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# A Gendered Edge: Auto/biographical Research into Doctors and Lifelong Learning in the Inner-city

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**Abstract:** *This paper considers “lifelong learning” among a group of doctors within the “male” medical profession. It explores their struggle to be effective and reflective practitioners, in a world where subjective knowledge and cultural understanding are often derided, and yet “success” may depend on the integration of medical with cultural and emotional literacy.*

## Introduction

This paper derives from recent research into the nature, scope and meaning of “lifelong learning” among 25 doctors, more precisely General Practitioners (GPs) or family physicians, working in difficult areas of inner London and the South East of England. “Lifelong learning” is the new mantra in the United Kingdom: everyone should be engaged in it but its meaning is often vague and reduced to a narrow vocationalism. The research, which was highly collaborative and dialogical, longitudinal and in-depth, explored, over a period of nearly four years, the experience and meaning of learning among doctors, in a context of their wider professional and personal development. The study was located in inner-city areas, where health needs may be greatest and resources - including doctors - most severely stretched. Put crudely, the poorer you are, the unhealthier you are likely to be and the shorter your life. Doctors as well as patients, in such situations, can exist on a kind of edge (West, forthcoming).

Doctors in the United Kingdom are also, like doctors elsewhere, facing a period of changing roles and expectations, and growing concern and criticism over levels of performance and accountability. The criticism is mainly about clinical effectiveness, and the adequacy of the knowledge base from which they draw, but also includes the fact that many doctors may not be good communicators. Some appear disinclined to give it priority because they feel ill equipped to handle difficult emotional topics, perhaps because they feel threatened by well-informed patients. Questions are being asked about how doctors are trained. This includes priorities in the

medical curriculum and, for some, the lack of attention given to the emotional/inter-relational aspects of the role, such as listening to the patient’s voice and story in the management of illness (Sinclair, 1998).

Change is also pervasive in health care. Relationships between users of services, and providers, as well as between different professional groups, are under constant scrutiny and subject to intense debate in a less deferential, better-educated and more litigious culture. Moreover, there are various “postmodern” challenges for the doctor: to the medical model’s “technoculture” and drugs based treatments, as evidenced in the burgeoning alternative and complementary medicine movements. “Authority” is more widely questioned, including that of medical science, not the least because science often produces contradictory evidence, even confusion, and scientists argue among themselves about what evidence actually is, as in the BSE scandal. At one time, Hodgkin suggests, it was obvious that doctors were there to battle against death and disease. The British National Health Service (NHS) offered a viable means to deliver good care for everyone. Medical research, and its technological by-products, provided the possibility of health for all. But nowadays, doctors must juggle with many competing ways of seeing the same situation, between themselves and their patients, or between themselves and other professionals. Clinical reality, as perceived by clinicians, has to be reconciled with patients’ beliefs, resources have to be balanced against individual patient need, and ethical dilemmas “spring ‘hydra-headed,’ daily, from medical advance.” As complementary or alternative therapies

increase in popularity some doctors embrace them, others remain sceptical. At some point, Hodgkin muses, medicine's modernist, confident "centre" may splinter into many professional fragments (Hodgkin, 1996).

### **Some Background:**

#### **Men and Women Managing Change.**

In previous work I focused on the stories of adult learners living in communities undergoing major economic and social dislocations (West, 1996). I wanted to understand more of how learners managed change and transition, and the resources they were able to draw on, and how this could best be conceptualized. I developed an interdisciplinary frame, a "cultural psychology," which used object relations theory to explain how significant others – who were often crucial in life spacing and managing transitions (Courtney, 1992) – were "internalized" as good objects in intra-psychic life. In feminist psychoanalytic theory, for instance, the development of a self is contingent and dialectical a product of the relationships in which we are embedded and the wider cultural scripts which shape them (West, 1996). Patterns in inter-subjective life serve as the building blocks of personality in early life. But such patterns, including good relationships, can also be crucial to processes of autobiographical reconstruction, and developing a more confident agency in the world, in later life too.

Frosh (1991), drawing on psychoanalytic theory, argues there are, at the extremes, two potential responses to life crises: a fluid and generative creativity or a pathological defensiveness against change and uncertainty of whatever kind. Frosh argues that the one "chosen" depends on the strength and cohesion of a self: whether this self is sufficiently secure to cope with perpetual uncertainty and remain open to new experience, or not. We all experience times of fragility: progression requires degrees of subjective cohesion and feelings of security. At the heart of such security, as well as more effective agency in the world, is openness to supportive others, to the possibilities for a potential diversity of self which others can encourage within us. We are, psychologically - as, for instance, in the growth of the feminist and black consciousness movements - all of a piece.

Women, it seemed, in this earlier research, were often better able than men to manage the emotional and biographical processes of transition. Women have often needed to adapt to new roles and demands, including finding paid work, while continuing to carry prime domestic responsibilities. They were better at patchworking a life, creating meaning and purpose from many fragments, which may partly be because women had less at stake in the older division of labour and its status and material rewards. Many feminist writers suggest that the construction of feminine identity has, in contrast to dominant forms of masculinity, emphasised co-operation, mutual support, the importance of emotional life and of sharing experience in all its dimensions. Many men, in contrast, when old roles fragment, can be locked into psychological defensiveness and the pretence of coping. It was interesting that those men in the study who were rebuilding lives, following redundancy or unemployment, through higher education, tended to give more attention to the private and intimate dimensions, including relationships (West, 1996).

### **General Practitioners:**

#### **Their Position, Status and Training**

GPs work in a medical lifeworld where specialist, hard, "scientific" knowledge has traditionally been reified, while the softer skills of human communication and psychological insight have often been considered "other" and feminine in what appears to be a highly masculinist culture (Sinclair, 1998; Seidler, 1994). Bennet (1997), from a psychiatrist's perspective, argues that doctors can also imbibe a myth (and a very male myth) of omnipotence in medical training. They learn that they are given a kind of sacred knowledge, trust and authority and part of the contract with society is that they must always be competent, beyond weakness, vulnerability, even doubt, like good men should. Or they had better learn to cope with their fears quickly, and disguise them. Reality often disappoints, as doctors become tired and disillusioned, not least with themselves. Initial optimism, idealism and commitment can be replaced, in the light of harsh reality, by feelings of loss, disillusionment and failure, in mid-career. This is a world where it can be hard, even

dangerous, to admit psychological distress, for fear of what colleagues say. And this in a context of increasing levels of stress, alcoholism and suicide among many doctors, and where medical training still seems prejudiced against social as well psychological knowledge (Seidler, 1994; Sinclair, 1998).

### **Auto/biographical Research**

The use of biographical, life history and/or narrative research methods – in the stories people tell, why they tell them in the way they do and how they may be shaped by culture and dominant truths, as well as psychological states of being - has developed rapidly in the “postmodern” moment, in an attempt to explore, more satisfactorily, the complexities of lived experience (Josselson & Lieblich, 1995). Auto/biography goes further in challenging the fiction of the detached, objective biographer or researcher of others’ histories; the idea that a researcher’s own history and identity play little or no part in constructing the “other’s” story. Stanley (1994) writes about the “intertextuality” at the core of all biography, which has been suppressed in supposedly “objective” accounts of others’ lives. The active and contingent presence of the biographer has been excised from the research account, preserving a kind of *de facto* claim for biography and life history research as science: a process producing “the truth,” and nothing but the truth on its subject. Fine (1992) argues, instead, for the reflexive and self-reflexive potential of experience, in which the knower is part of the matrix of what is known, and where the researcher needs to ask her/himself in what way has s/he grown in, and shaped the process of research. Such an aspiration assumes no monopoly of knowing but attempts, through collaboration and mutuality, to name more of what is difficult to say or articulate, and to think about its meaning collaboratively. This is a process that strives to surface power relationships, discomforts, dead ends and uncertainties. Rather than an absence of rigour, or truth, such auto/biographical methods ask much of the researcher, in terms of self-awareness, social and emotional intelligence, sensitivity, integrity, courage and openness. Such values, and aspirations, underlay the study (West, forthcoming).

A diverse group of doctors – men and women,

black and white, new and long-standing, older and younger – were involved in the research. The process began with an evaluation of an experiment in self-directed learning groups (SDL) in inner-London. The groups were designed to give time for doctors to address their fears and anxieties, and identify a learning agenda, through a careful and supportive analysis of interactions with patients, including their impact on the doctor. Each SDL group consisted of about 8 doctors, was confidential, and had a skilled facilitator. The evaluation provided the basis of the more extended study into how GPs manage change, including the use made of education. And the research sought to locate the doctors’ stories in whole life histories as well as present contexts. 25 doctors were interviewed up to 6 times, over nearly four years, in an intense and collaborative dialogue about what facilitated or inhibited development.

### **Two Case Studies**

Many of the GPs in the study considered their initial training, most especially its textbook approach and its construction of illness as primarily physical and biological, was often unhelpful in managing their work among the diverse peoples and problems of the inner-city. There were a number of doctors who - because of their own multiple identities and experiences of oppression – felt on the margins of the profession. But such doctors could raise radical questions about the health of medical culture and their initial training. Hart (1998) has used standpoint theory to consider the position of such “insider-outsiders” who seek to cross boundaries between different worlds and knowledges. Standpoint theorists argue that we need to see the world from diverse perspectives, across groups and within individual selves. This is not simply a matter of accumulating different knowledge, from different standpoints, and composing a more diverse mosaic. The process is more painful because of a complex power relationship between different identities and knowledge. There is often a hierarchical relationship between what is culturally “inside” and what is “other,” what is acceptable and what is hard to say. This applied to many of the doctors, and transcending the difficulties involved, including the marginalisation of important parts of self and story, was often

the key to professional and personal health.

Dr Aidene Croft, for instance, is a Lesbian, who works in a difficult, impoverished part of London's East End. She is white but talks with a "*different*" accent. She mentioned her sexual identity, from the beginning, and that this fitted uneasily into the "male" and predominantly heterosexual culture of medics and training. She was glad to be a representative, in the study, of women and men like her, against the presumption of many doctors, that they are all, or should be, straight, have a heterosexual partner and "2.4 children" at private school. Aidene's experience of being an outsider, as well as emotionally vulnerable, was pivotal to her developing story.

Towards the end of the research, as we revisited various themes, she said:

*.... When I started off as a doctor, I think I was just be petrified and stunned between my living as, I was going to say, a rampant lesbian. No, a very active, social life and political life and campaigning life, lobbying. Very much as an umbrella of socialist, feminist, a whole umbrella group dealing with employers, employment issues, day care, abortion, all the things that make up, that actually made up in the early '70s. Very burning issues. And when I was at medical school they were very separate. That was my person and then I would take the head to medical school. The head: in a motor bike, in leathers, in trousers for my exams and breaking all the images, but still just very much my head and they can take or leave the rest of me. But not really, that wasn't real. It was real in so far as I needed to earn a living, find a role in life. It was real, but they were actually very, looking back, they were very, very separate... I was very much trying to connect the two, but it was that I knew that I couldn't actually tolerate that level of incompatibility.*

Aidene hated her training, hospital medicine and its mores, and considered giving up being a doctor altogether. She tried general practice, and "*found more humanity*" there. She forged a strong relationship with a GP trainer. For the first time, she said, she felt seen, valued and "fed," as she did in her personal life with a new partner. The trainer

accepted and respected her as she was, and made her feel that she could be more of herself as a doctor. The secret was being authentic and the experience relieved her, as she put it, "*of the burden of the whole hierarchy of medicine. That I could just be the particular doctor that I am, with that particular patient.*" Aidene was an active lifelong learner, and developed an eclectic style in her work, drawing on a range of therapies. She was interested in mental health issues – she had suffered a major breakdown herself and had been in therapy – and talked of being able to understand what it was like to be an outsider, from the inside. Her patients knew, in some sense, she was one of them, and responded openly to her. She had also learned to be realistic: she could write a letter asking that a patient be rehoused by the local council, but she could not provide the house. Omnipotence too had to be transcended.

Daniel Cohen, like Aidene, considered himself an outsider, on the inside. Questions of self, and the cultural and familial roots of many of his anxieties, were inseparable from his work as a GP. There was no neat distinction between questions of "*who am I?*" or "*Where do I come from?*" or "*Why do I have the kind of problems that I think I have?*" and those such as "*Why am I doing my work – what is the nature of my work?*" "*How can I best help the people I'm working with – what is the nature of their problems?*" There was a seamless web connecting him to patients, their story to his. Daniel, like Aidene, experienced a major crisis in his career, and entered a period of psychotherapy. And he too had been engaged in recovering diverse parts of his identity, over a long period, some of which had been repressed or denied. His life partner was crucial to his ontological project of self, as was therapy. He recovered his Jewishness, for instance; and a spiritual awareness. Integrating these different aspects of self and knowledge into his core identity was at the heart, he said, of his lifelong learning, and had enabled him to work more effectively with diverse patients. He told me about a Somali woman refugee who came to the surgery one day. She had five children, whose father had been killed in a war. The patient brought Daniel a gift and he was immensely moved. It was, he felt, a symbol that he was providing "a secure

base,” which related, in turn, to his own experience, as a child of refugees:

*I can remember how incredibly important the GP was to us as a secure base. We had a very very intelligent link worker who is a Somali doctor herself, but can't practice here so she works as a link worker. And we ended up having the most extraordinary conversation with the mother about Darwinian evolution in relation to why were her children getting asthma and eczema here when children didn't get it in Somalia and we talked about the way sort of the immune system might be adapted for one environment but actually then is mal-adapted to another environment because the sort of ancestral immune system as it evolved is not to meet what it meets here. And I found myself having a grown up conversation with this mother of the sort I might have with you and she was transformed from being a sort of exotic stereotype into actually being an intelligent equal. And... I felt it was part of, part of a process of her becoming a person again....*

He had never, he said, made that connection before, prior to the research. Daniel hated the profession's antipathy to subjective insight. He argued, instead, for a subversive synthesis, taking what was essential from the medical model but locating this within a more psychologically and culturally literate paradigm.

### **Lifelong Learning and the Split between Personal and Academic Ways of Knowing**

Research such as the above raises basic questions about lifelong learning. The Delors Report (1996) argued that it should encompass learning to relate, to be, to do, as well as think, in an uncertain, fragile world, but one redolent with new possibilities. Part of the problem may be a profound split between personhood and medical practice, science from subjectivity. Palmer (1997) has observed that the split is the consequence of a culture, which distrusts the idea of personal truth. If the academy, including medicine, claims multiple ways of knowing a world, the objective way – taking us into “*the real world*” and “*out of ourselves*” – remains a hegemonic value. The self within the culture is not a resource

to be used but “*a danger to be suppressed, not a potential to be fulfilled but an obstacle to be overcome.*” Parker refers to the importance of recovering the teacher within, the teacher we knew as children, but tended to lose contact with on becoming an adult; someone who invites us to honour a truer self rather than ego, expectations or image. In psychoanalytic terms, this is the good object “parent,” who can become available to us in later as well as early life. For many doctors, the trainer, partner and or colleague – when times were hard, messy and they felt most inadequate – was vital to progress. The good object mirrors other possibilities for a self in professional as well as personal life and the more we can people our minds with such objects, the more we can experiment with who and what we are, in progressive ways. There is in fact a connection between the growing diversity of a postmodern culture and the potential diversity of selves, in considering lifelong learning. The twentieth century has been one in which many groups and whole cultures have made various and, sometimes, viscous attempts to reject “otherness.” But engaging with otherness can be the means to a potential hybridity of self, which is no disaster but the means to a profoundly dialectical learning – the ontological project of the self – over a whole life.

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