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THE DUAL NATURE OF ENCULTURATION IN POSTGRADUATE MEDICAL TRAINING AND PRACTICE

Jill Gordon, Pippa Markham, Wendy Lipworth, Ian Kerridge and Miles Little

Centre for Values, Ethics and the Law in Medicine

Faculty of Medicine

University of Sydney

Abstract

Context: Enculturation is a normal and continuing part of human development. This study examined how medical graduates perceive the process of enculturation after graduation.

Study: In a qualitative study of the values of medical graduates associated with the Sydney Medical School, we identified two processes that contributed to the ongoing process of enculturation. Participants were aware of having passively *absorbed* the explicit and implicit culture of medicine, and of having actively sought to *assimilate* (or avoid assimilating) the medical culture. The processes of enculturation were particularly evident in relation to three major concerns: competence, patient-centredness and self-care.

Conclusion: The participants in our study demonstrated the capacity to reflect on and differentiate between two types of enculturation, absorption and assimilation. They were aware of the impact of enculturation with respect to three main sets of values - epistemic, interpersonal and personal. Faculty development programs could benefit from paying explicit attention to the process of enculturation and its influence on learning and practice.

Keywords: Enculturation; medical education; hidden curriculum; mentors

Introduction

When new students enter medical school, they begin a process of induction into a well-formed discourse community. Over time they are equipped with a vocabulary of words with situated meanings, and with special, sanctioned knowledge and skills.[1,2]

They have, of course, already experienced socialisation within the immediate context of their families, neighbourhoods and schools and they bring to medical school the broad range of values, as taught explicitly and implicitly during childhood and adolescence. During their medical training

values are reinforced or reshaped through processes of explicit education, role-modelling and mentoring.[1-3] This represents "professional formation", that is deliberative moral and professional development,[4] toward the goal of what we recognise as professionalism.[5]

Inherent in the formal processes of organizational enculturation (ie. the process in which newcomers learn how to get things done)[6] there are informal processes that teach students, new graduates and specialty trainees to accept the conditions of their working lives [7,8,9,10]

Despite the importance of enculturation, junior doctors may be only dimly aware of the extent to which the process influences their values and behaviour. As doctors move from one clinical environment to another, they notice that systems vary and people change as a result of working within different contexts.[11-13] Some hospitals foster collaboration; others foster competition. Some hospitals focus on broadening community outreach; others focus on highly specialised services. Desirable values find their way into mission statements and policy documents, while undesirable values and behaviours are often blamed on a 'hidden curriculum' that begins in medical school, [14-17] the "cultural mores that are transmitted, but not openly acknowledged, through formal and informal educational endeavors".[18] (p440)

While we have some knowledge of the process of enculturation in medical school far less is known about enculturation after graduation. This is significant because there have been numerous attempts to ensure that residency programs emphasize the acquisition of the values and behaviours associated with professionalism.[19,20] While a theoretical base has been developing, many of these efforts do not have a strong empirical basis, paying only limited attention to how enculturation takes place during the postgraduate years.

In a study of doctors' professional and personal values, statements emerged that suggested that the doctors were aware processes of enculturation before and after graduation. We therefore decided to examine the interview transcripts to identify specific aspects of their experiences that might help us to understand more about these enculturation processes.

Methods

The researchers invited 22 medical practitioners associated with the Sydney Medical School (because they were graduates, teachers or both) to participate in an interview-based study of values-based medicine as an approach to health care. Purposive sampling was directed toward maximum variation in age and specialty, using a snowball approach, "a non-probabilistic form of sampling in which persons initially chosen for the sample are used as informants to locate other persons having necessary characteristics making them eligible for the sample."[21](p 438).

Participants' ages ranged from 28 to 76 (median 49), and in years since graduation from three to 52 (median 26). Twenty of the doctors were available at a mutually convenient time - seven women and thirteen men. Their specialties included anaesthetics, emergency medicine, general practice, internal medicine, ophthalmology, paediatrics, psychiatry, public health, radiation oncology and surgery. At the time of interview, the doctors who were hospital-based were working in nine different hospitals in Sydney and, between them all, had worked in more than fifty. Seventeen of the interviews were conducted by two researchers, (PM and JG) one of whom was known to some of the participants, and lasted about an hour. On three occasions one of the interviewers was unable to be present due to last minute changes to hospital scheduling, etc.

Interviews were anonymised with code numbers for each participant; ethical clearances were obtained from the University of Sydney. The interviews were semi-structured, with participants being asked to reflect on their experience of medical education and medical practice and to describe episodes that had stayed in their minds because of their moral dimensions. We asked participants to reflect on the influence of colleagues, patients, educational programs and health services.

Participants were not asked specifically about their experiences of enculturation, but relevant statements began emerging throughout the interviews.

All transcripts were coded thematically by four of the five authors, who met regularly to identify areas of convergence until full agreement was reached. One of the interviewers (PM) maintained an audit trail to track the team's developing thinking. A process of dialectical empiricism[22] was used to categorise the emergent themes into more abstract concepts, using constant comparison[23-25] and reformulation of research questions and theories.[26] Table 1 provides some examples of value statements, analytic categories and their broad grouping.

Results

Because our participants came from similar educational backgrounds, had studied medicine as their tertiary course, were embedded in the culture of medicine, and were associated in meaningful ways with a single medical school, we approached their transcripts with the assumption that they belonged to a loosely formed discourse community. Although their graduation year ranged over fifty years and they were practising in ten different speciality areas, there were many similarities in their experiences of enculturation during and after medical school.

Their three major areas of (often overlapping) concern were epistemic (acquiring knowledge and skill), interpersonal (relating to patients, families, colleagues and administrators) and personal (achieving work-life balance). In each of these areas, medical enculturation was achieved by two over-lapping processes – 'absorption' and 'assimilation', each of which may have distinct implications for postgraduate medical education. We understand 'absorption' as the implicit incorporation of cultural norms, practices and beliefs and 'assimilation' as a deliberative process which involves the choice to adopt or reject institutional norms or to align one's behaviour with that of another person or group.

Absorption

One participant commented on the power of the enculturation process, which caused them to absorb both desirable and undesirable organisational values, traditions and practices.

> Medicine is a very what I'd call personality changing course. It doesn't tolerate outliers very well, and they tend to get pushed out quite quickly … Medicine produces very homogeneous people, whether you like it or not. P11

<u>Absorbing desirable organisational values</u>

One participant "just assumed", as a result of early hospital experience, that the hospital environment would always be "wonderful" and, having absorbed that message, was disappointed to find that this was not always the case:

> Hospital A is a wonderful hospital full of dedicated people … and I just *assumed* all hospitals had that sort of personnel and resources. At Hospital B …there was no effort to teach, no matter how keen you were, and essentially I just felt like we were treated as, you know, just slaves essentially, and I was very disappointed with the training there. P20

Another participant was only aware in retrospect of how research, to which he assigned a high value, underpins clinical care in a teaching hospital.

> I guess the other thing, *even though I didn't really probably quite click to it at the time*, was the … research being an intrinsic part of the day-to-day work [of clinicians in a teaching hospital]. So it wasn't like they did their clinical work and they did their research and they were separate. It was very much that research was part of the ongoing practice. P9

Good teachers facilitated absorption regardless of whether or not the junior doctor had as yet acquired the capacity for actively assimilating skills and confidence.

> The best consultants/mentors are the ones where you don't actually know that they're doing it … So it's a matter of support and helping people acquire the skills and building confidence, and knowing when to step back so that people can find their own feet. P2

Absorbing undesirable organisational values

A number of participants described how they absorbed the message that junior doctors are on the lowest level of the hierarchy. Participants described their early postgraduate positions in terms of "slave labour"(P1, P20), "dog eat dog competition" (P10) and being "at the bottom of the totem pole"(P16). The process of absorption was facilitated by requiring junior doctors to perform at their physical and emotional limits.

> As a job, it's enormously frustrating and time consuming and exhausting, both emotionally and physically. P12

> In neonatology … in the middle of the night- four or five exchange transfusions - I was actually hallucinating. P18

In these contexts, there was little opportunity to do anything other than gain clinical competence, described by one as "battling and nailing things down". Epistemic concerns often trumped all others:

> It's easier to admire and think about mentors when you've been through a process, and you feel far more secure about it, than when you are going through a process and you're still battling and nailing things down … Being an intern or resident, I wanted to know what to do in the acute situation. That was my nightmare - that if I had to be left in an acute situation, I wanted to know what to do. P7

It was also common to absorb what are now unacceptable norms in relation to patient care, based on a lack of knowledge of human needs. An older participant recalled some of these:

> When a girl was an unmarried mother, they used to throw a sheet over the frame to cut off any view, and take the baby straight away out of the room and she never ever saw it … You didn't visit children in hospital, because when parents visited, the children would cry for a long time afterwards, so don't visit. Whereas we now know what harm that does, with separation anxiety… So they had it totally wrong. P8

Assimilation

There was also a more conscious side to enculturation. Practitioners responded to experience by making active judgments about what new experiences meant to them personally and whether or not to incorporate them into their own practice.

The decision to assimilate

Participants could pinpoint many specific instances in which they chose to assimilate particular desirable behaviours and values. They had mentors and role models and were able to articulate what it was about these people that they admired.

> I think from a human point of view, [I admired] the interaction, *the personal respect for the people they were looking after*. P9

Making conscious, considered decisions about which mentors to emulate was stressed by a number of participants. In the following example, passive absorption occurred initially, but again it led to active assimilation.

> I've actually also actively sought mentors. I didn't realise that that's what I was doing, but I did that over a long period of time, and I still do that in informal and sometimes formal ways. P4

The decision to resist assimilation

After being relatively open to absorbing new experiences, participants found themselves more actively appraising the values of those around them and needing, from time to time, to "contend" with values they saw as problematic.

> The hospital training years were quite restrictive, and imposed maybe a set of values on me at that time that I hadn't thought I would have to contend with when I went into medicine … There were people who… weren't good role models in terms of demonstrating wanting the best for their patients - some of them were just doing the minimum. P1

As time went on, participants were able to consciously reject certain values, norms or behaviours on the part of individuals or groups.

> An eminent physician … said 'Now you can be a good doctor or a happy person, but you can't be both', and [I was] just thinking 'That's daft, how can anyone possibly say that?' P6

A mid-career participant, reflecting on the outstanding achievements of some of his colleagues at the expense of their personal lives, commented on the need to be conscious of the "little things":

> And so now I find that over the last five years, the most difficult decision has been how to balance work and life. And, you know, it's little things, like not reading the newspaper in the morning because the kids are awake and want to talk, and leaving it until 10.30pm when everyone is asleep. P3

Older participants also described rejecting 'recruitment' into particular institutional norms:

> You find that there are camps that are warring, fighting ... I was asked 'Whose side are you on?' by both sides. And there was a big political thing …. and I said 'Neither'. And they said 'Well if you're not on my side, you're against me'. And I said 'Well, fine'. P12

However younger participants were still struggling with an environment that was inducting them into a poor work-life balance:

> [I'm] in my 30s, not married, no children … and looking at some of the people I know and how they work, and how I don't want to work … So I think it's finding that balance ... I'm a bit afraid… P15

> And the work/life balance thing, I think that's my main concern, and I don't actually know that I have a great model of any doctor for that. P20

The lasting effects of assimilation

The experience of assimilating new values led our participants to recognise lasting changes in their attitudes, decisions and behaviours. P14 recognised that, over time, he had become more proactive in trying to influence the system.

> I realised, well, you can influence the system. And I'd read books on, I can't remember - some guy from the UK called it the 'resentful prisoner syndrome', that a lot of doctors end up being locked into this position of creating their own prison ... And there was a broadening of my horizons in the sense that "Yeah, there's a whole different world outside that you could affect and influence". P14

P1 noticed that, over time, she had developed a different attitude towards life in general.

> I certainly came away from that, on a personal and a professional level, sort of thinking about how life is short, and we need to live every day, and appreciate the important things in life … I think from that moment on, I probably took on a different view of life, hope, and I've never forgotten that. P1

One doctor described becoming more assertive in calling on senior doctors for help, regardless of whether she was criticised for lack of knowledge or for not having a firm diagnosis:

> [When] you're not sure what's wrong with them, but you know that there is something wrong … Sometimes you look at a patient and you think 'They look really sick, and I'm really worried', and I act on that… it's hard to put in words. P16

Another participant, who had watched patients being pushed through the system without regard for their concerns, decided to counteract a "treadmill" approach

> I'm really conscious here that we do have a big turnover of patients, and it's really nice here that … people know their names, and they have a doctor that is nice and personable and cares, and says 'Contact me anytime'. You've got to be very careful with the treadmill mentality. P10

Another person who spoke about the active choice of work-life balance decided over a more prestigious post:

> I couldn't identify the mentors and the role models that I wanted to be like. People seemed to be very bad at relationships and enjoying life and balance. While they were generally good clinicians, there didn't seem to be much fun in what they were doing. So during that year I decided I wouldn't look to stay on. P6

<u>The relationship between absorption and assimilation</u>

While there was a continuum from passive absorption across to active assimilation, many participants could identify how more active skills acquisition had happened over time. One participant traced his development in his use of role models from absorption ("I didn't see it at the time") to assimilation, which he chose on reflection, to make part of his own value set.

> [He was] very balanced in perspective. Although I didn't see it at the time because I wasn't party to it … he kept groups together and said *'We're here for patient care, we're not here to politicise medicine'*. I think that selflessness - that ability to be compassionate and caring to his patients as well - that was a real important set of values to me. P14

Another contrasted the way one can "pick up" competencies by absorption, and also learn via practice and feedback to assimilate new learning experiences.

> Registrars, almost 99% of the time, do a lot of the teaching. The good registrars you pick up communication things from, or like the way they examine the patient and you get to see things, or they give you the opportunity to practise with them observing and they'll give you feedback on it, and that's the best learning experiences that I've had. P19

Overall, our participants had been subjected, with or without realising it, to a process of organizational enculturation (learning how to get things done) and professional formation (deliberative moral and professional development). Younger participants were still actively engaged in the process, while older participants, who already knew how to get most things done, also tended to have more settled opinions about moral and professional issues.

Discussion

Although enculturation is a process that has been documented for individual office practices[6] in nursing[27,28] and in pharmacy faculty[29] little is known about how this process actually takes place, and the two mechanisms of absorption and assimilation that we have identified in this study have not been clearly differentiated in the past.

Our study had a number of limitations. Penrod pointed out that "the inherent danger in simple snowballing is that the social network of members will be limited, thus limiting the application of the findings."[30(]p102) However in our study, we asked each participant to suggest potential recruits in other medical specialties, to enable us to achieve maximum variation sampling with respect to their clinical roles. We believe that our findings are likely to be relevant to a broad range of medical graduates, because the marks of the profession are largely shared across cultures and have changed little over time.[31,32]

Another limitation is the fact that we were not able to differentiate between the influence of systems and the influence of particular individuals, but there is probably an important relationship between the two; workplaces tended to attract like-minded people, suggesting that institutions develop and reinforce their own ethos by attracting or repelling certain types of doctors. It appeared that participants, when given the opportunity, sought out workplaces that suited their own values.

Yet another limitation within our study was the decision to gather data based on doctors' perspectives on enculturation via interviews, rather than undertaking an ethnographic study. The latter would certainly complement our study, but our initial focus was on doctors' values. We found, in the course of the study, that enculturation was an important emergent concept relevant to their view of themselves, rather than others' views of them.

There is also the possibility of recall bias, especially with older participants, but we were interested in their perceptions and attributions around the theme of enculturation whether or not this represented the reality of their situation. We expected to find that older doctors had had quite different training experiences, but we were mainly struck by the similarities, which suggest that recall bias was not a major factor, or that it was widely shared.

Having two interviewers, one of whom was slightly known to some of the participants, may have influenced responses, but this seems unlikely. The use of two interviewers and the semi-structured approach appeared to facilitate a free flowing, conversational approach among the participants, some of whom described it as a thought provoking experience. For example:

> Your questions have been searching and made me think, and no doubt I will keep on thinking for several weeks after, so it's been a helpful process to me. I expect that values probably get lost quite easily in the helter skelter of daily practice, and I don't know the extent to which practitioners have forums where those things are re-raised and discussed in the "Why I am doing this?" at the social and personal level. P2

Our findings are consistent with both structural functionalism[33] and symbolic interactionism[34] since, on the one hand, the doctors' behaviour was shaped unconsciously by institutional norms and traditions, while on the other hand they were creating meaning through their interpretation of the social environment, including the behaviour of others.[35] When they were junior doctors our participants had felt like "slave labour" with all the helplessness that this implies. At times, their educational and working environments appeared to value their three major concerns (epistemic, interpersonal and personal) in descending order.

A faculty development program could encourage clinical teachers to more clearly identify these three areas and stimulate junior colleagues to reflect on them.[36] For example, our older participants talked about techniques for resisting enculturation into a poor work-life balance, usually after they had realised that unconsciously absorbing this behaviour had had a harmful effect on themselves

and their families. Meanwhile, younger participants were still worrying about finding a better balance, because they had already absorbed this aspect of the culture. Many other issues yet to be addressed by younger participants were thoughtfully reviewed by older doctors, with reference to the values that had led them to particular decisions about how and where to work, with whom and with what priorities. Other practical examples that are not typically discussed in training include the processes of acquiring and maintaining competence, the meaning and importance of patient centredness, the strengths and weaknesses of various hospital systems and the right and wrong way to behave towards colleagues. Residency training programs might, therefore, usefully alert residents to the way enculturation both 'creeps up' on them and offers opportunities for reflection and assimilation.

Conclusion

The participants in our study were able to reflect on their experiences of enculturation and to differentiate between the experiences they had absorbed and the experiences that they had assimilated and used to direct their future behaviour.

While they had been vulnerable to enculturation by absorption as junior doctors, older participants felt themselves to be more resistant to those forces. They appreciated environments that reinforced desirable values. They tended to avoid, rather than challenge, environments and people whose values were not a good match with their own.

These findings suggest that three key areas - competence, patient-centredness and self-care - are of significant concern to practitioners. Enculturation impacts on each of these concerns. A clearer insight into how enculturation occurs could help junior colleagues to make more conscious choices to shape their career paths in ways that are consistent with their values.

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Table 1: Examples of coding value statements into analytic categories and broader groups

EXAMPLES OF VALUE STATEMENTS	ANALYTIC CATEGORIES	BROAD GROUPING
Participant describes how they unquestioningly - admired senior doctors' interpersonal skills - took many positive values for granted - observed how knowledge is transmitted - absorbed the research culture - felt gratitude for being treated as a colleague - learned new skills from good mentors	**Unquestioning respect** for science/scientific method; for knowledge; for intellectual life; for clinical competence; for interpersonal competence; for wisdom; for others **Perceptions of duty** **Attitudes toward** patients and families **Attitudes toward** colleagues **Ethical behaviour**	ABSORPTION OF DESIRABLE VALUES
Participant describes how they unquestioningly - accepted being treated as slave/working excessive hours - accepted being humiliated/bullied - accepted hospital routines that are no longer acceptable - accepted that some doctors behave unethically.		ABSORPTION OF UNDESIRABLE VALUES
Participant describes choosing - patient-centred values/respect for patients - to fulfil obligation to the society that educated me - to learn from thoughtful observation of experienced doctors - to seek mentors - to improve skills in negotiation - to achieve work-life balance	**Considered evaluation of institutions and individuals** **Active personal and professional development** with respect to - clinical competence - patient care - mentoring (giving and receiving) - ethical decision making - ongoing professional development - work-life balance	ASSIMILATION OF DESIRABLE VALUES
Participant describes choosing to - reject greed - reject poor interpersonal skills - reject failure to care - bullying - laziness - reject self over other interest		DECISION TO RESIST ASSIMILATION

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