the detailed language of a 90yr old person (.) ... there's sometimes a deep cultural root behind the language ... – *Gillian*

The above quotation highlights the point that, in order to communicate well with patients, considerably more than purely technical, verbal and linguistic competence is required. Gillian became aware that, to truly understand a patient's perspective and to grasp the meaning of what was being communicated, she needed a far deeper knowledge of the patient's culture and language than she could hope to achieve herself. She had sometimes used pictograms when communicating with patients who did not speak English as an aid to overcome language barriers. It was also interesting to note that in Gillian's current practice, the languages she encountered were French and an East African language; for which she employed a nurse practitioner in her clinic to assist with translations.

Philip also explained that, rather than learning to speak Zulu as an undergraduate, he had learned the art of negotiating help when required. He preferred to work in collaboration with other practitioners in the clinical environment, especially nurse practitioners, who spoke the patient's language better than he did. For the most part, however, when he encountered a language barrier, he paid greater attention to the clinical signs and symptoms he observed on examining patients. Therefore language barriers were often regarded by participants as obstacles that needed to be circumvented by utilising alternate means, which included translations by helpful others who had the necessary cultural acumen, using non-verbal communication, and placing greater reliance on physical findings for purposes of medical management of patient cases.

6.2.2.2 *Emotional distance or clinical detachment*

Some of the participants described an emotional distancing in their affect that was most likely to be a protective mechanism; generally recognised as a degree of clinical detachment necessary for doctors to cope with the very nature of their work (Bleakley et al., 2011):

... on one or two occasions people have come to me and said, "why have you become so cold?" (.) so it's almost as though emotionally I've got no connection to what's happened, but I've felt that I have to do that, otherwise I wouldn't survive ... – *Ian*

However, there were also times when clinical detachment developed as a consequence of encountering prevalent social pathologies to which NQDs became hardened:

I did develop a very negative feeling towards male patients who arrived at casualty drunk and injured. I did manage them, but lacked any sort of sympathy or empathy. – *Juanita*

... you'd be on a weekend and see three women being brought in for sexual assault. And you've got to take a detailed history and 99% of them are drunk, as in *drunk*, and they put themselves in situations. ... and it always came in after 12 o'clock, after midnight ... trying to get a few hours sleep, and they phone you. So, you became frustrated with it, with the system and how society was ... You never once thought that this woman has now been through this great trauma, she's been emotionally, physically-, you need to be a bit more sensitive ... well after doing 10 or 15 of them you lose that [empathy]. – *Ian*

6.2.2.3 *Issues of racism*

Racial tensions and prejudices could be expected in the South African context given the legacy of apartheid. However, only one participant disclosed a critical incident during internship in this regard that had impacted his identity. Philip's encounter with a mother of a paediatric patient who refused to allow him to attend to her child caused him to react in a way that he was ashamed of, as he had "lashed out" in anger. Philip expressed his awareness of the 'feeling rules' and "emotional labour" (Hochschild, 2003, p. 7) of the medical profession, according to which doctors are expected to maintain open channels of communication with patients even when patients are unreasonable or openly display aggression. Philip claimed, however, that he had not personally been previously subjected to overt racial discrimination. In this incident, there was no recognition of his qualification and capabilities; only identity-damaging disrespect (Honneth, 2007) was directed at him, which led to a complete breakdown of communication. The experience had permanently altered his outlook on racial prejudice and he was aware, even recently prior to my interviewing him, of having to actively control negative emotions emanating from this critical incident that occurred during internship.

6.2.2.4 *Breaking bad news*

When the need arose to break bad news to patients' families, mainly about the death of a patient, it was interesting to compare Ian's particular difficulty with the task and Lana's determination not to shy away from the associated emotional pain. As much as Lana made the effort to muster up courage, with the support of others in her COP, to face the challenge head on, Ian said "to do it and get out" in an emotionally detached manner was the only way he had been "able to cope". On the other hand Lana found that by her second year of internship she had managed to grow into a deeper level of communication where she "found comfort in speaking to families". This contrast between Lana and Ian in this aspect of clinical practice, in their initial responses as well as their learning trajectories, is a clear example of how personal dispositions shaped learning and practice in the real world. In comparison the most advanced simulated skills training is unlikely to enable more than

mechanical aspects of doctor-patient communication. This might explain Ian's statement that "no medical school in the world could equip" him for the function of breaking bad news, implying that such an internal transformation required more than propositional and practical knowing. He was presently "slowly learning to do better"; therefore a reshaping of dispositions was not an absolute impossibility, but it did represent a fundamental shift that could take place only through sustained experiential learning or 'learning for being'.

In conclusion, the main elements that facilitated patient-centred practice were enablers of participants' overall ability to establish mutually respectful relationships. Whether a self-sacrificing dedication was espoused, or self-preservation was prioritised in particular instances, added an important dynamic in determining whether patients interests were given due consideration or not. Constraining factors consisted of excessive workloads, and societal ills that led to a hardened affect. An overly reserved disposition and language (and/or cultural) barriers, without the means to overcome them, had also hindered doctor-patient dialogue.

6.2.3 Positioning of patients by narrative language (the 'telling') in relation to identity claims of NQDs

Given the overburden of disease in the broader context of the study, which was the public healthcare arena in South Africa, patients were most often deemed to be the excessive 'workload' of interns. Therefore it was not surprising to find that some NQDs would dehumanise or objectify patients under such conditions. Although most participants expressed some degree of regret when reflecting on how they had rushed through patient consultations as described in the previous section, they had generally come to accept that this was part of the system, and that they as NQDs needed to learn to cope with and get through the number of patient cases. They had devised strategies to do this, which often involved exercising a degree of clinical detachment and focusing on patients, however numerous, as learning opportunities. The following exemplary quotations reveal how

patients were positioned by what was most likely to be unintentional or less intentional language used while describing their situations:

Not all of them [were patients with] acute trauma, like a stab abdomen or whatever, um, some of them were 'cold cases' [non-emergencies] as well. – *Ezera*

... a lot of the Orthopaedics guys who'd just wanted 'cutting time' or Surgery people ... I'd get excited when 'things' came in ...

... a lot of responsibility came to you, and then== you learned. It's the only way you really learn? – *Juanita*

I was more confident and more willing to do things and to try things as well ...

... if you [are] running around with X-rays and to the Blood Bank and things all day and, you know, not really getting to 'do stuff', when you get to community service you need to get that- [experience] – *Ian*

Socialisation into a medical culture or medicine as an establishment that objectifies patients was also visible in such phrases, particularly where participants appeared unaware of how their use of language pointed to attitudes they had internalised towards patients. For example, disease entities or types of injuries were used when referring to patients, such as "stab abdomen". When differentiating between patient cases needing immediate surgical attention and non-emergencies, Ezera described the latter as "cold cases" indicating a clinical distance being maintained as a means of enabling functionality. Learning opportunities were described as "cutting time" for surgeons in training, exciting "things" that came in with reference to medical conditions, and the need to "do stuff" in order to gain experience. These examples also indicated ways by which NQDs distanced themselves from considering patients as persons. In addition, such language use also seemed to demonstrate the propensity of particular disciplines such as Internal Medicine and Surgery to lean more heavily towards a biomedical approach towards patients, which may well be unavoidable when patients are seriously ill and unable to speak for themselves. However, it might also be a consequence of personal dispositions, which in turn are likely to draw individuals towards particular disciplines and cause NQDs to then more easily adopt the language prevalent in the clinical practice of those disciplines. Juanita, for example, having just completed her specialisation in Internal Medicine admitted that she now found it challenging to work through the entire night, although when she "got an interesting patient at two in the morning" she would "get excited about it still", clearly inferring that what was

uppermost in her mind was the presenting medical condition rather than the patient as a person. The inference here was that Juanita's identity claim of 'I-as-enthusiastic-learner' was an "I-position" (Hermans' 2013 p.83) that had persisted whenever she encountered new and interesting patient cases, despite her having attained an advanced level of expertise.

Some participants, such as Lana and Gillian, were able to maintain a caring attitude towards patients in their linguistic choices despite the overburden of disease and whatever discipline they were describing. In addition, I found no unintentional language use that pointed to objectification of patients in their narratives. Interestingly they both claimed that previous exposure to the healthcare system in their individual histories had given them a somewhat different perspective; Lana by having been hospitalised when she had contracted Guillain Barré Syndrome; and Gillian by virtue of her experience as a paramedic:

I had the hospital experience and I, I understood what it felt to be a patient.
I wanted to be a doctor, and the reason for that was, to change the system you have to be in the system. – *Lana*

When I was working on the road I got to see the patient's experience and the patient's family's experience from a different angle, seeing it from their home environment first.
– *Gillian*

Apart from the undergraduate curriculum, both Lana and Gillian reported prior learning from life experiences that had resulted in their different ways of being in the world. Their respective I-positions had been influenced by personal experiences, confirming Hermans' (2012 p.8) view of the dialogical self being positioned and re-positioned temporally as well as spatially. Lana's I-as-previous-patient could be considered foundational to having real empathy. Gillian's I-as-considerate-of-patient's-family through her previous I-as-paramedic position, inferred that she had appropriated the other-position of patients' families as part of her identity. Therefore Lana and Gillian claimed that their way of relating to patients had been influenced more by their 'school-of-life' experiences; quite different to what the conventional undergraduate curriculum (formal or informal) might be expected to offer.

Lana's and Gillian's stories further indicated that their personal dispositions had shaped their choices regarding the kind of practitioner they wanted to become. This resonates well

with Bourdieu's ideas of *habitus*, capitals and field (see section 3.3.2 Bourdieu's theorising: habitus, capital and field p. 62) where individual ways of being position persons in social environments, enabling them to negotiate learning journeys or trajectories in exchange for various capitals they have at their disposal. Consistent with the above-mentioned motivations of these two participants, Lana described herself as being "more of a Public Health person" and Gillian, if she ever reached a point in her life when she was ready to specialise, expressed that she would consider Family Medicine as a speciality. In terms of Bourdieu's analytic categories, Lana was expressing her *habitus* as being disposed towards improving healthcare on a broader scale, transcending individual interests, and focusing on the greater public good. Gillian's caring approach towards patients' families could be viewed as capital acquired from her prior experience as a paramedic, which had shaped her *habitus* to focus more on family wellbeing. Both Lana and Gillian were further identifying with the collective dispositions (and collective *habitus*) of the specialities they would consider choosing, demonstrating that they had gained a fair sense of the (specialising) game during internship and were able to predict how they might play those fields successfully.

6.2.3.1 *Patients as work / learning / calling*

NQDs generally regarded patients as being needful of their assistance. Whether they enjoyed interacting with patients, for example Lana who said she "loves interacting with patients" or whether it was simply an essential part of the job, patients were positioned as needing a doctor's counsel or medical care. It was also part of a doctor's duty to be approachable, to put patients at ease if there was any potential cause for anxiety or discomfort. Doctors were generally expected to be wiser than patients, to rise above any inappropriate behaviour on the part of patients, such as aggression, drunkenness or a display of prejudice. Sometimes participants found it was beyond them to meet such expectations, whether this was due to being overworked, exhausted, becoming intolerant of social or societal problems or being antagonised beyond their personal capacity to endure.

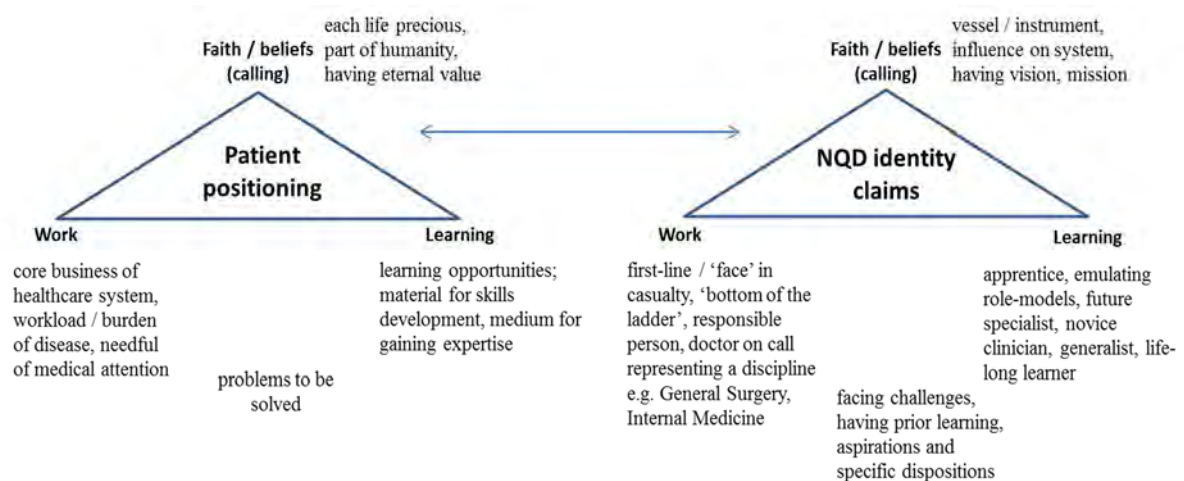
As medical internship is essentially work-based learning, the tension between the activities of work and the motivations of learning and professional development was unavoidable.

Relating to the role of work, for example, patients were the ‘core-business’ of the healthcare system where NQDs were often the patients’ first point of contact with the system. On the other hand patients were seen as ‘learning opportunities’ by NQDs for them to gain experience towards developing professional expertise. Such patient positioning and NQD identity claims emerging from the data could be clustered around either ‘working’ or ‘learning’, as they generally aligned with one or the other, although some positioning such as viewing patients as ‘problems to be solved’ was applicable to both working and learning.

In addition to working and learning, in this study I found a third focus in the way NQDs related to patients, which was embedded in the participants’ faith and beliefs, where the medical profession was viewed as a calling (see section 6.4 In relation to God p. 202).

The following diagram (Figure 3: Patient positioning in relation to NQD identity claims) depicts these three foci of work, learning and faith- or beliefs-based calling – as they related to patient positioning and to NQDs’ identity claims:

Figure 3: Patient positioning in relation to NQD identity claims



Although patients might in some way be considered as ‘teachers’ of medical personnel, in this study overall I found that participants had not considered “reading the patient’s condition *in collaboration with the patient*” (original emphasis) (Bleakley et al., 2011, p. 189). Patients were there to be taught by and/or acted upon by clinicians. This finding may

well be more applicable to the specific context of public healthcare in South Africa than the private sector, for example, where the patient population is likely to have better access to medical information overall and to be more demanding concerning patients' rights to be heard by doctors attending to them.

6.2.3.2 *Patients as problems*

Patients (with their illnesses) were occasionally depicted as challenging problems to which NQDs needed to find solutions. In these instances NQDs usually positioned themselves as the central actors in the narrative structure (Riessman, 2008; Toolan, 2001), which is understandable as it was their experiences that I had sought, and they were the experts in recounting what happened to them. Using Goffman's (1959) dramaturgical performance metaphor, where roles of persons in narratives are constructed as, for example actor, director, prop or audience, in some instances the patient(s) occupied an uncomfortably (in my view) peripheral position. In these encounters that ultimately should have been about the patients' best interests as the incidents concerned them the most, they were found portrayed as supporting actors (Gergen & Gergen, 1984) or even as props. Three scenarios from the narrative data that illustrate this point are recounted below:

Scenario 1: Three days into internship Ian was called to attend to a female patient undergoing a lengthy and difficult labour, where there was the distinct possibility of foetal distress. The nurse practitioner asked Ian to perform a vacuum assisted delivery (VAD), about which Ian wrote: "... having no practical experience with the procedure I remember panic setting in, the baby was in distress and the mother could not assist me".

Scenario 2: On an occasion when the orthopaedic surgeon was absent, Lana administered an intra-articular cortisone injection into the knee joint of a patient. Despite knowing that she possibly lacked the necessary anatomical knowledge and skill to perform the procedure, she did not refer the patient to a more experienced clinician. Reflecting back on this incident Lana said: "... this happened in my second year of internship, so I think that is the reason I didn't call anyone; because I felt that ... I should have been able- ... to do this by now."

Scenario 3: A patient with low blood pressure was not improving despite replacement fluids being administered and the NQD could not understand why. The Registrar on duty, known for his intolerance of interns calling him out during the night, had

instructed Ezera to periodically record the blood pressure and other vital signs of the patient. Rather than risk antagonising the Registrar with repeated phone calls, Ezera continued to monitor the patient's blood pressure but did not call the Registrar again, resulting in the death of that patient. Referring to hierarchical power structures in the clinical environment Ezera said: "... your responsibilities were clear ... as an intern [this] was to make sure that you are there, and if you identify a problem you let your Senior know ... as long as you spoke to your Senior Registrar, if there was an issue that happened, the next day ... you were sort of covered.

In the first scenario, the patient (the expectant mother) was portrayed in a supportive role (in terms of dramaturgy) in stating that she "could not assist" the NQD (as the main actor) as he struggled to resolve 'the problem' of having to deliver her baby with no experience at performing a VAD.

In the second and third scenarios, beyond the narratives being primarily about the NQDs' dilemmas, the stance adopted by participants in relation to patients indicated to me that their main concern had been for self-preservation above the patient's wellbeing. This is also consistent with the concept of 'face-work' (Gergen & Gergen, 1984; Goffman, 1959) where individuals manage other's impressions of them to maintain a positive face. The patient in Scenario 2 was positioned as a prop, while the intern had to 'save face' and appear competent rather than risk revealing any lack of knowledgeable skill on their part. In the third scenario, the NQD was more concerned with being absolved from blame for the negative consequences suffered by the patient rather than ensuring patient safety at all costs. In this instance the cost to the intern had been the risk of antagonising a Registrar who was typically unwilling to be inconvenienced by repeated calls for assistance during the night. The intern had been unaware that the patient had an undetected internal abdominal injury and that death was a possible consequence. In retrospect, he regretted his decision not to call the Registrar again. However, his primary concern had been how he would be judged by his senior colleagues rather than the direct impact of his actions on the patient.

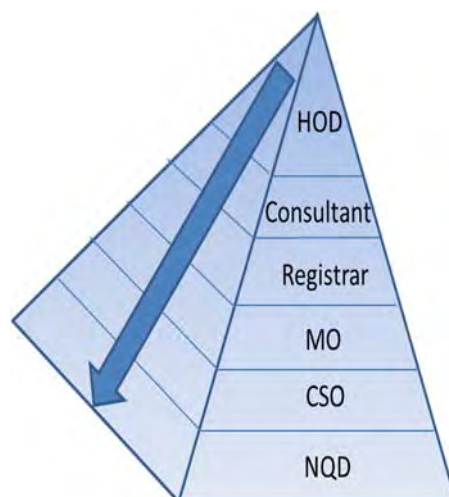
In the third scenario, by adopting the second person pronoun Ezera also demonstrated a phenomenon that Hermans refers to as 'collective voice', where the individual speaks for a social group to which they belong (Hermans & Hermans-Konopka, 2010). The implication therefore was that the situation was common to NQDs, where the expected role of interns was to communicate the problem to their supervisor, beyond which the supervisor was then

responsible for what eventually happened to the patient. In the following section, positioning of self and others through language use or the 'telling' of narratives, in addition to the referential content (what is told), is applied to the participants' relationships with various members of internship COPs (Riley & Hawe, 2005).

6.3 In relation to internship COPs

At most teaching hospitals there are typically a number of clinicians occupying all the following posts in order of ascending seniority: Intern (NQD), Community Service Officer (CSO), Medical Officer (MO), Registrar, Specialist Consultant, and Head of department/discipline (HOD). The levels of medical hierarchy and the direction of power flow (depicted by the downward arrow) within these COPs is shown in the diagram below (Figure 4: Levels of medical hierarchy), where NQDs occupy the lowest level:

Figure 4: Levels of medical hierarchy



The reader might be led to assume that the direction of power flow is accompanied by concurrently diminishing authority or even a counter flow (upward arrow) of accountability.

However, this is not necessarily the case. MOs, for example, might be highly experienced and senior practitioners who have opted not to specialise for various reasons. In practice therefore particular MOs may be seen as having equal or superior authority and accountability when compared to junior Registrars. The status of the Registrar is depicted in the above diagram as being higher than MOs simply because Registrars are engaged in scholarly activity towards becoming Consultants. This would however be understood as a transient status, as it is entirely conditional on them successfully completing the necessary professional examinations.

At tertiary institutions accredited to accommodate interns, the supervision of interns is generally delegated to those who are Registrars (practitioners enrolled as postgraduate students with a University towards specialising in a discipline, albeit in a work-based learning programme). Variations in the way interns related to and were supervised by Registrars were consequently highlighted in the study as a key factor determining the nature of NQDs' learning experiences. However, there were participants in my study who were based at Level II hospitals where there were discipline specific Specialist Consultants to offer a service but no Registrars were present, as there were no formally structured academic disciplines in operation. Considerable variation in internship experiences could therefore be attributed to this single factor as a difference across the internship COPs of participants. Both Juanita and Ian, for example, were interns at such hospitals serving rural communities. In Juanita's case, being at a very busy Level II hospital in rural KZN where senior colleagues were in short supply, she was often expected to fill the shoes of an MO or Registrar. She described in detail how interns were treated equally for the distribution of on-call duties. Personally, Juanita was able to appreciate and even to thrive on learning opportunities to take on this greater than usual level of responsibility. She regarded her situation as enabling her to gain more experience and to develop her clinical skills more rapidly than interns at urban institutions would be able to. This was facilitated by her perception of being well supported by the Consultants and other senior colleagues in her environment.

On the other hand, Ian, who was based in a semi-urban area of the Western Cape, had not enjoyed the same quality of close relationship with senior colleagues as Juanita had. His perception as an NQD was that he and other new interns were "in the way" of his senior

colleagues, especially when they needed to ask for information or assistance. This changed with time and he was able to (re)construct his identity as an eager and willing participant whenever opportunities arose to assist with surgical procedures that were new to him. However, at the outset, while he had the same degree of responsibility thrust upon him as Juanita, he felt overwhelmed and somewhat abused by the system. Interestingly, he linked a former interpersonal experience as an undergraduate student of being disrespected by a clinician educator in Obstetrics and Gynaecology, to his under-preparedness to deal with an obstetric emergency on commencing internship. Consequently, when faced with a failed VAD and the death of a neonate, he felt he was predisposed to the damaging effects this incident was to have on his development as a NQD.

This contrast between Juanita's and Ian's transition experiences also brings to the fore the importance of NQDs' personal capacities to adapt to greater levels of responsibility which influence how they cope with prevailing conditions in particular COPs. As the level of challenge encountered at understaffed rural and semi-urban institutions is likely to be considerably greater, it seems advisable to ensure that NQDs being allocated to such facilities have the appropriate personal resources in conjunction with the required degree of mastery of knowledgeable skill.

In the following section I elaborate on various 'models of clinician' found represented in the narrative data, as this seemed to be a useful way of viewing how NQDs perceived and related to senior colleagues within COPs.

6.3.1 Models of clinician

A synthesis of nine models of clinician as presented here is based on the different interactions and incidents contained in the personal narratives of the participants. Six of these models generally enabled learning opportunities and positive identity constructions while three models constrained them (see also section 7.3 Identity and ways of being in clinical practice, Table 3: Models of clinician p. 217). It is important to note that these models are not 'labels' that apply one per individual. There may have been a combination of

models displayed by a single senior colleague, they may have changed over time, or they may have depended on who they were interacting with.

6.3.1.1 *Caring (self-sacrificing) doctor*

Clinicians who overtly expressed a caring attitude and a connection towards patients at a personal level were admired by participants. Whether such role-models were encountered before, during or after internship, senior clinicians exhibited attributes which were discriminately chosen by participants as being worthy of emulating. Participants therefore expressed intentionality and agency in their choices of the other that would be appropriated in their own identity constructions. The following descriptions of role-models and mentors encountered by Ezera, Gillian and Lana during internship or community service, exemplified how the self was extended by incorporating the significant other (Hermans, 2013):

I think I saw ... what I'd like to be in others ... I'd interact with a Registrar I really respected, the way they approached patients or the type of practitioner they were, I'd pick out qualities that I'd want from that – *Ezera*

... one of her patients being so grateful he hugged her. She returned his hug with genuine empathy. Witnessing that one moment between a highly skilled doctor whom I respect, and her patient, taught me more than any textbook will ever teach me about being empathetic and compassionate. – *Gillian*

... people would come ... from far and wide ... people would wait in queues to see her. And she was my Supervisor in the clinic ... and I would watch her, she would go and take 5 minutes [to have lunch] ... and she'd get back to work. And I would do the same thing. – *Lana*

Therefore the ability to openly express empathy and give of themselves as doctors was highly valued by participants, portrayed in the narratives as practitioners who demonstrated connectedness to patients, or were sought after by patients. These significant others, projected by participants as modelling caring and self-sacrifice, were found to lead by example, NQDs would observe and follow their example depending on their own dispositions and motivations.

6.3.1.2 *Excellent generalist*

Gillian and Lana made mention of being impressed by “really good generalists” during internship. Gillian felt she still aspired to become this sort of practitioner, recalling two specific Family Medicine practitioners who had been part of her COP:

... just to be able to walk into an operating room and do a caesarean section and then go and ... set a fracture and go into casualty and do resuscitation and just be a generalist, ... there's two I've met ... they were really inspiring. – *Gillian*

Gillian admitted, however, that she had not had an opportunity to interact very closely with these role-models she described; therefore I surmised that there was an element of her projecting an identity onto them that she had hoped for as well as what she had actually observed. In terms of DST, significant others may exist in the extended self in “real, remembered, anticipated or imaginary” forms (Hermans, 2013, p. 87). The process is consistent with the ‘other-outside-the-self’ (e.g. the role model) becoming the ‘other-in-the-self’ (what the internalised role model represents for the self). In this way the clinicians that Gillian had admired during internship could also be understood as promoter-positions in her identity. A promoter position is further explained by Hermans as the other-in-the-self who provides inspiration and a sense of direction in situations of ambiguity and unpredictable change (Hermans, 2012, pp. 17-18).

As an intern Lana had also admired some clinicians who she perceived to be excellent generalists. While reflecting back, she came to the realisation that her current practice involved her being one of those “really good generalists” she had previously aspired to be:

... [currently working] in an ARV Clinic and I see patients with HIV and TB who are complicated ... now when I'm sitting and thinking about it, I'm being exactly that – I'm being a generalist! – *Lana*

According to Hermans' theorising, Lana might be said to have taken up a ‘meta-position’ of reflection during her interview (in stepping back and taking an aerial view of her development), which is a learning position. In this way she was able to unify the two positions (the-other-outside-the-self and the-other-inside-the-self) by identifying herself as the one she admired, the ‘excellent generalist’.

6.3.1.3 *Supportive supervisor*

Whatever their level of seniority or position in the hierarchy of the clinical environment, more experienced colleagues providing supervision and support for interns were the mainstay of internship learning. Lana's experience of being guided by a Surgical Consultant while being allowed to perform an appendectomy was a good example of how relationships of mutual respect led to positive identity construction and learning:

It astounded me that such opportunities were given to newly qualified doctors ... He reflected the value system of the hospital as a whole ... interns in particular were a fundamental part of their staff ... All these factors helped me in my transition from medical student to intern. – *Lana*

Ezera expressed his appreciation for those Registrars who were willing to accompany interns when they went to examine patients and how he had learned the art of clinical reasoning from being with more experienced colleagues in action. Gillian noted a few Registrars who were committed to teaching in her environment and highlighted that it depended on "the dedication of the person". Juanita also described supportive Consultants in her COP who had taught her various procedures and enabled her to take on greater responsibility than was usual for NQDs, and had thus facilitated her professional development.

While the critical incident of a failed VAD in Ian's narrative was a negative experience for him overall, there was an HOD who had taken the time to reassure Ian that he had in fact done everything in his power to ensure the safety of the patient while waiting for a theatre to become available. Sometime after the critical incident, yet another Consultant noted Ian's subsequent reluctance to perform obstetric procedures and took it upon himself to challenge and compel Ian to overcome his fears emanating from the incident. This could be viewed as essential follow-up guidance and supervisory support without which it may have taken Ian much longer to develop competence in that discipline.

These examples show that the 'supportive supervisor' model of clinician was actively and purposefully engaged as an educator or mentor. Clinician educators would make their motives explicit using verbal communication, practise alongside NQDs and challenge them

when necessary. They therefore employed multiple modes of teaching in addition to leading by example in areas where demonstration was required.

6.3.1.4 *Comrade CSO*

In Gillian's environment it seemed that encounters with unhelpful seniors were not uncommon, and Gillian explicitly depended on the CSOs to make up for the inadequacies of more senior colleagues who were absent or unwilling to supervise interns:

... as interns you develop ... working relations with the Community Service doctors ... there was a lot of camaraderie ... If you worked hard as an intern, then the Comm. Serve. doctors would enjoy working with you, and when you called them for help, then they would know that it was not because you were trying to be lazy ... Like the Comm. Serve. doctors, I think we were all in the same boat ... most of the Comm. Servers that I found had a dedicated work ethic. – *Gillian*

CSOs were not often mentioned by the other participants. However, Gillian's strategy for overcoming deficiencies in the healthcare system involved her relying on them, especially to counter a deliberately unhelpful senior. Consequently she identified very closely with the CSOs in her environment, positioning them "in the same boat" as interns. Although the CSOs had no formal responsibility to teach interns, this was an example of a situation where slightly more experienced others had facilitated the progress of NQDs towards fuller participation within the COP.

6.3.1.5 *Professional researcher / scholarly clinician*

Lana mentioned clinician role-models who had been actively engaged in research activities in her COP and had included interns in meetings where they presented their work:

... the clinicians there [in Internal Medicine] were very passionate ... extremely research-orientated ... they were pushing out papers on a monthly basis. They had collaborators from the USA, they had so many people involved in research [multi-disciplinary teams of scientists and clinicians].

And now ... I find myself joining those same meetings, as a Medical Officer and finding them so interesting. And the whole conference that we used to attend as interns, I do remember those were very, very interesting and I still attend them now. – *Lana*

Although some of the other participants mentioned attending ‘academic meetings’ in various disciplines, these were in the format of journal clubs or case-based discussions. There was no mention of other participants having encountered or aspired to conduct research projects. Lana, however, had taken a career path that was directly related to conducting research on HIV pathogenesis and TB infection and felt that her internship experience had shaped and equipped her by the exposure she had had to these role-models. Again this was evidence of the way Lana’s environment had been particularly enabling for her with regard to achieving her aspirations. Her narrative position as I-as-clinical-researcher was therefore another example of an initial other-outside-the-self position that was gradually incorporated as the other-within-the-self in a process of becoming.

6.3.1.6 *Medicine’s ‘Greats’*

There was a distinct notion that was evident, for example in Philip’s initial motivation for studying medicine, in Gillian’s quest for mentors, and in Ezera’s explicit optimism about the profession, regarding ‘honourable’ doctors who uphold the public healthcare system. Related to this view, participants aspired to join the ranks of an amorphous, otherwise nondescript mass of ‘the great men and women in medicine’:

... the environment doesn’t change, even now [as a Registrar] ... when you go and walk along the corridors, and it’s the doctors that are there and that dedication, or that effort that they put into it, for that patient they are seeing ... that’s the kind of doctor I wanna be ...

I think certain doctors I encountered within my experience shaped my attitude. Dr P [an O&G Registrar] I remember for his dedication to his patients and the way he approached each patient as an individual. This has stayed with me and I continue to glean from great men and women in medicine that I’m privileged to meet. – *Ezera*

Whether the attributes ascribed to these persons were in fact tangible or imagined by the participants, they were nevertheless a characterisation that demonstrated the way in which participants chose to embody the medical profession.

6.3.1.7 *Power misuser / abuser*

Instances of medically qualified personnel misusing their positions of authority were found in some of the narratives. For example, Gillian's story of being watched by a senior colleague who offered no assistance while she struggled to resuscitate a patient was a more blatant example of a clinician abusing his power. However, there were other instances where participants expressed that they felt a moderate threat of being shouted at, ridiculed or otherwise verbally abused as NQDs.

Ezera also mentioned practitioners who became "frustrated with the nurse that's not doing this or that, again!" or had "made the other interns cry". Such behaviour is clearly not condoned by the medical profession as a whole. However, it needs to be acknowledged as a phenomenon that is present in internship COPs, so that reporting mechanisms and solutions might be sought towards eliminating it.

This 'Power misuser / abuser' model of clinician was usually appropriated in the self of NQDs by being positioned as the opponent or the enemy, who was to be resisted or even openly confronted about their attitudes or actions. In Gillian's case she was also aware of a collective intolerance and resistance among her peers that had developed towards such unhelpful practitioners. It is worth mentioning that simply encountering negative and even obstructive role-models and organisations was not necessarily a cause of damage to identities, as long as participants had recourse to resist them. By the time Gillian's cohort of NQDs entered their second year of internship, she recounted that they had openly opposed the 'Power misuser / abuser' type of practitioner who had previously made her feel helpless and inadequate by withholding assistance. This could also be viewed as an instance where NQDs were able to influence the existing organisational culture to an extent by their collective demonstration of a different work ethic.

Ian recollected that he had been repeatedly humiliated in the presence of his peers by a Consultant in Obstetrics and Gynaecology during medical school, while he had not had the necessary personal resources to resist that more powerful other. Ian inferred that this previous interaction had damaged or injured his identity, predisposing him to further negative experiences during his internship rotation in that same discipline. The heightened emotion and minutiae disclosed as he narrated this encounter, even six years post-graduation, bore witness to the damage he claimed to have suffered.

6.3.1.8 *Self-interested senior*

There were some Registrars and MOs who prioritised their own learning to the extent of using interns by either overloading them with specimen collection and paperwork, or otherwise depriving them of meaningful learning opportunities. For example Gillian said that some Registrars in her COP had treated interns as “blood takers” in order to free themselves up for their studies. Ian had observed MOs who would go to great lengths in order to ‘chalk-up’ numbers of procedures they had performed in the hope that this would prove advantageous when competing for limited Registrar positions.

Other clinicians were noted to be unwilling to be called out by interns after hours, or they were reported as “lazy” or simply absent from performing their supervision duties. Ezera came across several such Registrars and he pointed out that the relationship between intern and Registrar was also an important dynamic in deciding whether interns were able to request the supervisory support they needed:

they’d always say ... “you can call us”, but the truth was, not everybody was available ... if you don’t get along with them, or you don’t have that interaction, you tend to call them less. – *Ezera*

Gillian expressed that she had felt cheated by the lack of supportive senior supervisors in her COP, particularly referring to senior colleagues with private practices who were employed on a sessional basis to provide a service and to teach interns, but would disappear after making a brief appearance:

... we didn't get that training they were supposed to give us and for me, I think the whole of medicine is based on mentorship, you can't get around it. And so ... it's unfair.
– Gillian

6.3.1.9 *Contextually toughened clinician*

There were some seasoned senior colleagues whose approach to interns projected unreasonably high expectations as they had left them to cope or fail ('sink or swim') on their own. Rather than being deliberately unhelpful, the lack of support from these practitioners was due to them being overly extended themselves. For example, Ian's critical incident involved him having to undertake a clinical procedure that a new intern should probably not have been expected to perform independently, especially as he had had no prior experience with the procedure. Yet he was told by his supervisor "you are a doctor, start acting like one, what do you expect me to do? I am busy at the clinic; you need to get the baby out". Ian was then left to fumble his way through a VAD that failed repeatedly leaving him feeling responsible for the death of an unborn infant.

Another example of a contextually toughened clinician was a casualty officer who had referred to Ezera as the "surgeon-on-call", despite him having just commenced his internship rotation in General Surgery. Working during the New Year period, generally known for its high case-load, the said casualty officer was most likely trying to manage too many patient cases himself. Therefore, instead of continuing with the resuscitation of patients until the Surgical Registrar on duty was able to attend them, he had expected Ezera to shoulder some of the responsibility and independently manage multiple trauma cases. In retrospect, Ezera judged that this "should never happen"; however, senior supervision was not always available due to the shortage of medical personnel.

The above synthesis of clinician role-models aimed to showcase a range of diverse possibilities regarding relational influences within internship COPs. The influence of role-models, senior clinicians' supervision and guidance, availability of appropriate resources and authentic opportunities for LPP, were enabling factors in NQDs developing positive identities.

6.3.2 Nurse practitioners

Participants written reflections made reference to nurse practitioners, mostly as helpful others in various aspects of clinical practice. For example, Philip relied on the support of nurse practitioners in communicating with patients and colleagues in Afrikaans; Lana received encouragement from nurse practitioners that she could get through communicating bad news to a patient's family. Gillian mentioned that nurse practitioners had generally been more experienced and knowledgeable in specific patient conditions, such as intoxication with herbal remedies, and where other Zulu cultural practices were involved, in helping her decipher the patient's medical history.

In Juanita's written reflection she humourously positioned a nurse practitioner as being "scary" in the role of overseeing the new interns' induction into the clinical work environment. It was also a nurse practitioner who communicated a senior colleague's instructions to Ian regarding what he was expected to do for an obstetrics patient in prolonged labour.

Nurse practitioners did not feature in the narrative data generated by follow-up interviews with participants, except fleetingly about relaying instructions to patients to shorten consultation times, or about the disrespect that was shown by some senior colleagues to nurses and interns. Therefore I surmised that nurse practitioners were primarily positioned as "brokers" (Wenger, 1998, p. 105) at the practice boundary with regard to NQDs transitioning from medical school to clinical practice. They were the links between expert and novice medical practice domains, connected NQDs to allied healthcare professional practice, and provided some specialised knowledge relating to patients.

6.3.3 In the context of the South African Healthcare System

In this section I focus on the relationships between the participants and the healthcare system. The chief aim of the public healthcare system is to provide all citizens with adequate

healthcare and with a more equitable redistribution of resources than in South Africa's notoriously inequitable past. However, there is a severe shortage of medical personnel willing to work in South African public healthcare institutions for various reasons, especially in rural and remote areas (Burch & Reid, 2011). This study confirmed an over-reliance on NQD participants to shoulder the responsibilities of providing healthcare services at their internship sites. It appeared to be commonly expected that NQDs would sacrifice their own time to fulfil these responsibilities, while there was minimal regard for their interests, and there were situations that required them to act contrary to their values regarding patient care. The primary concern of NQDs, on the other hand, was focused on their learning and professional development, in line with their dispositions and aspirations. In this milieu of conflicting interests I also found a disturbing lack of attention was given to the personal well-being, family health and overall learning needs of interns.

The strategy of the DoH administration to use NQDs for the major part of healthcare delivery in the public healthcare sector has been questioned by others on the basis that it does not have entirely satisfactory outcomes (van Niekerk, 2012). While NQDs might appear to provide temporary relief for the overburden of disease and shortage of medically qualified personnel, the lack of continuity of care is reported as a challenge (Burch & Reid, 2011). The same authors have questioned whether mandatory exposure to the public healthcare system during internship and community service might also deter NQDs from pursuing future careers within the public healthcare sector (Burch & Reid, 2011; Reid, 2002). In this study, albeit with a small number of participants, patient care and safety had been compromised in instances where NQDs had been overwhelmed by the workload, or due to their inexperience, or both. Participants' narratives further demonstrated that managing the tension between self positions of 'I-as-developing-professional' and 'I-as-provider of healthcare' had been problematic for them. In situations where the participants felt 'covered' by senior colleagues, identities relating to learning and working might comfortably co-exist. However, in practice they were often found to be a source of self-conflict. The participants in this study did not appear to be unduly deterred by the conditions within the public healthcare sector, with the exception of Gillian who portrayed herself and other NQDs as having to survive an untenable system. Others such as Lana and Juanita expressed that they felt motivated by the areas of great need (mainly relating to HIV and TB) to make a

meaningful contribution towards providing better healthcare. This lack of de-motivation was further corroborated by four of the participants choosing to remain employed within the public healthcare sector, as was the case at the time the interviews were conducted.

6.4 In relation to God

In this section I focus on the participants' belief-systems to the extent that their relationship to God had a bearing on their development as doctors. I declare my own bias in this area, unapologetically, to enable the reader to reach their own conclusions (see also pp. 77, 106). Due to my *habitus* as a Christian, I am inclined towards cultivating a positive relationship with God and allowing divine influence and guidance in every sphere of human participation. My personal beliefs and position as a former faith-based mentor to the participants would undoubtedly have influenced my perspective of their relationship to God. It is also possible that participants discussed this aspect of themselves in a particular way because of this pre-existing relationship I had had with them.

As previously discussed in the presentation of data (Chapter 5), Christian beliefs and values had been an important part of all participants' belief systems while they were medical students. During internship their beliefs had shaped their identities and practice in different ways. Clearly these aspects of relating to God are of a highly personal and individual nature; however, there was a sense in which the participants in my study acknowledged that God had a purpose for their lives, which included their professional development.

Philip, Lana and Juanita were particularly explicit about their current relationship with God and how this had influenced their choices and ways of being:

I believe in God and there's the whole Divine order ... my fundamental belief is that God orders our steps. – *Philip*

Philip held a firm conviction that, despite the many obstacles he had faced in his career, God's plan for his life was unfolding. He was unsure whether this plan would ever lead him

to return to clinical practice. However, he felt fulfilled in, and was excited about, his current work, which he viewed as a vehicle to influence healthcare systems and uplift communities around Africa more rapidly than if he had been “just a clinician”.

Lana’s internship COP that overtly upheld Christian values had been a nurturing environment that she appreciated immensely for having shaped the practitioner she aspired to become. She expressed the way she regularly sought God’s will for her life. Even as she currently deliberated whether she needed to specialise or not, her faith was her primary guiding influence:

I wake up one day and I’ll say “What am I supposed to do God?” it’s like I just don’t know (with laughter). – *Lana*

Juanita highlighted a different aspect of her relationship with God while reflecting on the power structures and hierarchy in medicine:

[Referring to some of the Consultants] ... they’re like crazy (laughs), like *power* (loudly, demonstrative gesture) ... fortunately, I think God is on my side ... I’ve never had problems, even with the incredibly difficult ones ... I’ve had one bad incident in my entire training ... I think that’s fairly OK huh, it’s with someone who’s difficult, but in the end we actually got along ... to this day ... I’ll tell her what I think. I mean I resisted things, her opinions of managing our patients ... because I thought what we were doing was wrong. And I think she actually respects me (raised pitch) for that. – *Juanita*

She inferred that her relationship to God had given her the confidence and resilience to take a stand for what she felt was the right thing to do for a patient, even when it had meant opposing a more powerful senior colleague with a reputation for not taking kindly to having their instructions questioned.

When negotiating professional journeys as NQDs, the participants had found their faith and relationship to God to be a source of strength and hope. Ezera’s optimism and refusal to dwell on the negative aspects of the medical profession were also motivated by his beliefs. He did, however, reflexively revise his position of ‘I-as-always-positive’, claiming that “it was not wrong” to disclose the negative aspects as it would have made for a “more honest” reflection.

Philip made reference to patients having “eternal value” and Lana spoke much about the “sanctity” of each life. Gillian, when she had been unable to help a dying patient by calling for the family of that patient, had questioned what kind of person that made her. Ian adopted a somewhat fatalistic attitude regarding patients’ lives, saying: “... you are not in control of peoples’ destinies you are merely an instrument there to aid them ... you cannot save all”. Again, his use of the second person pronoun here indicated a collective voice where Ian identified himself as belonging to a group of medical practitioner vessels engaged in a calling to render medical assistance to patients. These examples demonstrated a link between participants’ beliefs and patient positioning, as previously discussed (see section 6.2.3.1 Patients as work / learning / calling p. 185).

These God-conscious beliefs of participants reportedly prompted them, whenever time permitted, to be more caring individuals and to connect more sincerely with others than if they had held no such values. Their relationship to God also generally caused them to exercise ‘soul searching’ reflection and to construct their identities more positively. They had also deliberately sought what was positive in whatever context they found themselves and faced challenges with God-inspired confidence.

Hermans (Hermans, 2013, p. 87) accedes that for persons “with a religious or spiritual background” consulting a religious image, holy person or a god might take on the meaning of an ‘ultimate promoter position’. My understanding of Hermans’ suggestion in this regard is that, any belief system that acknowledges a ‘higher power’ may give rise to that higher power occupying a powerful promoter position within the self of the believer. Likewise, in the ‘I-as-doctor’ position of the study participants, I found their belief-system had inspired them to achieve a level of dedication to their profession in excess of what they otherwise felt capable of. Self-positioning of ‘I-as-God’s-servant/instrument’ added a dimension of reflection and reflexivity that involved the participants’ beliefs in their clinical practice. In my view this promoted self-enhancement and motivation to achieve the best they could, to counter negative emotional responses in problematic situations, and at times to supersede their natural limitations.

6.5 In relation to family

Practitioners relationships with their families was another crucial if varied factor influencing their learning and identities. The influences of family on NQDs' internship experiences were diverse in the extreme. Not surprisingly, family dynamics were unique to each individual participant, defying any generalisations. Participants' gender and gendered responsibilities in relation to family life were also important factors that came into play, especially for the female participants. Therefore I have presented the female and male participants' experiences grouped separately.

6.5.1 Female participants & family

Gillian was married at the end of the first year of internship and relocated to an internship site nearer to where her husband was located at the time. This enabled her to compare internship experiences across several healthcare institutions. She felt that the two COPs in which she had participated as an intern, had generally lacked suitable mentors for NQDs and she attributed this lack to a preponderance of clinicians serving their own interests, including senior colleagues operating in private practice. After internship, again her primary concern had been proximity to her spouse with regards to a community service post. She described resisting the system almost to the point of refusing to do her community service because the DoH administration initially appeared to disregard her marital status and repeatedly posted her to remote areas of a different province. As a result of her negative experiences, Gillian positioned herself as 'I-as-survivor' of an altogether unaccommodating public healthcare system, which she had no option but to endure through internship.

Lana was not only married during internship but had "fallen pregnant" (in her own words) with her first child. She revealed the most intriguing details of trying to balance her family commitments with the requirements of her medical career. Her internship work became impossible for her to perform in the late stages of her pregnancy, especially the on-call duties for which her colleagues volunteered to stand-in for her. She experienced Braxton-

Hicks contractions, which were probably due to over-exertion, and had to commence maternity leave a month earlier than the due date for the birth of her first child. After her maternity leave, Lana still had to complete four months of internship and was required to “pay back” her on-call duty hours. She was very grateful to her mother-in-law for the dedicated support she received in caring for her infant during this time. A room was made available as a “concession” to accommodate her mother-in-law and baby at her internship site so that she could continue breastfeeding. In addition, as her family was then resident a considerable distance from her internship site, they had travelled to and fro, Lana driving the motor vehicle while exhausted from working shifts lasting 28hrs at a stretch.

Although it had been a longstanding aspiration of hers to specialise in Virology, she wondered if she would be able to balance the requirements of being a Registrar with her desire to give of herself to her young family. A subtle and possibly culturally shaped influence of her supportive role as a wife and mother was evident in her internal conflict regarding whether she needed to specialise or not. Her husband’s position as a Registrar in General Surgery appeared to be given precedence over her own career trajectory:

I don’t do calls. Um, so I don’t see overtime at all ... it is a basic salary, and with [husband’s name] being a Registrar, you know, it would be like the same salary for him for the next four years so to speak. But we are happy. And ... being a Mum, you don’t want to spend more time away from your child than is needed. And I think that was also one of the key reasons why I just decided not to specialise. – *Lana*

Juanita remained unmarried and focused on pursuing her goal of specialising in Internal Medicine. Although she had close ties to her family of origin in Durban, she chose a rural community hospital for her internship site because the temporary period of separation seemed worthwhile for her to improve her practical clinical skills in line with her aspirations. In describing her internship site in a rural setting she conveyed that in her view it was not a suitable place in which to bring up a family. It was rather a place for the young, adventurous and “unhitched” practitioners who went there mainly for the experience they could gain performing surgical procedures in numbers that they might not have had an opportunity to perform at other hospitals situated in urban areas.

6.5.2 *Male participants & family*

Philip's engagement to his future wife during internship had influenced his feelings about being based in a rural area for any length of time, as he was no longer willing to be separated from his fiancée. This was to have career-altering consequences, particularly for Philip who was categorised as a 'foreign doctor' and was hence obligated to spend an additional five years in rural practice if he was to continue practising medicine in South Africa.

Ezera was married during internship and was able to negotiate staying on at the same institution in an urban area to complete his community service on account of his wife. Apart from that, he made no mention of his internship being affected by family relationships.

Ian had chosen his internship site to get as far away from home as possible due to the restrictions he felt were imposed on him while living with his family of origin. He was married after internship and remained in the Western Cape to be near his family-in-law. Another interesting aside Ian noted was that he recalled spending time in the company of children at family gatherings, something that affirmed his eventual choice of speciality as a Registrar in Paediatrics.

Influences in relation to family therefore depended on various choices participants had made; for example, whether to get married or stay unmarried; when to marry, whether after graduation, during, or after internship. Decisions concerning having children, where to live, and whether to specialise or not, also involved their spouses and in-laws in some instances, and had impacted on internship experiences.

Comparing the gendered nature of family relationships, it appeared that the married female participants' identity as a wife and/or mother had to necessarily take precedence over an identity of aspiring Registrar. Gillian expressed this imbalance by categorically stating that she did not know of any female Consultant who was "happily married with children". Where further postgraduate learning was a definite goal, Juanita remained unmarried. However, the male identity as a husband was not nearly as prohibitive or mutually exclusive; in fact it did not seem to conflict with participants' medical career aspirations at all.

6.6 In relation to self (dispositions and aspirations)

As previously alluded to, relational influences were not only with others and with institutions, but also within the self. These inner relations are elaborated on in the following chapter using positioning theory to explain diverse self-positioning and the interactions between positions. In this section I highlight the relevance of participants' dispositions and aspirations, as these were implicated in internship learning and identity construction in a more consistent and enduring manner than any other relational influence. The striking finding with regard to participants' identities was that they each had a certain way of being in the world and in the clinical environment. Each participant had their own specific characteristics: they were inherently relational or reserved, had a propensity for learning languages or not, were exceptionally approachable, academically inclined, or whatever it was that made them unique as persons. Their innate dispositions were not a result of conscious choices per se and at times participants might not even have been aware that they were expressing these traits. Therefore in the narrative data, in addition to what was being told, distinctly characteristic styles of writing and ways of speaking about internship experiences yielded clues towards individual dispositions.

Dispositions that enabled communicating well with others became of primary importance given the highly interactive nature of clinical practice. The nature of interpersonal relationships with various others, as discussed in this and the following chapter, had a bearing on the way participants negotiated learning experiences and their overall internship journeys. Individual aspirations were also a dominant force that influenced participants' choices. However, regardless of NQDs' dispositions and aspirations, much of what they did as interns rapidly became routine and could be considered as contributing towards healthcare services that needed to be rendered due to the nature of clinical work. Whenever learning opportunities arose in the course of their work, or when they were able to align themselves with particular clinician role-models, these choices were motivated by underlying aspirations. Dispositions were seen to sway inclinations to embody the medical profession in particular ways; be it as caring or empathetic practitioners, as efficient diagnosticians, well-rounded generalists or future specialists.

Although previous studies have interrogated final year medical students' aspirations to specialise (Burch et al., 2011), aspirations of participants in this study were found to have been surprisingly flexible at the time of graduation. Many participants described a process of gleaning from mentors and role-models, recognising in others what they wanted to be like. Most also reported that they had been undecided regarding an area of specialisation prior to internship, relying on their experiences of various disciplines during internship to guide their medical career choices. Gillian was an extreme example of such an NQD as she felt she might like to specialise in each discipline in which she commenced a new internship rotation. However, at the time of interview, she was in general practice and unsure if she would ever specialise due to prioritising her family commitments, especially as the expectant mother of her second child. Juanita, at the other end of the spectrum, having set her sights on Internal Medicine from her fourth year of undergraduate study, was possibly the most settled in her choice of speciality.

To conclude this section, considering the interests of NQDs, I found that whatever the context of their internship sites and whatever role-models they encountered in their COPs, they would ultimately search for a space that was a good fit for their dispositions and aspirations.

In summary, the findings discussed in this chapter delved into the various relational influences featured in participants' internship experiences, providing insight into a range of relationships and diversity of interactions that shaped the professional trajectories of NQDs. The associated learning processes and identity construction of NQDs are further interpreted in the following chapter, where the relational influences, particularly with regards to senior colleagues in COPs, have been examined through the theoretical framework of the study.

Chapter 7: Framing Relational Influences in Theory: learning, identity and power relations

7.1 Introduction

In the previous chapter various relational influences that had a bearing on the learning and identity constructions of NQDs were discussed at length. In this chapter, to further interpret the data and enrich understandings of how relationships in the clinical environment enabled or constrained learning opportunities and positive identity constructions, these relational findings are filtered through the five theory lenses as applied in the study (see section 1.5 Introduction to socio-cultural theoretical framework p. 12, and Chapter 3 p.52). Theoretical framing for exploring medical internship experiences employed a combination of socio-cultural learning theories of Vygotsky (1978) and Bourdieu (1988, 1990) with Lave and Wenger's (1991) theories on situated learning and community of practice (COP) pertaining more specifically to workplace learning.

Hermans' (2010) Dialogical Self Theory (DST) was incorporated as an analytic framework to elaborate on the process of identity construction of becoming doctors. To better understand the nature or quality of relationships with various senior colleagues, the application of Honneth's (2007, 2012) contemporary philosophy of recognition and disrespect yielded valuable insight into cultural and ideological aspects of medicine. I have also considered the findings of this study in the light of some prominent and current discourses in the medical education literature and drawn parallels with other socio-cultural studies of internship learning. This study overall has foregrounded the importance of identity construction in the learning processes of becoming doctors. In this chapter I propose how relationships, especially those with senior colleagues, influenced the professional development of NQDs pertaining to the application of expertise in the clinical workplace.

7.2 Learning in the clinical workplace

NQDs in this study echoed the sentiments of medical interns around the world who felt they had been ‘thrown in the deep end’ (Luke, 2003; Prince et al., 2004; Tallentire et al., 2011), suggesting that the commencement of clinical work, regardless of other contextual differences, inherently involves an extensive adjustment. Consistent with learning being intensified during times of transition and when confronted with a ‘disorienting dilemma’ (Mezirow, 1990), NQDs could be considered to experience a liminal phase (Pierce, 2007) when new identities need to be constructed and previous self-positions have to be reassessed.

Also consistent with other studies on internship experiences, participants’ confidence levels were considerably higher at the beginning of their second year of internship (Cameron et al., 2002; Satterfield & Becerra, 2010; Wijnen-Meijer et al., 2012). Although rotating through various clinical disciplines involved a degree of new learning and re-orientating, especially from an organisational culture perspective, NQDs had acquired a ‘feel for the game’ of clinical practice overall and found these transitions less challenging than when they first started internship.

In the following section I discuss the role of the ‘significant other’ in the learning processes and identity construction of NQDs by combining two perspectives I regard as adding different but complementary insight to the study findings; Vygotsky’s internalisation and Hermans’ dialogical self. Although identity construction is recognised as integral to learning, for purposes of organising this chapter I have broadly considered learning, identity and power in relationships as formally separate from each other.

7.2.1 Learning Processes: from “Mind in Society” (Vygotsky) to “Society of Mind” (Hermans)

In Vygotsky’s terms, the development of higher mental functions involves interpersonal processes being transformed into intrapersonal ones, and is the result of a series of developmental events (Vygotsky, 1978, p. 57). He proposed the ZPD, defined as the area between two levels of learning; what an individual is capable of achieving on their own, compared to that which they are potentially capable of achieving with the help of others (see section 3.2.1 A Vygotskian framework for learning and development p. 54). Essentially, the individual constructs new knowledge in relation to others, for example, as adults and educators assist a child to understand new concepts. Learning is seen by Vygotsky as occurring through a profoundly social process, focusing on socially elaborated learning that emphasises dialogue and language: higher mental functions are socially formed and culturally transmitted. The relation between the individual and society is described by Vygotsky as a dialectical process that flows somewhat like a river, sometimes combined with its tributaries, sometimes separate. My interpretation of Vygotsky’s metaphor of a river is that it symbolises the fluidity of thought processes as they alternate between intrapersonal processes (represented by the tributaries) and interpersonal and collective thought (represented by the river). ‘Conversational dialogue’ between two or more persons, which is dialogue at its most straightforward (Rule, 2015), would form the basis of learning relationships. According to Vygotsky, language is the means of reflection and elaboration of experiences. As such it is both a highly personal and a profoundly social human process, and if the tools available to a mind are changed, it would have a very different structure; hence “mind in society” (Vygotsky, 1978, pp. 126-131).

Hermans’ understanding of dialogue is that it goes beyond a productive exchange between individuals to be a learning process where existing ‘I-positions’ are confirmed or further developed on the basis of the exchange. He distinguishes intrapersonal dialogue from ‘inner speech’ in at least four ways: that dialogue is multi-voiced, that voices are not only private but collective, that the other is conceptually included in the self and that dialogue includes non-verbal, embodied precursors of verbalisation (Hermans & Hermans-Konopka, 2010). According to DST, dialogue shifts the self to achieve greater awareness of and integration

between multiple self-positions. Where positioning theory previously made a more distinct separation between self- and other-positions through descriptions of ‘membering’ and ‘othering’ or ‘in-group’ and ‘out-group’ (see section 3.4.1 A case for synergising psychology and social theory through DST p. 68), in DST there is a more gradual progression between the self- and other-positions. The self of each person being multi-voiced and incorporating other-positions (both external and internal), therefore becomes a “society of mind” (Hermans, 2013, p. 84) in that it combines a number of socially informed self- and other-positions. Hermans (Ibid.) further elaborates on the various ways in which these multiple positions may relate to one another, particularly in responding to situations of uncertainty. These diverse self- and other-positions, in different situations and at any given moment, may agree and coalesce, or give rise to inner conflict between opposing self-positions. In both Vygotsky’s ‘mind in society’ and Hermans’ ‘society of mind’ therefore, learning is culturally and socially mediated and the role of the significant other is of primary importance. For Hermans (2013), the meta-position which operates through acts of self-reflection from a distance (similar to an aerial view) is particularly important for learning. Integration or merging of diverse self-positions can be achieved by the development of promoter-positions that enable positive identity development over time. Whether interpersonal and intrapersonal interactions are seen to achieve transformation through favouring the confrontation of contradictions to find areas of commonality (dialectical) or more harmonious exchange between interlocutors (dialogical) processes, they do involve relationships. The essential process of socio-cultural learning may be viewed as “diacognition”, defined as “coming-to-know through a situated process of positioning and repositioning in dialogical exchange with oneself and others” (Rule, 2015, p. xxiii).

7.2.1.1 *Development of clinical skills and clinical reasoning*

In medical education, the importance of concrete operations (clinical skills) in which graduates must be competent cannot be marginalised, and they also contribute to positive identity constructions. In efforts to evaluate what medical graduates are able to do (measure competencies deemed necessary for residency or internship), the concept of Entrustable Professional Activities (EPAs) has recently been developed (Association of

American Medical Colleges, 2014). EPAs aim to integrate professional competencies with affective and professional values-based development (O. Ten Cate, 2013). In a publication of the AAMC (2014) various behaviours typical of EPAs are listed, allowing assessment of learners as either 'pre-entrustable' or 'entrustable'. EPAs are defined as units of professional practice, implying that it is a stage of development in authentic clinical practice situations that should be evaluated rather than indicators purporting to measure finite qualities of learners or evaluate static 'products' of a curriculum. Therefore EPAs may offer a more holistic way of assessing NQDs' capabilities than previous checklists that were meant to represent competencies in postgraduate medical education (see section 2.2.4 Competency approach in medical education p. 28). EPAs therefore also allow for potential development that takes place *after* graduation, during internship, when NQDs take on responsibility for patients, experience the uncertainties of medicine first-hand, encounter the practicalities of the clinical environment, and construct new identities. The term 'entrustable' is also inherently relational. It implies that someone (a senior colleague) has recognised someone else (in this case an intern) to be worthy of trust, and is therefore entrusting them with doing something (clinical management) for someone (a patient). It implies that the value of trust should be the basis of professional relationships that manifest in activities.

The findings of my study supported NQDs' claims in general that much learning takes place during internship (Bearman et al., 2011; Sheehan et al., 2012); the kind of learning that is only possible in the context of clinical practice. Participants retrospectively positioned themselves as 'pre-entrustable' learners on many counts when they had initially transitioned to internship. However, they rapidly grew in confidence and competence through their workplace learning and while being with more experienced and helpful others. Through a process of observing senior colleagues as they performed and modelled clinical procedures and clinical reasoning, interns were able to move from a position of 'I-as-inexperienced / ignorant' to one of 'I-as-capable / knowing'. In terms of positive identity development, they had thereby gradually owned the external other-position representing expertise and mastery. Through gaining their own experience of procedures, they progressed to a position of 'I-as-confident clinician'. Considering these shifts of self-position in terms of situated learning in COPs, this progression would imply that appropriate

opportunities to engage in legitimate peripheral participation (LPP) had been available to interns. These LPP engagements had then enabled them to move in a centripetal direction towards fuller participation in their COPs (Lave & Wenger, 1991).

Informal and implicit learning from others, shown to be of primary importance in the early career learning of several other professions (Eraut, 2007; McNally et al., 2009), was also found to dominate medical internship experiences. The development and application of clinical reasoning was a particularly important area of such learning for NQDs. They reported that, as novice practitioners, they had relied on a deductive and analytic process of clinical reasoning that was more time-consuming at the outset. Their thinking had involved an exhaustive list of differentials (possible alternative medical conditions) which then had to be narrowed down to a 'most likely diagnosis'. There are empirical findings to demonstrate that developing expertise in clinical reasoning involves greater reliance on first impressions and non-analytic processes of pattern recognition and intuition (Ilgen et al., 2013). Participants in my study as inexperienced 'new comers', compared themselves to 'old timers' (Lave & Wenger, 1991) and similarly judged that their reliance on analytic thinking was the most likely explanation for NQDs taking longer to conduct patient interviews than more experienced clinicians:

... sitting paired up with one of the senior guys, they'd immediately begin to talk to a patient and class them into a disease profile ... My interviews were usually very broad ... I guess retrospectively ... I realise that I just ... tried to consider too many options. – *Ezera*

Experience is the best teacher and I think it became easier to 'make differentials' as I saw more patients and learnt from colleagues and Consultants as *they* managed patients. – *Juanita*

In my view such modelling by senior colleagues represents a classic illustration of the 'scaffolding' of Vygotsky's ZPD in operation, where NQDs' problem solving (or clinical reasoning) capabilities were at the 'bud/flower' stage of development at the commencement of internship. The senior practitioners in COPs demonstrated more advanced problem solving capabilities: their practice of clinical reasoning represented the 'fruits' of development, and what the NQDs would soon be capable of doing independently. Whether these expert capabilities were achieved through automatic pattern recognition or

analytic reasoning or a combination of both (Ilgen et al., 2013), the learning processes of NQDs while developing expertise was found to be more complex than 'seeing and doing' which was the process most commonly linked to the learning of technical clinical skills. The level of potential development of clinical reasoning required a prospective view of functions "not yet matured, but in the process of maturation" (Vygotsky, 1978, p. 86). In order to reach their actual developmental level, undergraduate medical education was pre-requisite, but to reach the stage of capability observed in the senior clinicians' consultations, experiential learning while 'being with' (Sheehan et al., 2012) more experienced professionals was regarded as essential. Sheehan et al. (2012) elaborate on the concept of being with others in the context of medical internship; suggesting that it includes not only the physical presence and direct observation of others, but also the use of protocols, tools or procedures previously developed by other medical practitioners, which might form part of a repertoire of "boundary objects" (Wenger, 1998, p. 105) of the profession. The focus of the New Zealand-based study was the supervision relationship. However, the implications of different senior practitioners' 'ways of being' and how these would influence the nature of relationships with colleagues was not discussed. The narrative data of this study were useful for illuminating this aspect of different clinician models as represented, and how learning opportunities and possibilities for positive identity construction were enabled or constrained by them. I discuss this further in the following sections, first applying Hermans' positioning theory, and then Bourdieu's theorising on *habitus*, capital and field, to gain insight from two different approaches, into the identity constructions of NQDs.

7.3 Identity and ways of being in clinical practice

7.3.1 *Modelling clinical practice*

While moving towards fuller participation in COPs, NQDs were found to be in crucial relationships of learning mostly with senior colleagues, whether their support and supervision was made directly available to the participants or not. In my view, clinicians were found portrayed in ways that were not only positive or negative, helpful or indifferent, but also in ways that participants had hoped, assumed or imagined them to be. This finding corresponds well with Hermans' ideas about personal position repertoires (Hermans, 2001; A. Kluger, Nir, & Kluger, 2008) consisting of other-positions being appropriated in the self, where the other-positions might be real, anticipated, remembered or imagined (Hermans, 2012, p. 9).

The significance of the various projections of senior clinicians' identities in the narrative data was that their ways of being and practices were implicated as either enabling or constraining NQDs in their learning opportunities and positive identity constructions. Specific other-positions being ascribed to senior colleagues represented how NQDs had experienced being with them in the clinical environment. The various models of clinician as discussed in the previous chapter are listed in the table below (Table 3: Models of clinician), in relation to the identity construction of NQDs:

Table 3: Models of clinician

Models of Clinician	
Enablers / Promoter positions	Constrainers / Anti-promoter positions
Caring (self-sacrificing) doctor	Power misuser / abuser
Excellent generalist	Self-interested senior
Supportive supervisor	Contextually toughened (tough-nut) clinician
Comrade CSO	
Professional researcher / scholarly clinician	
Medicine's 'Greats'	

Enablers included the 'Caring (self-sacrificing) doctor', the 'Excellent generalist' and 'Supportive supervisor' models. Community Service Officers came to the rescue when more senior colleagues were absent or unhelpful; and several narratives made reference 'Medicine's Greats' who inspired NQDs. The constrainer models did not inevitably translate to damaged identities; it depended on whether NQDs had recourse to resist them, individually or collectively.

7.3.1.1 *Covered or exposed*

To further interpret how participants experienced being with these various models of clinician, there was a recurrent theme found in participants' discussions of the support (or inadequacy thereof) made available to interns. The degree of support available could also be productively viewed from the perspective of participants feeling either 'covered' or 'exposed' in their work of managing patients and during their development as professionals. The concept of being covered primarily involved NQDs feeling safe from any harm or damage to their identities, which included being safe from harming others. For example, NQDs needed to be shielded by the 'other-as-supportive supervisor' from taking on responsibility before they were ready. In this sense Lana felt that NQDs were "safe" in her COP as they were valued as novice practitioners and assured of adequate supervision and guidance while gaining experience. The exemplar from Lana's narrative where she was allowed to perform a surgical procedure under the direct supervision of a Surgical Consultant was an experience that had enabled her to adopt positive self-positioning such as 'I-as-valued part of a team', 'I-as-capable', 'I-as-trusted' and 'I-as-mentored'. On the other hand, Ian had felt vulnerable and exposed when expected to independently perform an obstetric procedure while he was not confident to do so and which had a devastating outcome. Despite being reassured by the Head of Department that he had done everything he could have done, Ian's self-positioning following this critical incident was extremely negative, including 'I-as-ashamed', 'I-as-incompetent', 'I-as-resentful' and 'I-as-damaged/crippled'. He alluded to using numerous skills training courses "as a crutch".

Revision of these negative I-positions was not an easy process and had required the assistance of a discerning senior colleague who intervened to restore a positive course to Ian's self-positioning. It is interesting to note that the 'other-as-mentor' in this instance could be seen to have 'covered' Ian by paradoxically 'exposing' his fears and challenging him to overcome them by performing the obstetric procedures that Ian had strategically been avoiding. It had taken a special way of being on the part of this senior colleague to ensure that Ian gained the experiential learning needed to restore his self-positioning to 'I-as-confident', 'I-as-competent' and 'I-as-trusted'. The 'Supportive supervisor' in this case was positioned as the 'other-as-concerned' and the 'other-as-healer / restorer' of Ian's identity.

Any conditions that led to possibilities of interns being reprimanded, ridiculed or inadvertently implicated in malpractice were considered to expose them. Therefore, apart from a lack of personal commitment to the supervisory role, NQDs were also exposed (to harm or damage) by seniors being too busy with their clinical duties, exemplified by the 'Contextually toughened clinician' model. A lack of resources, facilities, or time, leading to compromised or delayed medical management of patients, compounded by the overburden of disease, could also be seen as causing interns to feel exposed.

The notion of being covered or exposed could also be extended to include some contextual factors, including prior learning, that were not directly associated with adequate supervision or support for NQDs. For example, the context of medical hierarchy was considered as providing some cover for NQDs by Philip and Ezer, in that NQDs were absolved from any blame for negative patient outcomes, as long as they had consulted a senior practitioner or had followed due process in adhering to appropriate referral protocols. Being with senior colleagues whose values were consistent with ethical conduct was also a contextual example mentioned by Lana that was linked to NQDs feeling covered, or to use her own words "not exposed to any kind of malpractice". Feeling adequately prepared by the undergraduate curriculum for particular aspects of clinical practice, such as reported by Juanita, Ezer and Gillian when they independently commenced patient interviews, had led to positive identity constructions such as 'I-as-competent', 'I-as-knowledgeable' and 'I-as-confident' and 'I-as-trustworthy'. Therefore there was also a sense in which NQDs felt covered by being adequately prepared (or conversely exposed if underprepared) for aspects of clinical practice by the undergraduate curricula they had experienced.

7.3.1.2 *Positive ‘other-positions’ based on practice*

Apart from the personal ways of being described above, positive attributes relating to the work of clinicians were also used to position senior colleagues. For example the ‘excellent generalist’ models that Gillian and Lana admired and aspired to be, positioned the other-as-adaptable / flexible, able to transition seamlessly between very different activities and applications of knowledge. The ‘Professional researcher’ role-models encountered by Lana had also enabled possibilities for her to later develop a self-position of ‘I-as-clinical researcher’. In retrospect she appreciated that encountering these clinicians during internship as they presented their research had influenced her own career path.

Finally the collective other-position described as ‘Medicine’s Greats’ was a somewhat different category that appeared to be primarily seated in the imagination of participants. These models of clinician, relating to the work ethic of real, remembered, or imagined others, were appropriated first as the external-other-in-the-self, then as the internal-other-in-the-self. They gradually assumed internal promoter positions; a source of inspiration and having a voice that spoke mostly to the aspirations of NQDs. These enabling other-positions, symbolic of masterful skill, dedication and integrity within the profession, represented to various degrees the models of clinician that participants hoped to become.

7.3.1.3 *Repertoire of possible ‘I-positions’*

From the findings of this study regarding the clinician models discussed above, it appeared that the various clinicians’ ways of being within COPs offered NQDs a repertoire of diverse possibilities for self-positioning. By intentionally and deliberately extending or strengthening some of these possibilities of I-positions, it should theoretically be possible to bring about positive change in existing systems. This suggestion is not made as a means to control the environment, the variables were too numerous to make the prediction or control of participants’ situations in clinical practice a feasible option. However, as an adaptation of Hermans’ concept of a Personal Position Repertoire (PPR) based on DST, (Hermans, 2001; A.

Kluger et al., 2008), I would like to suggest that NQDs are able to selectively own or oppose particular I-positions, as illustrated in the diagram below:

Figure 5: Repertoire of I-positions



I would suggest that the current repertoire of possible positioning is limited by the culture of medicine as an establishment, by the organisation of internship work, and by the ways of being of senior colleagues in COPs. Hermans (2013) notes that, as other people are represented in the dialogical self, confrontations and conflicts between a multiplicity of voices causes the self to be open to initiative, for construction and reconstruction, and to the innovation of positions. The findings of my study demonstrated how this process took place in and through relationships with significant others (both individuals and organisations) in the clinical environment. My understanding is that for effective change to take place in various problematic areas associated with medical education and practice, such as an unacceptably high level of stress during internship and a prevalent lack of patient-centredness, the ideology and culture of medicine would need to be transformed. In conclusion, my interpretations from this study lead me to suggest that new possibilities for identity construction are needed. The strengthening of existing positive influences for NQDs to construct their identities differently seems to be a reasonable starting point towards achieving transformation.

In the following section Bourdieu's concepts of *habitus*, capital and field provided a set of lenses for viewing identity from historic, social and cultural perspectives. This was useful, especially as I argue in the following section that the various ways of being of doctors

influenced the quality of relationships in the clinical workplace, and somehow a collective *habitus* and culture were reproduced.

7.3.2 *Habitus, capital, and field in negotiating internship as ‘fish-in-water’ or ‘fish-out-of-water’*

As NQDs transitioned to clinical practice environments, they became integral to complex networks of relationships as discussed previously. From Bourdieu’s perspective, depending on their individual *habitus* and various forms of capital they had at their disposal, NQDs were able to ‘play the field’ of the social structure of clinical practice quite differently (see section 3.3.2 Bourdieu’s theorising: *habitus, capital and field* p. 62). Bourdieu credits his concept of *habitus* with transcending “dualistic vision” that acknowledges only the “self-transparent act of consciousness or the externally determined thing” (Bourdieu, 1990, p. 56). Working as accumulated capital, *habitus* gives rise to the “real logic of action” by bringing together “two objectifications of history, objectification in bodies and objectification in institutions” (Ibid p. 57). In applying these ideas to clinical medicine, Bourdieu’s (1988) thesis on academic faculties elaborates how clinical educators and practitioners of his day claimed their practice was an “art of applying knowledge ... inseparable from an overall manner of acting ... or *habitus*” (p. 57). Bourdieu proceeds to insightfully critique the social structure of medicine where knowledge of underlying pathophysiological mechanisms is subordinated to the essentially practical medicine of clinical reasoning for diagnosing medical conditions (Ibid.).

The diverse manifestations of social and cultural capital found between participants could also be viewed in Bourdieu’s famous terms of being “fish-in-water” or “fish-out-of-water” (Bourdieu & Wacquant, 1992, p. 127) depending on whether an NQD’s *habitus* was in sync or at odds with their COP. An NQD’s *habitus*, being the product of history, upbringing, as well as educational and life experiences, was found to come to the fore, particularly when they encountered challenging situations in their COP. A clear illustration was the contrast between Ian and Philip in responding to their predominantly Afrikaans speaking

environments. Ian was presumably able to access some linguistic capital he had banked from his early education and responded with determination to master the unfamiliar language sufficiently to communicate with patients and colleagues. He therefore began his internship journey as a fish-out-of-water, but became a fish-in-water. Philip had no prior learning of Afrikaans and in any case had no disposition for learning new languages, thus his (linguistic) cultural capital could be considered to be of a low level. His response to having his learning needs ignored was to withdraw and engage in activities that were unrelated to medical internship, such as his studies towards an MBA, sleeping, or socialising. However, Philip's considerable intellectual or academic capabilities came to the fore in an English-speaking organisation during his rotation through Internal Medicine where he was recognised as a suitable candidate for specialisation. Therefore, although he was a fish-out-of-water in most areas of his COP, he became concurrently a fish-in-water in a particular domain.

Lana could be considered as having exceptionally high levels of social and cultural capital matching her COP. She was clearly a fish-in-water as her beliefs and values were fully congruent with her environment. Bourdieu refers to this condition as 'ontological complicity' where a person simply "needs to be what they are in order to be what they have to be" (Bourdieu, 1990, p. 11). Consequently Lana enjoyed the support of colleagues and found several mentors and role-models. Her *habitus* was possibly the best match within a COP of all the participants, particularly as her predilection for research had been nurtured during internship, which came to fruition in her current work.

NQDs were also covertly or implicitly evaluated for the outworking of capitals. For example, Lana was aware that senior colleagues in her COP drew comparisons between interns according to the various undergraduate curricula interns had experienced and the educational institutions they had attended. However, she dismissed this as being something that she was well accustomed to, from belonging to a pioneer cohort of a PBL curriculum. She declared that she was confident that her diligence and commitment to her work would be recognised above anything else.

Juanita could be considered to be another fish-in-water in respect of her capacity (and predisposition) to immerse herself in her internship work. She was able to capitalise on the

many learning opportunities presented to her in her internship COP, which she viewed as having enabled her to fulfil her aspiration to specialise in Internal Medicine. Her busy rural practice environment, however, possibly represented the most turbulent of waters, as there were many potential hazards in being expected to take on a greater than usual degree of responsibility that she described. I was therefore cognisant of the fact that although Juanita was able to thrive due to her individual *habitus* and high level of economic (educational) capital, less accomplished NQDs being placed in the same environment might easily have been overwhelmed to the point of causing damage to their professional identities. Consistent with Bourdieu's notion of *habitus* being largely unintentional, Juanita seemed oblivious to her having any advantage or special disposition, taking for granted that everyone was equally excited about the "adventure" presented by her context.

Ezera was able to negotiate positive learning relationships in his environment overall; his *habitus* and capitals were therefore adequate for him to 'play the field' and successfully complete his internship. His environment, however, also seemed to pose several challenges to NQDs. He found himself left in situations where there was inadequate support and supervision. He also encountered particularly self-interested seniors (see section 6.3.1.8 Self-interested senior p. 198) who presented a potential threat to his identity, as they could be considered to have exposed rather than covered NQDs.

Gillian had found supportive CSOs in her COP who came to her aid when she encountered unhelpful seniors. Like Ezera, she reported having been able to adapt to various disciplines sufficiently to enjoy her internship learning. However, she had also found herself swimming against the current, so to speak, where she discussed her struggles to survive, lamenting the lack of suitable mentors and role-models in her context. Therefore Ezera and Gillian were more aware of the power struggles associated with having to 'play the game' during internship. In my view their experiences were not clearly definable as fish-in- or fish-out-of-water. Perhaps they had to learn to swim comfortably through a much more unpredictable and turbulent body of water than they had expected to face or had previously experienced. What enables NQDs to learn this art seems to be a combination, in different proportions according to the context, of their own personal qualities (*habitus*, capitals and aspirations) and the support they receive from others, which develops positive identities as medical professionals. In addition to the propositional and experiential knowing that is required for

‘knowledgable skill’, there also seems to be a ‘strategic knowing’ of how to manage contexts and relationships.

Ways of being of both NQDs and senior colleagues had enabled opportunities for LPP through relationships of reciprocal respect. Relationships of recognition (of needs, beliefs and abilities) in clinical contexts were therefore intimately linked to the positive identity constructions of NQDs. Conversely, in the following section I illustrate this point further by presenting how the opposite of mutual respect and recognition (disrespect) featured in the participants’ experiences.

7.3.3 *Disrespect*

Being disrespected, according to Honneth (2007, 2012) involves having ones needs, beliefs and capabilities disregarded. Self-centred motivations and tending to take advantage of others, were found to evoke disrespect and constrain positive self-positioning of interns. For example, the ‘Power misuser / abuser’ and ‘Self-interested practitioner’ models of clinician deprived interns of opportunities for LPP due to the absence of positive role modelling resulting from their ways of being. These models of clinician, being focused on their own gains or professional advancement, were reported to have exerted their superior status by overburdening interns with levels of responsibility greater than they were able to handle, or by expecting them to perform more than their fair share of tedious duties. Gillian’s encounters with unhelpful seniors for instance had led to self-positioning such as ‘I-as-undermined’ and ‘I-as-used / abused by others’.

It should be noted that experiences of disrespect did not lineally and inevitably lead to damaged identities. However, at least initially, possibilities for positive identity construction were hindered. Where participants were sufficiently empowered to resist disrespect and/or abuse of power, either immediately or later on in their professional development, they were also able to transform their immediate clinical environment. By opposing anti-promoter other-positions, overtly (confrontationally) or covertly (behind the scenes), they demonstrated acts of resistance and awareness of their own influence and agency to effect

change within institutions and the broader healthcare system. This was possible even from the lowest levels of medical hierarchy (see section 6.3 In relation to internship COPs, Figure 4: Levels of medical hierarchy p. 189). According to Gillian's narrative, for example, solidarity developed amongst her peers as they began voicing their intolerance of unhelpful senior colleagues. Ezera reported being mindful of his strategy of "blurring the boundaries" between himself as a Registrar and the interns he currently supervised, with the intention of being more approachable than some of the senior colleagues he had encountered in his internship COP. Gillian and Ezera had both assumed positions of 'I-as-influencer / change agent'. While Gillian's response had been a collective stand together with other NQDs during their second year of internship, Ezera's act of resistance had been an individual act of resistance some time later. However, they could both be seen to resist and oppose the 'other-as-unsupportive senior colleague' in their respective I-positions that deliberately challenged the status quo.

Juanita recounted an incident when she had confronted a senior clinician who was "known to be difficult" regarding a clinical management plan, because she felt she had to "do the right thing for a patient". In this encounter Juanita could be said to have openly adopted an 'I-as-assertive' self-position, one that was understandably not common for junior doctors to assume, and had achieved a satisfactory outcome.

However, experiences of disrespect generally held more possibilities for damage to the identities of NQDs, such as Ian's undergraduate experience in Obstetrics and Gynaecology and Philip having his learning needs and capabilities ignored due to a prevalent cultural inflexibility in his COP. The knowledge that there was an "expiry date to internship", to quote Philip, was a source of encouragement to endure conditions that were far from ideal. Therefore, there were situations where NQDs chose to tolerate the status quo, mainly because they did not have the recourse to resist for whatever reason, but also when they judged that it was not worth the effort it would take them to 'fight the system'. Whether they were active or passive in their responses, being subjected to disrespect was unlikely to leave NQDs identities entirely unscathed.

7.4 Power and relationships

Power asymmetries appear to be inherent in the daily practices of clinical teaching at the bedside of patients (Rees et al., 2013), unavoidably affecting the nature of relationships in the clinical work environment. In this section I describe some trends observed in the data relating to power flows in relationships that influenced the learning processes of NQDs. As previously discussed in this chapter, theoretical framing incorporating situated learning in COPs was an appropriate way of evaluating LPP and the learning trajectories of NQDs. Bourdieu's theorising on *habitus*, capitals and field, and Hermans' DST added further insight into the experiences of NQDs and how their identities had been shaped during internship. However, an additional lens was needed to better understand and theorise the nature of learning relationships in clinical contexts. For this purpose I employed Honneth's contemporary philosophy about recognition and disrespect as discussed below.

7.4.1 *Patterns of recognition or disrespect in power dynamics of medical culture*

In Honneth's (2007, pp. 71-75) theorising, he distinguishes three forms of social recognition that may exist in any society: emotional concern such as love or friendship; rights-based recognition as a morally accountable member of society; and social esteem of individual abilities and achievements (see sections 2.4.2.1 A multi-disciplinary theory of relationships p. 42 and 3.4.3 Relationships and identity construction p. 72). The manner in which a particular society constitutes its framework of recognition can be explained by analysing institutionalised embodiments of these patterns of reciprocal recognition. Therefore in this section I endeavour to examine the patterns of relationships experienced by the NQD participants of this study in clinical work environments. Trends and incidents that were perceived as disrespect (involving the denial of recognition), as they pertained to medicine as an establishment, added further insight regarding how a particular framework of recognition is constituted within internship COPs in South Africa.

The narratives of participants in this study implied that NQDs had received no lack of the rights-based form of recognition of Honneth's schema, which was afforded them for having

achieved the pre-requisite professional qualification. In some other contexts, particularly in first world countries, interns reported being relegated to a very low status in their internship COPs and being overloaded with paperwork and administrative duties (Bearman et al., 2011; Luke, 2003). However, South African NQDs in this study consistently experienced the challenges of excessive responsibility and were expected to independently deal with overwhelming volumes of patient cases. When interns lacked the necessary experience and confidence to meet such demands, were denied adequate supervision and support, or became exhausted by the overburden of disease, these could be viewed as forms of disrespect.

I have argued that, under such conditions, interns had their needs, beliefs and abilities ignored, as they were constrained in learning opportunities and possibilities for positive identity construction, which was paramount to being disrespected. This disrespectful condition was perpetuated by individuals, by institutions, the healthcare system and by medicine as a rigidly hierarchical establishment, inclined towards hegemonic behaviour as corroborated by others (Apker & Eggly, 2004; Schryer et al., 2003). I found the participants in my study generally accepted these practices and power flows, viewing them as inevitable norms of the medical profession. For example, the hierarchy of medicine was judged by Ezera and Philip to be “everywhere” and was considered to be a “good thing” by which interns were “covered”. In Lana’s specific internship experience, having to rush around attending to medical emergencies while she was heavily pregnant, there was little consideration possible for her own wellbeing. Also in the requirement that she “pay-back” on-call duties after maternity leave by working 28-hour shifts, she deemed the situation to have made her life “crazy”, but conveyed this situation as a necessary evil. She seemed even grateful for the “concession” of a room being made available by the institution to enable her to breastfeed her infant. However, from my ‘outsider’ perspective, Lana’s situation at the time went beyond ignoring her needs, and could be construed as an example of inhumane and negligent labour practice where interns may well be described as “slaves of the state” (Erasmus, 2012, p. 655).

Even after internship there were examples of systemic disrespect in that participants reportedly continued to have their needs, beliefs and abilities ignored. Gillian, for example, had to “fight with the DoH” for a Community Service placement that did not force her to live

separately from her husband. Philip being categorised as a ‘foreign doctor’ and being required to spend a further five years in rural practice was also an example of disregard for a medical practitioner’s needs and capabilities at a systemic level. This apparently bureaucratic interpretation of regulations, which were intended to prevent ‘poaching’ of medical graduates from other African countries, had contributed to Philip leaving clinical practice altogether.

The form of recognition Honneth categorises as being based on acceptance and friendship seemed less ubiquitous in the data, but it was visible, especially amongst peers, CSOs, nurse practitioners, and some senior colleagues who explicitly valued interns. Gillian for example found “camaraderie” and support amongst the CSOs when more senior colleagues were absent or unhelpful. Her cohort of interns also bonded together against a ‘common enemy’, as previously discussed. Ezera described the recounting of “war stories” and “battle scars” amongst his off-duty intern colleagues. In Lana’s narrative the nurse practitioners in her COP provided encouragement and support when she initially had to face the task of breaking bad news to a patient’s family. Lana’s peers had also “covered for her” by taking on additional on-call duties when she became incapable of performing them in the late stages of her pregnancy. The Consultants in Juanita’s and Lana’s environments had reportedly valued their contributions and guided them in ways that enabled them to develop positive identity constructions. Ian also conceded in retrospect that most seniors had been supportive in his context, enabling his development as though he was “in a cocoon” during internship.

As interns are generally regarded as junior doctors, the third form of recognition in Honneth’s schema founded on honouring a person’s achievements (see section 3.4.3 Relationships and identity construction, Table 1: Honneth’s three forms of reciprocal recognition p. 74), was understandably not commonly expressed within internship COPs. There was perhaps a hint of it in Philip’s story of him being invited to return as a Registrar in Internal Medicine, and later on being sought out by patients at a community clinic where he was based after internship. However, during his internship, Philip being denied the opportunity to understand academic discussions in several Afrikaans-speaking disciplines, or experiencing rejection from a patient’s mother for being of a different ethnic or racial background, were further examples of overt disrespect at organisational and interpersonal levels.

The relatively subtle constraints imposed by self-interested colleagues, highlighted by Ezer and Gillian, appeared to be relatively commonly encountered, whereby NQDs felt ‘used and abused’. In some ways this pattern of disrespect could be considered to be a more widespread erosion of internship learning than the overt abuses of power discussed above, as NQDs were denied adequate support on a continued basis. In particular disciplines, interns were also used for copious specimen taking and administrative duties for the convenience of seniors, as detailed by Gillian. This practice also diminished NQDs’ chances of engaging in meaningful learning opportunities for their professional development. NQDs’ needs as learners and novice practitioners were therefore found to be inconsistently recognised and supported, which led to variable experiences during medical internship in South Africa.

7.4.2 Shaped by and shaping influences

Participants did have a sense of their influence on the clinical environment and most of them held personal convictions that desired a better healthcare system. However, the power distances in clinical practice, and the organisation of the healthcare system in South Africa, generally appeared to render NQDs powerless to actively shape the system to any great extent. Participants tended to position themselves as having a shaping influence on their immediate environments and especially at the level of interpersonal relationships in their COPs. In this section I consider how Bourdieu’s (1990) elaboration of *habitus* as “... structured structures predisposed to function as structuring structures ... principles which generate and organise practices ...” (p. 53), serves to illuminate the culture of medicine as an establishment. These views seem to provide possible reasons for the replication and perpetuation of some previously described problematic issues pertaining to internship.

Habitus brings to bear an individual’s entire life history up to that point on their practices and therefore the possibilities are infinite, yet their *habitus* and practices (individual and collective) are shaped and limited by the institutional *habitus* of social structures to which they belong. Bourdieu uses the analogy of witticisms to further illustrate his concept of *habitus* (Bourdieu, 1990, p. 57). Witticisms have an impact through both their

unpredictability (originality) and retrospective necessity (inevitability), creating history, and essentially being created in interaction with others. To my understanding the process of (per)forming a successful clinical encounter in terms of *habitus* is remarkably similar to what makes a witticism amusing. However, according to Bourdieu, “medicine is a practical science whose truth and success interest the whole nation ...” therefore it is certainly no laughing matter. By the same logic Bourdieu adds that “the very exercise of the clinical act implies a form of symbolic violence” (Bourdieu, 1988, p. 63), explaining that the application of clinical reasoning in each patient case is dependent on verbal and physical ‘indices’ being contributed by the patient in the form of solicited medical history as well as physical signs and symptoms. However, the clinical reasoning process takes place within a “dissymmetrical social relation” where the clinical expert imposes their own cognitive presuppositions on the patient’s “spontaneous discourse” translating it into the “codified clinical discourse” of medical practice (Ibid. p. 64). Therefore the power flows in medicine form an unavoidable backdrop for every clinical encounter and contribute to the perpetuation of medical culture, albeit with individually and contextually innovative realisations.

7.5 Conclusion

To summarise this chapter, theoretical framing was used to add insight to the learning processes and identity constructions of NQDs in relation to significant others in the clinical workplace. Patterns of recognition and/or disrespect were described as found in the context of internship in South Africa, and the power flows being extrapolated from the study suggested a possible explanation for the enduring culture of medicine as an establishment. In the concluding chapter that follows, I use the interpretations and discussions of findings to answer the key research questions as posed by this study. I reflect on my learning from conducting the study and consider ways in which this study of medical internship has generated theoretical and philosophical understandings and insight into learning to become and to be doctors.

Chapter 8: Conclusions and new insight

8.1 Introduction

In conducting this study, it was a better understanding of medical internship experiences that I sought from the retrospective views of fully qualified medical practitioners. Focusing on the learning processes and identity constructions during this impressionable stage of professional development became my narrative research endeavour. From the initial analysis of the data, relational influences emerged as an area that was of primary importance to NQDs; this was confirmed and elaborated on by further analysis through lenses of recognition and disrespect. I also used an analytic framework of psychosocial theory that proposes a dialogical relation between self-positions in identity constructions. This enabled inferences and theoretical suggestions regarding the potential contribution of significant others to early career learning in the clinical workplace.

In this concluding chapter of the thesis, I distil the findings of the study as relevant to each key research question as listed in the introductory chapter (p. 9). Reflecting on the insight that was gained from the study, and recognising the small-scale nature of the study and limitations on generalisability, I highlight some of the ways in which theoretical and methodological boundaries have been pushed by new knowledge generated. I acknowledge that It is through connecting narrative knowing to appropriate theoretical framing, and convincingly locating this study in relation to prevalent discourses and wider studies using different research methodologies (Clandinin, 2007), that the moderate generalisations and deeper understandings were enabled.

8.2 Research question one: What learning processes are evident in medical practitioners' reflections of their internship experiences?

In terms of situated learning, for the NQDs who participated in this study, it was apparent that there was minimal formal structuring or prioritising of learning opportunities during

their medical internship in South Africa. Learning processes were found to be mostly informal in nature and highly dependent on various helpful others present in the clinical workplace at internship sites. The daily work of interns, attending to patients and providing primary healthcare, was the basis of continual learning through practice. Evaluating patient-cases and making clinical diagnoses and management decisions, including when to seek assistance or refer patients to senior clinicians, gave NQDs the experience they needed to develop expertise and confidence as clinicians. Most learning opportunities in internship COPs were found to be negotiated by the participants as serendipitous by-products of the work they were formally required to undertake.

A period of adjustment and familiarisation was experienced when NQDs first transitioned from medical school to the clinical workplace; even the most capable of NQDs narrated a degree of liminality and a decrease in self-confidence during this time. With the guidance and support of helpful others in COPs, participants grew rapidly in their confidence and self-reported competence. Transitioning between disciplines subsequently became easier, and by the second year of internship some participants reported advising new graduates, particularly with regard to interpersonal and cultural knowledge relating to their COPs.

A Vygotskian view, especially applying the ZPD (Vygotsky, 1978), was helpful for understanding the development of clinical reasoning skills, primarily attributed to 'being with' more experienced senior colleagues (Sheehan et al., 2012). In close observation of experienced clinicians as they interacted with patients, NQDs learned a process of immediate and selective accessing of specific areas of prior learning. They developed the art of diagnosing patient cases more rapidly (the fruit) than by a novice's typical process of eliminating differentials, which relies purely on deductive reasoning (the buds) – (see section 7.2.1.1 Development of clinical skills and clinical reasoning p. 213).

The most salient insight gained from the study, concerned the importance of personal aspirations, individual and collective dispositions, and various relationships as they pertained to internship learning within COPs. Doctors are usually characterised by their expertise; however, in this study, a range of relational influences were highlighted that impacted on the learning processes of NQDs (see Figure 2: Relational influences p. 171). It was in and through these relationships, especially with senior clinicians, that interns were

able to negotiate learning opportunities aligned with their dispositions and aspirations. Therefore the nature and quality of participants' relationships – intrapersonal, interpersonal and with organisations – became the primary focus of the data analysis, inferences and interpretive findings.

A COP was found to comprise a microcosm of medical culture at large, but also having characteristic collective ways of being that were typical of local contexts. The congruence of an NQD's *habitus* with their environment, and their possession of capitals that were valued in a COP, came into play when they negotiated learning opportunities and progressed towards fuller participation. Using LPP as a theoretical position, as intended by Lave and Wenger (1991), illuminated the progress of interns along transformative learning trajectories (see section 3.3.1 Situated learning, COP and LPP p. 58). As NQDs participated in very different activities, and were engaged in clinical practice quite differently depending on their context, the notion that 'all activity is learning', which is linked to LPP, was a useful way to think about the changes of perspective taking place across all participants' journeys. Similarities and divergence became clearer by comparing participants' experiences, highlighting a need for more supportive supervision during internship learning in South Africa. Tracking learning trajectories towards fuller participation further enabled understandings of how learning opportunities for NQDs could be enabled or constrained by senior clinicians, either intentionally and deliberately, or inadvertently, while engaging in clinical practice themselves.

Analysis of narrative positioning also enabled a better understanding of how the participants learned from their interactions with patients. Most participants experienced self-conflict in this area, depending on whether they were able to act in accordance with their values and previous learning to practise patient-centred care, or whether they were constrained by individual, systemic and/or cultural factors during internship. The different ways in which patients were positioned in the narrative data were found to contain uncertainties and ambiguities, which could be unpacked by considering the tensions between working and learning, and participants' beliefs and sense of calling (see section 6.2.3.1 Patients as work / learning / calling p. 185). Participants had to balance these different ways in which they viewed patients, for example, patients were learning opportunities for interns, but they were also part of a daily workload that had to be

managed. Most participants expressed that they would have liked to connect better with patients in their care, but had felt unable to do so within the prevailing time constraints during internship. NQDs' identity claims in relation to patient positioning therefore revealed some of the sources of self-conflict, especially when participants felt they had been unable to adequately attend to patients' needs, when patient safety had been compromised, or worse still, when a patient died. However, patients were an integral part of the learning processes that led to participants developing expertise as medical professionals.

The findings of this study indicated that the workload of NQDs was rarely conducive to achieving the gradual increase of responsibility which is generally considered necessary for optimal learning in the clinical workplace. The tension between 'internship as working' and 'internship as learning' is a phenomenon that has been well documented elsewhere (Bearman et al., 2011). A qualitative study across Australia of junior doctor experiences in their first year of internship elaborated on this dialectic in the development of professional identities, highlighting a shifting balance between being supported and taking responsibility for patient care (Ibid.). Australian NQDs generally described a far more gradual assumption of responsibility compared to their South African counterparts of this study. Even in Australia there were some institutions that had expected interns to take on heavy workloads and work long hours, described as "bad rotations" (Ibid. p. 633), though these were not the norm.

Considering whether participants' attitudes towards internship had changed over time, there was considerable variation in experiences due to the disparity between internship sites in South Africa. Where NQDs were 'fish-in-water' or were able to become such, there was evidence that their appreciation of internship learning had increased with maturity. However, for others, their attitude towards internship remained that it was a necessary phase of postgraduate education that they had had to endure and survive in order to move forward with their choice of career.

8.3 Research question two: How do medical practitioners construct their (retrospective) identities as interns when reflecting on their development as NQDs?

While environmental and cultural factors shaped the identities of interns, this process was socially and relationally mediated. From analysing narrative positioning (see section 4.4 Narrative approach p. 81), what emerged was that almost the entire data set could be categorised according to various relationships, mostly interpersonal, but also with various institutions of the healthcare system, and within the self. This study also facilitated an examination of earlier self-positions in the light of present and prospective (anticipated) identities. Earlier self-positions may not have been viewed in the same way as they had been at the time. Ian, for example, explicitly revised his previous assessment of an 'I-as-abused' self-position during internship, to a more positive retrospective self-position of 'I-as-developing valuable expertise'. His attitude towards his internship COP had been transformed from his more mature practitioner perspective (later self). However, NQDs did not 'discard' previous self-positions, as there was an overall coherence of self-positioning that was evident in this study; all participants claiming that their written reflections still held 'true' to their experiences as interns.

Identity constructions of NQDs were influenced particularly by interactions with senior colleagues who were clinician educators, role-models and mentors. Different 'ways of being' were found to enable or constrain learning opportunities and positive identity constructions. In this study a synthesis of the various models of clinician represented in the narrative data was compiled (see section 6.3.1 Models of clinician p. 191 and section 7.3.1 Modelling clinical practice p. 217), based on narrated critical incidents and interactions with senior clinicians across all participants' internship experiences. Working at this level of abstraction made it possible to evaluate relationships with senior colleagues in a manner that yielded insight into the quality of relationships as enabling or constraining learning and positive identity constructions. Enabling models of clinician were, for example, the 'Caring (self-sacrificing) doctor', the 'Excellent generalist' and the 'Supportive supervisor' who primarily facilitated positive identity constructions of NQDs. Community Service Officers came to the assistance of interns when other, more senior, colleagues were absent, due to pursuing private practice interests or their own studies ('Self-interested senior' model), or

when seniors were deliberately unhelpful ('Power misuser / abuser' model). In several narratives there were also references to the 'great men and women in medicine' who had been a source of inspiration for NQDs. Using Hermans' DST as an analytic framework, I have proposed that these various clinician models contributed to a repertoire of possibilities of self-positioning. Whether these clinician models were real, remembered, anticipated or imagined, NQDs were found to somehow appropriate the significant other-positions as 'the-other-in-the-self'. New insight generated by this study was that, depending on their own ways of being, participants would either own certain I-positions or oppose them (see section 7.3.1.3 Repertoire of I-positions p. 220).

Again, dispositions, aspirations and ways of being (individual and collective) were implicated in the way NQDs were shaped by, and the way they shaped clinical work environments. For example, Juanita's academically inclined disposition and her aspirations towards specialising in Internal Medicine helped her to thrive in an otherwise extremely demanding rural practice environment. In that environment she described a collective disposition towards mastering clinical and surgical skills, and her participation and contribution within her COP regularly appeared to have been at a level resembling a junior Registrar rather than an intern. This was reflected in her narrative by the organisation of work described, the responsibility that was entrusted to her, and communication with her supervising Consultants (see section 6.3 In relation to internship COPs p. 189). Juanita was also able to compare her own internship experiences (earlier self) to the NQDs she had supervised as a Registrar (later self). At the time of interview, she reflexively contrasted the relationship she had with Consultants as an intern, and the lack of direct interaction between interns and Consultants in her current COP.

There was also a contextually dependent, complex interplay between personal dispositions of participants and the degree of support available from significant others that enabled or constrained the development of positive identities. This was best exemplified by comparing two participants with quite different dispositions and internship experiences such as Ian and Lana. Based in a semi-urban area of the Western Cape, Ian had faced a critical incident of attempting to perform a VAD on his own, because his 'Contextually toughened clinician' model of supervisor was occupied at a clinic elsewhere. Ian's usually reticent disposition became exaggerated after the procedure failed, and he became fearful of performing

obstetric procedures until another 'Supportive supervisor' intervened. Lana, on the other hand, was convinced that all interns were valued in her COP, and her enthusiasm was boosted further by a learning opportunity to perform an appendectomy under the guidance of a 'Supportive supervisor'. Lana was also particularly inspired by the presence of 'Scholarly clinician researchers' at her internship site, and at the time of interview, she attributed her active involvement in HIV research projects to their influence. If Lana had no interest in or disposition towards scholarly activities, the role modelling demonstrated in this area would not have been met with the same degree of receptivity (early self) or emulation (later self). This depth of insight and meaning is accessible only when researchers are willing to own their subjective judgements as part of their methodology, such as with the narrative and (auto)biographical methods used in this study.

Identity constructions of NQDs were found to be fluid and multiple, and did not appear to have a fixed arrangement or organisation within the self. Rather, identities could be seen to align with the notion of dialogism, as in Hermans' (2010) ideas of DST. In this perspective the self is viewed as multi-voiced, and as able to appropriate other-positions in diverse ways, by either owning or opposing them. Using an analytic framework of positioning theory combined with a philosophy of recognition and disrespect proved to be a productive way to understand various relational influences in the clinical workplace. The findings of this study pointed towards reciprocal relationships of recognition as being the most crucial factor in the positive identity development of NQDs. Conversely, inadequate supervision, excessive workloads and organisational cultures that otherwise disrespected NQDs, led to possibilities of damaged identities. However, negative role-models did not inevitably translate to constraining positive identities; it depended on whether interns had the recourse to resist them and to develop resilience (West, 2010).

I have argued in this thesis that the data pointed to some persistent problems associated with medical culture and internship experiences, which are extensively discussed in the literature (see section 2.3 Experiences of medical internship p. 34). These issues have been corroborated by wider studies; for example, the excessive workloads (Issa et al., 2009; Mansukhani et al., 2012; Sun et al., 2008), the perpetuation of hierarchical power flows (Apker & Eggly, 2004; Schryer et al., 2003; Witman, 2014), and autocratic doctor-patient relationships (Bleakley et al., 2011). Given the fluidity of NQDs' identity constructions found

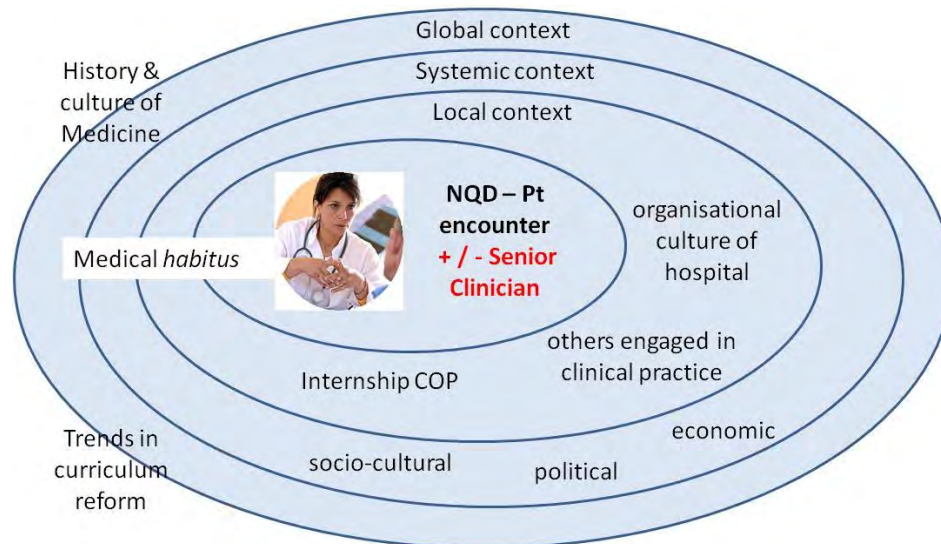
in this study, my suggestion is that a collaborative approach would be prerequisite to addressing these problems. The experiences of the participants suggest that their internship learning environments might have been more supportive of and responsive towards NQDs learning needs. In the previous chapter I alluded to the possibility of strengthening existing positive influences for NQDs to construct their identities differently. Strategies to achieve such a positive shift would primarily involve raising awareness amongst clinicians regarding their considerable influence on NQDs' identity constructions, as found in this study. Increased awareness would hopefully motivate clinicians who are already involved as exemplary educators and role-models, to provide more intentional supervision and support for NQDs. If clinician supervisors were more cognisant of how individual and collective ways of being in the clinical work environment translate to 'other-positions' that NQDs appropriate in constructing new identities, they may be more deliberate about enabling opportunities for LPP whilst they engage in clinical practice. Such a shift is likely to give rise to positive change within organisational cultures, mainly as the repertoire of I-positions proposed by this study becomes positively weighted with regards to the possibilities available for identity constructions of NQDs.

8.4 Research question three: In what ways did internship experiences enable or constrain NQDs to become the practitioners they aspired to be?

One of the key insights accessed by this study is the extent to which medical internship is a 'contextually layered' sociological phenomenon rather than a technical exercise aimed at developing professional competence. As alluded to in addressing the first two research questions, there were enabling and constraining factors at several contextual layers of clinical practice. Influences ranged from individual dispositions, family commitments, political, cultural and socio-economic conditions and the national healthcare system, global trends in curriculum reform and historic socio-cultural aspects of medicine. The medical *habitus* (Brosnan & Turner, 2009; Luke, 2003; Sinclair, 1997) and power dynamics in medicine also gave rise to shaping influences that enabled or constrained NQDs in becoming the practitioners they aspired to be. These various contextual layers that interactively

shaped the experiences and aspirations of NQDs are depicted in the diagram below (Figure 6: Contextual layers):

Figure 6: Contextual layers



The centre of the diagram indicates that there is an immediate environment where the encounter between the NQD and patient takes place, with or without a senior colleague present. Then there is the local context of the clinic or hospital, with an organisational culture (the way things are done there), where participants observed and/or interacted with others in their internship COP. The broader systemic and global contexts were also featured in the narratives, for example, the socio-economic and political conditions in South Africa influenced internship learning opportunities and experiences to a great extent. Aspects of medical culture spanned the different contextual layers, for example, the hierarchical power flows being accepted as the professional norm. Finally, it was the global trends in curriculum reform that instigated this study from the outset; participants maintained a distinct group identity from their undergraduate experiences and from belonging to the pioneer cohort of a PBL curriculum.

Participants' aspirations were unknown prior to conducting this study, and therefore the research question pertaining to aspirations was formulated in the manner stated above. However, what was revealed by the narrative data was the multi-faceted and cyclical nature of aspirations; meaning that aspirations had both shaped, and were shaped by, internship experiences. NQDs had some idea of the kind of practitioners they aspired to be at graduation, but most claimed that they had relied on internship experiences to explore further; to confirm and/or guide their aspirations while they spent time with senior clinicians. This point was made explicit by Ezera as he stated that he saw in others what it was that he wanted to become. The extent to which the participants' aspirations were open to being moulded by internship experiences of clinical practice and by the various role-models in COPs was surprising to me. Furthermore, these findings have implications with regard to future research into career choices and the professional development of NQDs, in that internship was found to offer significant opportunities for more deliberate and intentional professional influence and guidance.

I would like to offer the following set of diagrams (see Table 4: Aspirational contours below) as a heuristic to summarise and represent the 'size and shape' of participants' aspirations in some meaningful way. Please note that these depictions are not related to levels of competence, and they do not evaluate individual practices. They are my subjective understandings of the broad 'contours' of the participants' prioritisations regarding their aspirations, and are based on the discussions contained in the previous chapters of this thesis (the data, findings and interpretations). I realised that there were two main 'aspirational facets' that participants tended to prioritise differently, namely, 'expertise' and 'connectedness'. In order to visualise these variations, I have mapped individual prioritisations, representing 'expertise' on a vertical axis and 'connectedness' on a horizontal axis. I have further subdivided expertise into 'skills' (referring to various clinical skills in operational contexts) and 'science' (referring to scientific knowledge considered basic to medicine); and connectedness into contact with the individual 'patient' and 'systems'-based healthcare. The diagrams are juxtaposed with a few brief notes on each participant's aspirations overall, including the area(s) of specialisation they were engaged in, or were contemplating at the time of the interviews.

Table 4: Aspirational contours

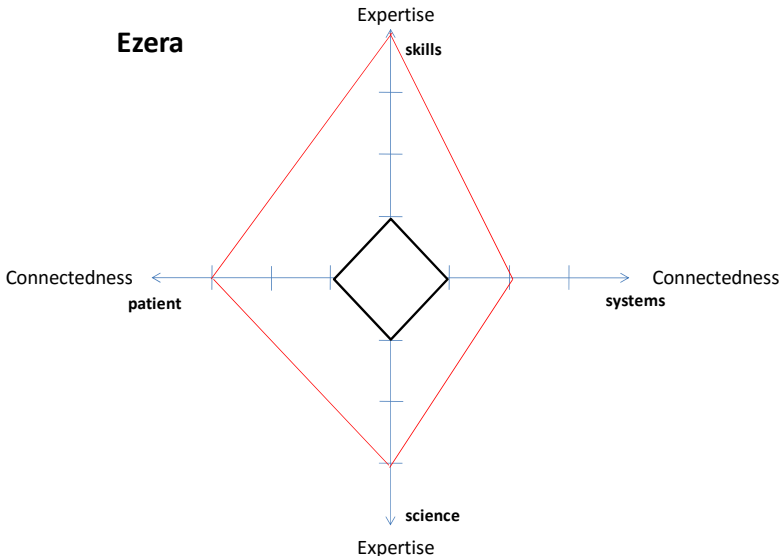
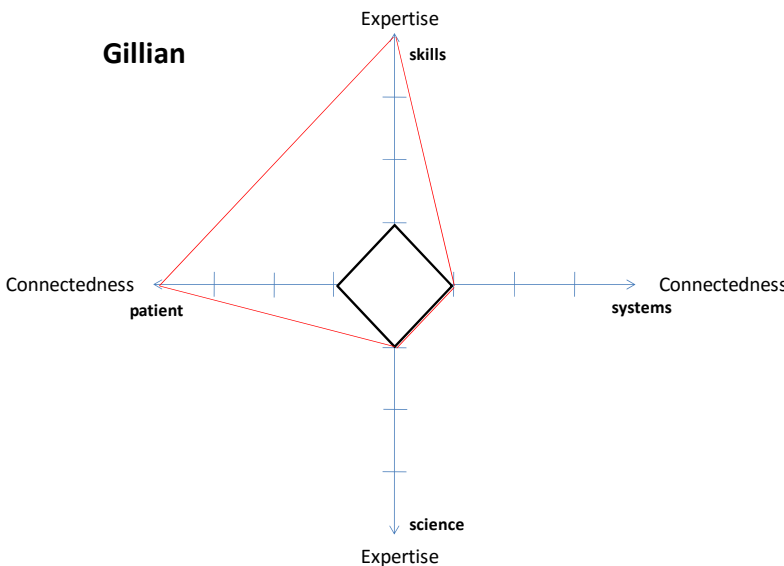
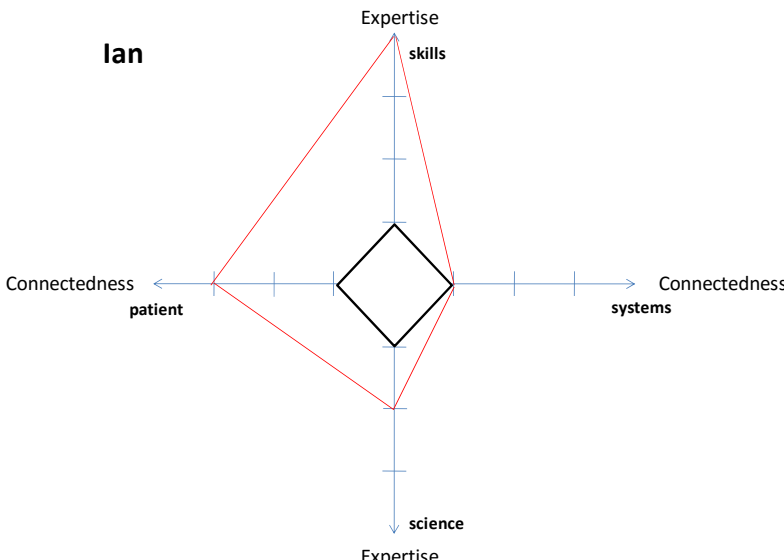
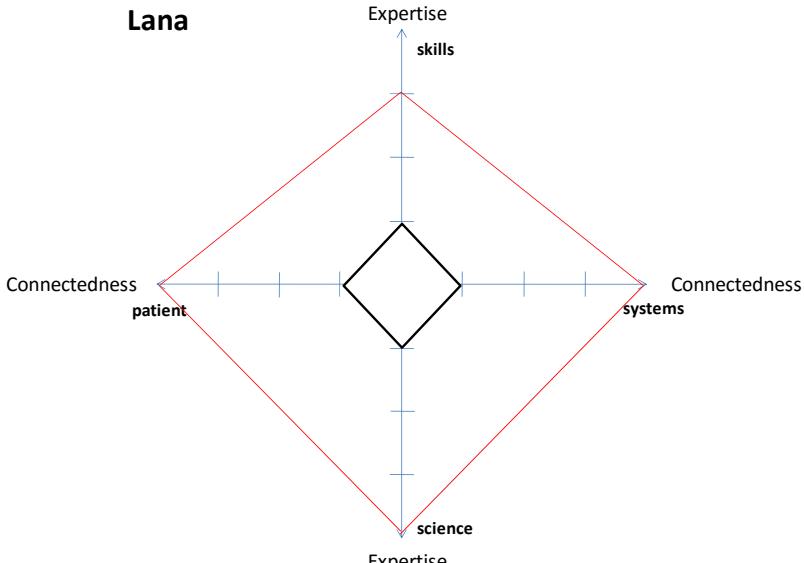
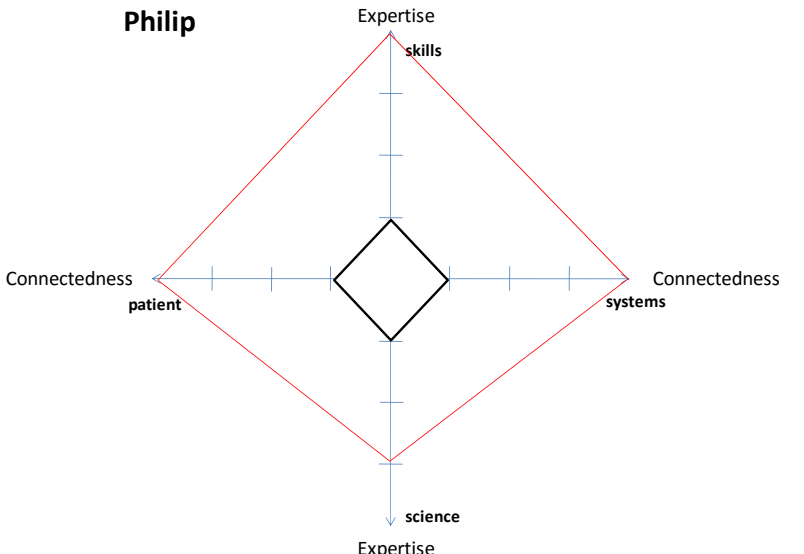
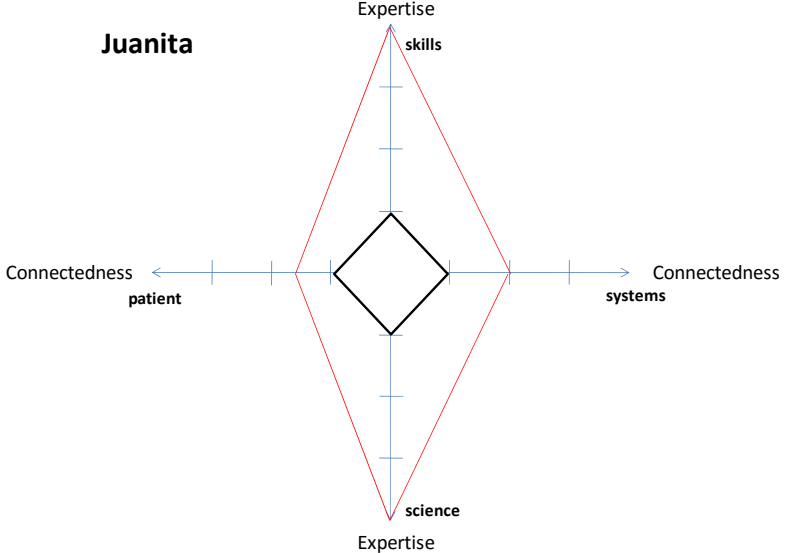
<p>Ezera</p> 	<p>Ezera found trauma and emergency medicine exhilarating during internship and he aspired to become a surgeon.</p> <p>He prioritised his connection to patients in the clinic setting, whenever time permitted, and he was uncomfortable when consultations had to be rushed.</p>
<p>Gillian</p> 	<p>Gillian was more inclined towards the 'art' than the science of medicine. Effective communication with individual patients and having empathy was her primary concern.</p> <p>She admired good generalists, and considered specialising in Family Medicine or Paediatric Orthopaedics.</p>
<p>Ian</p> 	<p>Ian was motivated to master clinical and procedural skills, seizing opportunities for LPP. He struggled with his interpersonal connections, and maintaining adequate emotional distance.</p> <p>However, Ian had found his 'niche' in discovering Paediatrics anew during internship. Improvements to healthcare systems were not a priority.</p>

Table 4: Aspirational contours (continued)

<p>Lana</p> 	<p>Lana was inspired by clinician role-models who demonstrated dedication and scholarship. She was motivated by the great needs in healthcare (HIV and TB related). She was also determined to be a 'change agent' from within 'the system', attributed to her early experience as a patient. She aspired to specialise in Virology or Public Health.</p>
<p>Philip</p> 	<p>Philip highlighted two aspects regarding his aspirations: he was energised by people, and was motivated by achieving excellence. His greatest motivation was to improve healthcare throughout the continent of Africa.</p> <p>Philip had contemplated specialising in Internal Medicine prior to exiting clinical practice.</p>
<p>Juanita</p> 	<p>Juanita was driven by learning new medical knowledge. She had aspired to specialise in Internal Medicine from her fourth year of undergraduate study.</p> <p>She felt it was her duty to take charge when patients were too ill to communicate, get them better first, and speak to them afterwards.</p>

It is arguable that all doctors should aspire to each facet of expertise and connectedness, at least to some basic or foundational level – depicted by the space in the middle of the contour maps – in order to meet the requirements of medical professionalism. The extent to which further development of expertise and connectedness was prioritised by participants was what I considered as their aspirational contours. Furthermore, participants appeared to have eventually gravitated to ‘spaces’ that were a ‘good enough’ match for their personal dispositions and aspirations. Clinical workplace environments in which NQDs’ learning needs were recognised and supported during internship had enabled participants to develop as professionals and progress towards attaining their aspirations. Internship experiences in general were vital for participants to gain a ‘feel for the game’ of clinical practice in the various disciplines of medicine, and how these disciplines functioned and interacted. Internship learning and identity development had enabled participants to negotiate the kind of practitioner they aspired to be, and had equipped them with the necessary expertise and connectedness to become successful generalists or to engage in further postgraduate study.

It was interesting to note that, following internship and community service, four of the six participants in this study (Ezera, Ian, Lana and Juanita) had remained employed in the South African public healthcare sector up to the time of the interviews. Gillian, who had emigrated with her husband, continued to serve as a GP in a mining community. Philip, who had left clinical practice, had found a career path where he could follow his aspirations towards uplifting communities around Africa, and especially through the betterment of healthcare. These career choices seemed to me to reveal an inner motivation of the participants in this study towards improving healthcare in Africa, which was consistent with their aspirations as shaped during internship.

In view of the malleability of aspirations demonstrated, I would recommend that further research is needed to investigate the aspirational contours of NQDs. Ongoing engagement with medical students on a wider scale about their intentions immediately prior to graduation, and with NQDs during internship, would be required to obtain baseline information and to evaluate the shaping of NQDs’ aspirations during internship. A deeper understanding of NQDs’ aspirations would consequently enable better collaboration (reciprocal recognition) between NQDs and healthcare institutions. Mutually respectful conditions would need to be actively fostered and promoted, in order to harness the

capabilities of NQDs in ways that would benefit patients, practitioners and healthcare systems.

8.5 Final reflection

Each participant's personal narrative taught me a great deal about medical internship: how their needs, beliefs and abilities were recognised (or not) in the COPs they joined; and how they were able to negotiate opportunities for LPP. Ultimately this study was about the way in which the 'learning lives' of doctors unfolded in the clinical workplace, as revealed through (auto)biographical narrative research methods (West, 2001, 2010). The role of significant others and the self, in various relationships, was understood through psychosocial theory lenses. It is my hope that the inferences and findings of this study might inform conversations between various persons who have an interest in medical internship, to optimise the learning and identity development of NQDs, and consequently to improve healthcare.

8.5.1 An unasked question about relationships

The common thread that emerged, in addressing the questions that were formally proposed by this study, was concerned with the nature of learning relationships in the clinical workplace. As these relationships were ubiquitous in the narrative data, I felt it was necessary to further analyse them and theorise their role in the learning, identity and aspirations of NQDs. To locate these thoughts within the existing literature on postgraduate medical education, depending on the epistemological persuasions of authors, relationships in the clinical workplace would be viewed as socialisation, as forming part of an extensive informal or hidden curriculum in medicine, as encompassed by professionalism, or possibly as not researchable due to the subjective nature of the topic.

With reference to recognition and disrespect (Honneth, 2007, 2012), all participants' narratives comprised a unique mix of both forms of relationships (see section 3.4.3 Relationships and identity construction p. 72). NQDs had received interpersonal recognition from various significant others within internship COPs, including senior clinicians, nurse practitioners, patients and peers. Honneth's multi-level schema of recognition and disrespect (see Table 1: Honneth's three forms of reciprocal recognition p. 74) was useful for generating insight pertaining to individual learning and identity development in relationship with others. The effects of 'good' learning relationships, especially direct encounters with the 'Supportive supervisor' model of clinician, could be viewed on the basis of an increased capacity for self-confidence and self-respect, developed through acceptance and approval extended to NQDs.

Incidents of interpersonal disrespect at the level of insult/denigration, revealed more than the established patterns of relationships in COPs, providing clues regarding the longevity of identity damage sustained. For example, Ian's experience of being disrespected by a senior clinician during his undergraduate education had persisted long afterwards, and had a detrimental effect on his affect and actions during his transition to internship, especially in the discipline of Obstetrics and Gynaecology (see section 5.3.3 Links to the undergraduate medical curriculum p. 134). Philip reported that the negative effects from a solitary incident of being overtly disrespected by a family member of a patient had persisted even to the time of his research interview (see section 5.6.2.2 Critical incident – racial prejudice p. 162).

Systemic forms of disrespect encountered by participants (see section 7.4.1 Patterns of recognition or disrespect in power dynamics of medical culture p. 227), did not appear to evoke the same intensity of emotional response. Whether NQDs responded with frustration, resignation, unawareness, resistance, or determination to endure, their learning and positive identity development had been constrained to some extent, even temporarily, by a lack of recognition at different levels. For example, excessive workloads, inadequate supervision and support, and other situational factors that were not consistent with optimal learning environments, were commonly encountered. Therefore, despite the small number of participants in this study, I would conclude that there is a need to cultivate mutual recognition and respect between NQDs and the healthcare administration in South Africa.

This may be a daunting prospect; however, considering that each NQD represents a valuable national investment, the results are likely to justify the efforts.

8.5.2 Patient-centred practice?

Clinical workplace environments where participants were based during internship were reported as having situational factors that were generally not conducive to practising patient-centred care. The abovementioned excessive workloads, and especially the distribution of work at these healthcare facilities, were also found to reproduce or propagate a biomedical approach that objectified patients. Even when such an approach was contrary to NQDs' expressed personal values and prior learning in this regard, participants felt that this approach was unavoidable in order to cope with the number of patients they were expected to manage. The patient-centred values of a well-intentioned undergraduate curriculum were also shown to have been impeded or thwarted by an understaffed healthcare system that leaned too heavily on NQDs. This confirmed the views of other researchers who have expressed concern with the current distribution of work in the South African public health sector (Burch & Reid, 2011; Erasmus, 2012). In my view, the findings of the study also appeared to confirm the tensions that exist between the interests of medical educators at undergraduate level and the interests of those who govern the healthcare system. Somewhere between these conflicting interests, patient safety and internship learning were, in specific instances, reported to be compromised. However, in their individual capacity, as participants became more mature practitioners, they reported having been able to return to a more caring and connected approach in relating to patients.

8.5.3 Further research into power and identity

Finally I would like to join other researchers of power and identity in medicine in calling for further in-depth studies into various relevant aspects pertaining to professional identity

development in different clinical contexts. Engagement with social and educational theories, and social constructionist methodology, was a fruitful way of gaining insight into the identity constructions of NQDs. Returning to Monrouxe's (2010) question posed at the beginning of this thesis concerning the relevance of identity construction to medical education, I believe this study has elaborated on several worthwhile outcomes of attending to identity during medical internship. The competency (and more recent entrustable professional activity) frameworks (see section 2.2.4 Competency approach in medical education p. 28 and section 7.2.1.1 Development of clinical skills and clinical reasoning p. 213), represent current expectations placed on doctors and reveal the extent to which socially interactive roles are part and parcel of medical practice. The 'social doctor' needs to manage relationships with patients, with other professionals, healthcare institutions and systems as well as within themselves; which are all interlinked and influenced by identity.

For an understanding of power in clinical practice, whether conceptualised as capillary flow or localised commodity (see section 2.5.2 Power discourse (current) p. 46), from the personal experience narratives of participants, it was the power differentials and asymmetries that were reinforced during medical internship as confirmed by this study. Through the organisation of work in the healthcare system, the ways of being of senior colleagues and even the expectations of patients, NQDs learned the scope of their duties, and how they had to practice medicine in a particular way in order to cope with the workloads and then to progress along the established hierarchical structures. There did not appear to be much room or motivation on the part of NQDs to resist or transform existing systems or the culture of clinical practice towards more democratic or flattened power structures or patient-centredness (Bleakley et al., 2011). However, as participants themselves became 'old-timers' (more mature practitioners) and assumed roles of greater responsibility and seniority, they claimed to have effected a degree of organisational change; their approach towards NQDs being deliberately more respectful and supportive.

According to Bourdieu (1990, p. 57), "the *habitus* is what enables the institution to attain full realization"; he sees the king, the banker, and the priest as embodiments of hereditary monarchy, financial capitalism and the church respectively. I would add that the doctor would then be the embodiment of medicine as an establishment; another powerful institution that successfully ensures its perpetuation. However, I believe it is the conviction

that each NQD has the potential to effect change, in COPs and in the broader healthcare systems in which they participate, that fuels the efforts of medical educationists to persevere. Creating opportunities to develop internal motivation in line with NQDs' aspirations, shaping aspirational contours more deliberately, and, through mutual recognition, allowing those crucial, metaphorical 'witticisms' to emerge (see section 7.4.2 Shaped by and shaping influences p. 230), would be an ideal to which medical internship in South Africa might aspire.

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Questions to guide written reflections (previous study)**What prepared you for internship and community service?**

Please reflectively recount your experiences (using your stories as examples) of the degree of "preparedness for practice" you felt as newly qualified doctors during the past 3 ½ years. Where you consider any particular elements of your training, or learning experiences you had (both formal and informal) as a medical student were directly related to your preparedness, please make these links explicit.

Consider the following as part of your reflection into this question:

- What was your experience of the transition from being a medical student to being an intern?
- How confident were you communicating with patients? – What helped or made things difficult?
- Were you able to discern when it was necessary to request assistance from a supervising medical practitioner? How did you learn when it was necessary to request assistance?
- Were there any instances when you felt the need to fill gaps in your basic sciences knowledge for a task at hand? Did you feel you had failed any patient in this regard? If possible please provide examples.
- How did you find further information you may have required in the management of cases you encountered?
- How did you develop your clinical reasoning skills? (arriving at differential diagnoses, selecting a final diagnosis and an effective management plan)
- In what ways have you continued your learning?
- What shaped your attitudes towards dealing with patients? Are you empathetic and considerate of patient needs (in your opinion)?

Interview Schedule

How did your internship experiences shape you as a practitioner?

1. Probes about choices of previously narrated events / incidents:
 - a) was the event described exemplary (representing something that happened often)?
 - b) or was it exceptional, but important because of ...(what reason?)
 - c) or was it a personal defining moment because ...(what reason? e.g. an encounter with person, admired qualities of a colleague etc.)

2. Probes about the language used in narration – and positionality inferred e.g.:
 - powerful / powerless
 - valued / undervalued
 - struggling / easy
 - resisting / accommodating authorities / systems

You appear to be describing that you felt ... why did you feel that way?

3. Probe where participant appeared to avoid a particular discourse (if relevant):

You appear to avoid writing about ... if so, why?

4. Current reflections on internship:

Do you agree / disagree with your previous written reflection? Have you anything to add?
/ would you tell it any differently from your current perspective?

5. Influence of internship experiences on the practitioner you became?

In what ways were you helped / hindered in becoming the kind of doctor you wanted to be?

INFORMATION DOCUMENT**Study title: Learning processes and identity construction of newly qualified doctors: a narrative study**

Dear (Participant's name)

As you will probably remember, you previously participated in my study of newly qualified doctors when you kindly supplied me with written reflections of your internship experiences in 2009. You may also remember that I intended to have a meeting of all participants from my previous study when I was ready to present my findings. This meeting did not take place, however, because I was struck by the individually unique styles of writing and use of language each participant had, and which I intuitively felt needed further investigation. As I did not have the necessary background knowledge in linguistics at the time, I decided to leave this aspect of the study for another time when I would be able to learn the necessary methodology! Therefore I would now like to invite you to participate in extending the research to more thoroughly investigate the learning processes and identity construction involved during internship. This work would be towards a PhD thesis.

Please be assured that participation in the study is entirely voluntary and you may discontinue your participation at any time i.e. if you find you do not wish to answer any question asked of you, you are in no way obliged to do so.

If you agree to participate, I would like to interview you one-on-one and ask you to reflect again on your internship, from your current perspective as a more mature practitioner. I would send you some of my previous study findings beforehand and invite your comments; then ask you some questions relating to the written reflections you submitted before – for points of clarity, to see if you would still agree with the way you portrayed your experiences, or if you would express anything differently / highlight anything else etc.

Everyone being invited to participate in this study got to know me quite well while you were undergraduate students. I am hoping that the trust that was established between us will help you to share your experiences openly and honestly. I do want to assure you that your names will not be disclosed in reporting my findings, and any sensitive information that you share with me will be kept in strict confidence.

I am looking forward to connecting with you again.

Kind Regards

Lakshini McNamee

Further information about data handling, risks / benefits:

All documents provided by you and data displays constructed by myself will be stored securely for a period of 5yrs as stipulated in the University research rules, after which they will be deleted or disposed of appropriately.

There are no particular risks associated with this study, except that it might be somewhat embarrassing to reflect back and share some details of experiences as newly qualified doctors, especially if the outcomes were negative or not as positive as you would have hoped. Apart from that, although there are no direct benefits either, I hope that this reflective exercise will help you learn more from your own experiences. Your stories are also likely to influence future strategies being designed at both undergraduate and postgraduate levels of medical education.

There is no remuneration associated with participation.

If you are willing to participate as detailed above, please sign the attached consent declaration and either post it to me at the address below or send it via fax / email:

If you have any questions, please feel free to contact me:

Mrs Lakshini McNamee Tel: 031 260 4538 e-mail: mcnameel@ukzn.ac.za
Fax: 031 260 4265

Address: Department of Forensic Medicine
Nelson R Mandela School of Medicine
Private Bag 7
Congella 4013

You may also contact my PhD Supervisor or the Ethical Clearance Office with any concerns you may have:

Dr Peter Rule **Tel: 031 260 6187** **e-mail: RuleP@ukzn.ac.za**

Contact details of Ethical Clearance Office (Human and Social Sciences):
Ms Phumelele Ximba Tel: 031 260 3587 e-mail: ximbap@ukzn.ac.za

Consent to Participate in Research

Study title: Learning processes and identity construction of newly qualified
doctors: a narrative study

I have been asked to participate in the above research study.

I have been informed about the study by Mrs Lakshini McNamee, from the Department of Forensic Medicine, whom I may contact on 031 260 4538 if I have any questions about the research.

I am aware that I may contact the Ethical Clearance Office (Human and Social Sciences) where inquiries may be directed to Ms Phumelele Ximba on 031 260 3587 if I have any questions about my rights as a research subject.

I am also aware that my participation in this research is voluntary and I will not be penalised in any way if I refuse to participate or decide not to answer every question. I retain the right to withdraw at any time and am aware that my details will be kept confidential.

Declaration:

The research study, including the abovementioned information has been explained to me in the information document. I understand what the study means and I voluntarily agree to participate.

Signature of Participant

Date



RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

5 OCTOBER 2009

MRS. LS MCNAMEE (52388)
ADULT AND HIGHER EDUCATION

Dear Mrs. McNamee

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0296/09

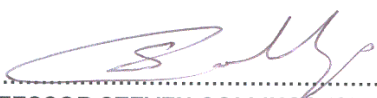
I wish to confirm that ethical clearance has been granted full approval for the following project:

"Exploring the experiences of newly qualified doctors who were graduates of a PBL curriculum in their development as medical practitioners"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
PROFESSOR STEVEN COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE



Research Office (Govan Mbeki Centre)
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
Ximbap@ukzn.ac.za

23 November 2011

Mrs L S McNamee (205527660)
Faculty of Education

Dear Mrs McNamee

PROTOCOL REFERENCE NUMBER: HSS/1220/011D

PROJECT TITLE: Learning processes and identity construction of newly qualified doctors: a narrative study

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steven Collings (Chair)
Humanities & Social Sciences Research Ethics Committee

cc Supervisor – Dr Peter Rule
cc Mrs S Naicker/Mr N Memela



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville