

**PROFESSIONAL IDENTITY DEVELOPMENT OF PRE-CLERKSHIP
MEDICAL STUDENTS: A CRITICAL ANALYSIS**

by

© Jinelle N. Ramlackhansingh

A Dissertation submitted to the

School of Graduate Studies

in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

Division of Community Health and Humanities/Faculty of Medicine

Memorial University

February 2022

St. John's Newfoundland and Labrador

Abstract

This dissertation examines how the undergraduate medical education learning environment shapes the development of “the good doctor” professional identity amongst pre-clerkship medical students. The research addresses the gap in scholarship on how the hidden curriculum shapes medical professional identity. The research highlights how the beliefs and practices of students are shaped not by a value-neutral curriculum, but out of and in response to official ideologies perpetuated in the broader learning environment (the “culture” of medical school) in ways that are often hidden.

This research was based on a two-year longitudinal critical ethnographic case study of one Canadian medical school. Data collection included focus groups with a core group of students during their first two years of medical school. This was supplemented by interviews with administrative staff and faculty, and observation of the medical school governance meetings. Undergraduate medical education training was examined from students’ perspectives, focusing on how the formal, informal, and hidden curricula shape professional identity. The critical theoretical frameworks of Pierre Bourdieu and Michel Foucault were used to analyze the complex relations of power and influence in pre-clerkship education. Particular attention was paid to how power intersects with the culture of medicine as the identity of a medical professional is constructed. The results show how official ideologies of what it means to be “the good doctor” as prescribed in the national *CanMEDS roles* and mandated locally through medical school governance structures, are in conflict with and resisted through the counter-ideologies promoted through the hidden curriculum.

This research has important implications for curriculum planning in medical education. The findings provide compelling evidence that the formal curriculum must be designed to account for the effects of a hidden curriculum. Specific recommendations are: (1) Medical students would benefit from having a pedagogical space in the formal curriculum to critically reflect on their experiences and the various ideologies and counter-ideologies of “the good doctor” that are shaping their identity; and (2) Establishing communities of practice as a pedagogical space model, would be a useful framework for facilitating this approach, supporting students to navigate the hidden curriculum and negotiate their own professional identity.

General Summary

This research examines the impact of the medical school learning environment on students during their first two years of training. The focus of the research was on the professional identity development of medical students. Professional identity refers to the way an individual views himself, their beliefs, and behaviours in the learning environment. Professional identity is not stagnant, rather it is fluid as students develop in response to their curriculum and interactions with faculty members, physicians, peers, and patients.

In Canada, the regulatory body responsible for medical training is The Royal College of Physicians and Surgeons (RCPSC). The RCPSC identifies specific roles which physicians must possess to practice. The roles are based on medical-scientific and the non-medical-non-science aspects of caring for patients. Canadian medical schools learning objectives are based on these roles, however, unintentional learning can occur in everyday interactions in the learning field.

In this research, group meetings were done with student volunteers every six weeks. Information was gathered on their views of their teaching sessions and their experiences on health care wards and clinics. Group meetings were also done with administrative staff and interviews were done with faculty members. The data were analysed, and conclusions were made.

The findings of the research showed that students were exposed to both professional and unprofessional behaviours in the learning environment. These experiences influenced their thoughts and actions in the medical education learning environment. The students would benefit from having time in the curriculum to allow for

reflection and discussion of their experiences as they learn what it means to be “the good doctor”. This discussion should take place with their peers and faculty members in small learning groups.

Acknowledgments

I would first like to thank all the medical students who participated in my research. These students opened up about their experiences and made my research the success that it is today. Also of course, I am also indebted to the faculty members and administrative staff who agreed to meet with me and discuss the medical school learning environment. My sincere thanks to Memorial University for supporting this research with funding through a Dean's Excellence Award and the Faculty of Medicine Deans Fellowship Award.

This dissertation would not have been possible without the support of my primary supervisor, Professor Fern Brunger. I am grateful for the endless feedback, words of encouragement and guidance during this research. I would also like to thank Professors Diana Gustafson and Vernon Curran for being part of my supervisory committee. Their guidance on the writing and content of this thesis was invaluable.

My sincere thanks to my colleagues in the Division of Community Health and Humanities Division, Valerie Webber, and Mohammad Syaket Shakil who were part of their own educational journey, and at the same time contributed to mine.

I would also like to acknowledge the Health Sciences Information Media Services (HSIMS), Faculty of Medicine, Memorial University for their help doing the graphics in my dissertation.

Lastly, I must thank my husband Ravi, and children Sanjana and Jayant. Without their patience and understanding this thesis would not be finished.

Table of Contents

Abstract	ii
General Summary	iv
Acknowledgments.....	vi
List of Figures	xii
List of Abbreviations	xiii
List of Appendices	xiv
Chapter 1 Introduction	1
1.1 The Ideology of The Good Doctor.....	4
1.1.i <i>The Good Doctor: The Canadian Context</i>	5
1.3 A Brief Overview of Theoretical Concepts	8
1.4 The Medical School Curriculum.....	10
1.4.i <i>The Formal Curriculum</i>	10
1.4.ii <i>The Informal Curriculum</i>	10
1.4.iii <i>The Hidden Curriculum</i>	11
1.4.iv <i>The Hidden Curriculum and Professional Identity</i>	15
1.5 Rationale for the Study	16
1.6 Aims and Objectives.....	19
1.7 Outline of Thesis.....	20
Chapter 2 Theoretical Framework	22
2.1 Post-structuralism	22
2.2 Bourdieu.....	24
2.2.i <i>Doxa</i>	24
2.2.ii <i>Habitus</i>	26
2.2.iii <i>Fields</i>	30
2.2.iv <i>Capital</i>	32
2.2.v <i>Symbolic Violence</i>	33
2.3 Foucault.....	37
Chapter 3 The Good Doctor.....	39
3.1 Defining a Profession and a Professional	39
3.1.i <i>The Concept of Professionalism in Medicine</i>	41
3.1.ii <i>The Hippocratic Oath</i>	43

3.1.iii <i>Self-Regulation</i>	44
3.2 Professional Identity	47
3.2.i <i>Professionalism and Professional Identity</i>	48
3.3 The Professional, Symbolic Capital, and the Medical Habitus	50
3.4 The CanMEDS Roles: The Orthodoxy of Being the Good Doctor	52
3.5 Summary Comments.....	54
Chapter 4 Methodology	55
4.1 Ethnographic Case Study	56
4.1.i <i>Justification for Using a Case Study in My Research</i>	57
4.1.ii <i>Critical Ethnography</i>	59
4.1.iii <i>Justification for Using Critical Ethnography</i>	60
4.2 The Field Site	60
4.2.i <i>The UGME Field</i>	61
4.3 The Curriculum	61
4.4 The Medical School Pedagogy	62
4.5 Students.....	63
4.5.i <i>Recruitment for Students</i>	64
4.5.ii <i>Recruitment for Student Focus Groups</i>	64
4.5.iii <i>Data Collection and Student Focus Group</i>	65
4.6 Faculty.....	71
4.6.i <i>Interviews with Faculty</i>	71
4.7 Administrative Staff.....	73
4.8 Anonymizing participants.....	73
4.9 Documentary Sources	74
4.10 Observation	76
4.11 Being an Insider	79
4.12 Data Analysis	81
4.13 Document Analysis.....	82
4.14 Rigour of data	84
4.14.i <i>Self-reflexivity</i>	85
4.14.ii <i>Limitations with Methodology</i>	86
4.15 Ethical Considerations	88
4.15.i <i>Consent</i>	88

4.15.ii <i>Anonymity, Privacy and Confidentiality</i>	89
4.16 Conflicts of Interest.....	91
Chapter 5 Performing The Good Doctor.....	92
5.1 Rites of Passage	93
5.1.i <i>Transition into Medical School</i>	94
5.2 The White Coat Ceremony: Wearing Power and Status.....	96
5.3 The Privilege and Hierarchy of Medicine.....	98
5.3.i <i>Medical Hierarchy, Privilege, and the White Coat Ceremony</i>	98
5.3.ii <i>The Medical Hierarchy of the White Coat</i>	101
5.4 Cultural Artifacts Used to Become a Physician.....	105
5.4.i <i>Experiences on Clinical Wards: Developing a Cloak of Competence</i>	106
5.4.ii <i>Using Medical Instruments</i>	107
5.4.iii <i>The Language of Medicine to Appear Competent</i>	110
5.4.iv <i>Patient Charts, the Cloak of Competence and Hierarchy</i>	115
5.4.v <i>The White Coat, Stethoscope, and a Cloak of Competence</i>	118
5.5 Summary Comments.....	119
Chapter 6 The Medical Gaze: Clinical Competence.....	121
6.1 Learning from Role Models.....	122
6.2 The Ideology of Humanism in Medicine	126
6.3 Learning about Humanism: Integrated Learning Sessions	130
6.4 The Anatomy Lab	133
6.4.i <i>The Language of Anatomy</i>	134
6.4.ii <i>Developing the Medical Gaze</i>	135
6.4.iii <i>The Process of Becoming “Removist”</i>	139
6.5 Learning with Standardised Patients.....	141
6.6 Written Assignments.....	143
6.7 Lecture Capture.....	148
6.8 Summary Comments.....	152
Chapter 7 Resistance and The Good Doctor.....	153
7.1 The Spiral Curriculum	154
7.1.i <i>Curriculum Integration and the Spiral Curriculum</i>	154
7.2 Self-Directed Learning.....	159
7.2.i <i>Acts of Resistance to SDL</i>	160

7.2.ii <i>The Consequences and Resistance to Independent Learning Modules</i>	161
.....	
7.3 The Research Curriculum	162
7.3.i <i>Cultural Privileging and the Research Curriculum</i>	163
7.3.ii <i>“Learned Hopelessness” and the Research Curriculum</i>	164
7.3.iii <i>The Checkbox and the Research Curriculum</i>	166
7.3.iv <i>Using the Research Curriculum</i>	168
7.4 Unprofessional Behaviour: Tutorials and OSCEs	168
7.5 Peer Assessment in Clinical Settings	171
7.6 Summary Comments	178
Chapter 8 Power and Privilege. The Hierarchy of Medicine	179
8.1 Counter-Orthodoxy in the Informal Curriculum	180
8.2 Getting Involved	181
8.3 Hierarchy, Harassment, and Bullying	187
8.4 Experience of Racism	194
8.5 Gendered Experiences	197
8.6 Competition in Subfields of Speciality Interest Groups	199
8.7 The Collaborator Roles in Interprofessional Education	203
8.7.i <i>Interprofessional Education: The Micropolitics</i>	203
8.7.ii <i>Challenging the Physician Status - Belittling Doctors in IPE</i>	204
8.7.iii <i>Wrong timing of IPE</i>	207
8.7.iv <i>Unintended consequences of IPE</i>	209
8.7.v <i>Benefits of IPE</i>	211
8.7.vi <i>The Hidden Curriculum of IPE</i>	212
8.8 Summary Comments	213
Chapter 9 Becoming The Good Doctor	215
9.1 The Medical Gaze	216
9.2 Achieving a Cloak of Competence	218
9.3 Power and Hierarchy	218
9.4 Recommendations	219
9.4.i <i>Critical Reflection and Communities of Practice</i>	221
9.4.ii <i>Address the Curriculum Issues</i>	226
9.4.iii <i>Reflect on the Null Curriculum</i>	228

9.5 Limitations	230
9.6 Future Research	231
9.7 Final Words.....	232
References.....	233

List of Figures

Figure 1 The Canadian Medical Education Directives for Specialists. The CanMEDS Roles	6
Figure 2 The Formation of the Habitus	36
Figure 3 The Formation of the Habitus: The Good Doctor	220

List of Abbreviations

CanMEDS	Canadian Medical Education Directives for Specialists
CaRMS	Canadian Residency Matching Service
CLSC	Clinical Learning and Simulation Centre
IPE	Interprofessional Education
MCQ	Multiple Choice Question
OSCE	Objective Structured Clinical Examination
RCPSC	Royal College of Physicians and Surgeons of Canada
SDL	Self-Directed Learning
SP	Standardized Patient
UGME	Undergraduate Medical Education

List of Appendices

Appendix A: Approval Letter	309
Appendix B: Script Read to Medical Students	310
Appendix C: Recruitment Flyer	311
Appendix D: Students Focus Group Discussion Guide	312
Appendix E: Faculty Members Interview Guide	313
Appendix F: Administrative Staff Focus Group Guide	314
Appendix G: Policy and Other Documents Reviewed	315

Chapter 1 Introduction

I'm no prophet. My job is making windows where there were once walls. (Berten & Foucault, 1988, p. 9)

This dissertation reveals how the undergraduate medical education (UGME) learning field¹ shapes the emergence of a professional identity that is constructed around an ideology of “the good doctor” identity in pre-clerkship² medical students. Using a critical theoretical framework (e.g., Foucault 1972; Bourdieu 1977a), I analyzed the complex and multiple relations of power and influence that permeate pre-clerkship education, examining the role they play as the identity of a medical professional is constructed. I explored UGME from the students’ perspectives, focusing on how the formal, informal, and hidden curriculum shape professional identity. By the *formal curriculum* I mean the prescribed curriculum; the *informal curriculum* refers to the ad hoc teaching that occurs outside of the formal curriculum (for example, shadowing physicians in clinics); and the *hidden curriculum* is the teaching that occurs implicitly in educational settings and conveys the unspoken, normative, culturally shaped ways that things are supposed to be done in that setting. This dissertation illustrates how medical students experience the effects of the powerful hidden curriculum that shapes their³ professional identity development as “the good doctor”.

The medical school curriculum influences the developing *habitus*, what Bourdieu (1977, p. 76) refers to as the way of being in the learners. My field site was one Canadian

¹ Field in Bourdieu’s formulation represents a social space where interactions and events occur.

² Pre-clerkship or preclinical refers to the first two years of training, which is mainly classroom based.

³ They/them/their is used as a non-binary term through out this thesis.

medical school, situated at Memorial University in the easternmost province of Newfoundland and Labrador. Medical schools, including the medical school at Memorial University, have a duty "...to shape the novice into the best available knowledge and skills and to provide him [sic] with a professional identity so that he comes to think, act, and feel like a physician" (Merton et al., 1958). Medical students are historically framed as "good" medical students, based on the admitting institution's preferred characteristics (Whitehead, 2011). These medical students will eventually become "good doctors" (Whitehead, 2011). The construct of "goodness" in medical education has been examined by Whitehead (2011). Whitehead (2011) illustrated how medical students are selected based on their ability to be trained to treat patients, and their ability to act as honourable members of the medical profession. Further, "the good doctor", discourse is tainted with medical professionals' power, privilege, and possession of a medical professional identity (Whitehead, 2011). Professional identity development needs to start at the beginning of undergraduate medicine and develop throughout postgraduate training (Cruess & Cruess, 2016). Medicine as a profession expects its members to exert the qualities and behaviours of a professional.

In my dissertation, I report on my findings of the effects of medical school training on the professional behaviours of the students. I illustrate how students navigate the medical education system, trying to be "the good medical student" and eventually "the good doctor". I argue that the values, beliefs, and practices of students are shaped, not by a "value-neutral" curriculum, but out of and in response to dominant ideologies perpetuated in the broader learning environment (the culture of medical school) in ways

that are often hidden. This is important, as the implications in medical education will be to help develop curriculum that can inform or counteract the effects of a hidden curriculum.

Medical education in Canada is based on the medical and non-medical expert roles of the Canadian Medical Education Directives for Specialists (CanMEDS). These roles identify the expected learning outcomes that students should achieve during their medical school training (The Royal College of Physicians and Surgeons of Canada, 2014). I show how the official ideology of “the good doctor” promoted through the CanMEDS roles (that is, inclusive of both medical and non-medical aspects of being a physician) is contradicted by a dominant counter-ideology taught via the hidden curriculum – a counter-ideology that sees “the good doctor” as a medical expert at the expense of the non-medical humanistic aspects of medicine. I illustrate how the complex ways in which culture and power intersect in medical education, with students sometimes explicitly accepting the dominant counter-ideology; sometimes unwittingly perpetuating the dominant counter-ideology; and sometimes actively resisting either the official ideology or the dominant counter-ideology. In all cases, it is the dominant counter-ideology of “the good doctor” as medical expert that becomes reified.

For example, I show how students appear to accept the official ideology by “playing the game” in their informal curriculum, while explicitly acknowledging the problematic nature of the dichotomy of medical-nonmedical roles in the anatomy lab, clinical skills sessions, and written assignments. The dichotomy between the medical expert and non-medical expert roles refers to the tensions between being a medical expert, while at the same time trying to be a humanistic professional. I illustrate how the students'

resistance to the official ideology took forms like unprofessional behaviours towards faculty and colleagues. The students ultimately shaped their professional identity by embodying and enacting the dominant counter-ideology of what it means to become “the good doctor” while ascribing to (or acting as if they adhered to) the official ideology.

1.1 The Ideology of The Good Doctor

There is no standard definition of “the good doctor”, however, the views of physicians, medical students, and patients are similar. A British survey of medical trainees says that communication, expertise in their area of practice, and having a work-life balance are important to being a good doctor (Muddiman et al., 2019). A narrative analysis of American and Canadian students' essays on “What it means to be a good doctor”, reports that the doctor-patient relationship is the most important theme (Rutberg et al., 2017). Patients also tend to value competence and communication skills concerning their care (Paterson, 2012).

Whitehead’s (2011) discourse analysis of the evolution of what a “good doctor” should be shows how the concept has evolved over the last century. Abraham Flexner’s original 1910 report on medical education in North America, favoured a “good doctor” being a white man from a higher socioeconomic background; that is the “educated man” (Flexner, 1973; Whitehead et al., 2013). This ideal evolved from Flexner’s view as a scientist in the early 20th century to be a standardised model of competencies, including values and attitudes that medical students must achieve (Bennett et al., 2017; Whitehead, 2011). There was a shift in the late 1950s around the discourse, of what a doctor is or should be, identifying certain characteristics that doctors should display. Medical schools

selected people based on age, personality scores, intelligence scores, gender, and marital status, all characteristics that were judged to predict the chance of success at medical school (Whitehead et al., 2013). In the 2000s the discourse of competence arose, based on production and performance, to produce “the good doctor” (Hodges, 2009; Whitehead et al., 2013). It is assumed that once medical students can achieve all the required competencies then their professional identity as “the good doctor” is complete (Cruess et al., 2016; Whitehead, 2011).

1.1.i The Good Doctor: The Canadian Context

Medical students develop their outlook and opinions of medicine through various often conflicting discourses of what it means to be “the good doctor” (Bennett et al., 2017), and in Canada, this would include the discourse of the CanMEDS roles (Figure 1).

The Royal College of Physicians and Surgeons of Canada (RCPSC) states that a physician's professional identity is essential to the role of a professional in the CanMEDS framework (The Royal College of Physicians and Surgeons of Canada, n.d.c). Cruess et al.(2015, p. 718) recommend that professional identity should be included in the formal curriculum, “the part that is ‘stated, intended, and formally endorsed’ ” (as cited in Hafferty and Franks, 1994, p.644). The CanMEDS roles are divided into “medical expert” and “non-medical expert”. These roles are visualized as a daisy, with the medical expert being situated in the center, and the non-medical roles being attached as appendages (Whitehead et al., 2011). This daisy represents a powerful way of becoming for the students.

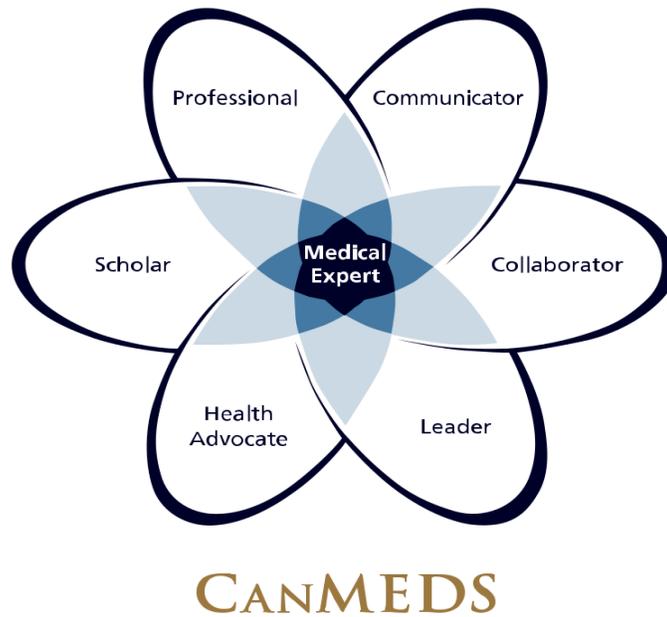


Figure 1

The Canadian Medical Education Directives for Specialists. The CanMEDS Roles

Note. Image reproduced with permission. From: The Royal College of Physicians and Surgeons of Canada. <https://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>.

Copyright © 2015.

1.2 The CanMEDS Roles

Across Canada, the UGME curriculum is based on the CanMEDS roles. These roles dichotomize the medical expert (scientific knowledge, the basis for clinical competence) and non-medical expert roles (non-scientific, the basis for competence in caring and compassion). This dichotomy draws on, and reinforces, a tension between two facets of being “the good doctor”: science and humanism. These competing discourses can lead to confusion about the value of the non-medical expert roles (Sherbino et al., 2011). This separation of humanism and emotion (non-medical expert roles) from the science and the body (medical expert) occurs in various ways throughout the medical curriculum. For example, the use of plastinated models to teach anatomy (which was examined in this research and will be discussed in Chapter 6), reinforces the dominant counter-ideology by de-emphasising the humanistic aspects of being “the good doctor” and contradicts the RCPSC’s official ideology about how to be a “good doctor”. Foucault (2002) regards knowledge that individuals possess as historically and culturally constructed, making it “legitimate” in a particular social structure and historical context. The interaction of legitimate knowledge, practice, and constructed identity produces an official “discourse” in medical education. As Macleod (2011) writes, “According to Foucault, discourses give meaning to the world and organize processes and institutions. Be they complementary, challenging, or competing, discourses structure experiences, society, and institutions—and, in this case, the development of professional identities through medical education” (p.376).

1.3 A Brief Overview of Theoretical Concepts

In my thesis, I use Bourdieu's concepts of habitus, doxa, orthodoxy, counter-orthodoxy, or heterodoxy⁴, fields, and capital. I also draw on Foucault's ideas on power to show the disciplinary nature of the medical school in the formulation of the ideology of "the good doctor". I am mainly using Bourdieu's theoretical framework, but Foucault's concepts of power, the medical gaze and self-surveillance are useful in my research and play a supplemental role in my data analysis.

Bourdieu's *doxa* is described as the accepted, intuitive knowledge of how a field operates (Bourdieu, 1977, p. 164; Deer, 2012, p. 115). Doxa shapes the dispositions of the *habitus*. Habitus refers to the way individuals think and act in fields. The habitus is influenced by the past, like family upbringing, and is structured by the present (Bourdieu, 1977, p. 76; Maton, 2012, p. 50). The habitus allows for the doxa to be accepted in practice resulting in *orthodoxy*. Orthodoxy means that the arbitrariness of the doxa is accepted (Bourdieu, 1977, p. 165; Deer, 2012, p. 118). The orthodoxy tends to be prescribed and is often written in policy documents. In situations where individuals resist the orthodoxy, *counter-orthodoxy* occurs. Counter-orthodoxy, or what Bourdieu calls *heterodoxy*, is the realization of competing interests and beliefs which results in emerging new opinions (Bourdieu, 1977, p. 169). The habitus operates in different *fields* as individuals compete for available capital. By *field*, Bourdieu means the social space where interactions occur (Bourdieu, 2005, p. 148). In medical education, the UGME curriculum is one of the fields. In UGME there are different subfields, each having their

⁴ The terms heterodoxy and counter-orthodoxy are used interchangeably in the dissertation.

own rules and available capital. The subfield I focused on was the pre-clerkship phase of the curriculum, the first two years in UGME. In the pre-clerkship course, there were also different subfields, like the clinical skills lab and the research curriculum.

The power of the medical school enables the development of discourses and knowledge which informs what “the good doctor” should be. This power represses other possible discourses:

Power is needed for production of knowledge, while knowledge is required for the exercise of power. There is no power relation without a correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault, 1979, p. 27).

The impact of this power and the doxa of the UGME fields are the subjects of my research. Foucault (2002) also speaks about “capillary power,” which runs throughout systems and individuals resulting in self-surveillance (Bleakley et al., 2011). I show in my research how the students are actively involved in self surveillance in order to appear competent. I also show in my research how the students develop a medical gaze, as described by Foucault (Foucault, 1973). The medical gaze refers to the objectifying of the body and the loss of the humanity of the person⁵.

I continue in the next section to explain the structures of the UGME curriculum subfields where the students are exposed to the doxa and power of the medical school.

⁵ Foucault’s theories played only a minor role in my data analysis. For this reason, in my thesis I will not be explaining how the two theorists complement each other or are in tension; that is a larger discussion that is beyond the scope of this dissertation.

1.4 The Medical School Curriculum

Medical students learn through the formal (structured and planned) and informal (non-formal but structured, e.g., shadowing physicians on clinical wards) curriculum; and they also learn through the “hidden curriculum”, which includes daily interactions that shape learning in implicit ways.

1.4.i The Formal Curriculum

The formal curriculum is documented and directed by regulatory bodies like the RCPSC and The Committee on Accreditation of Canadian Medical Schools. The learning in the formal curriculum is officially taught and assessed in medical school. The null curriculum, as a subset of the formal curriculum, is special as it includes what the medical school curriculum does not teach (Flinders et al., 1986). The null curriculum is defined by Eisner (1985) as “the options students are not afforded, the perspectives they may never know about, much less be able to use, the concepts and skills that are not part of their intellectual repertoire” (p.107). Decisions on the general objectives content of the Canadian medical curriculum are made by the Medical Council of Canada (Medical Council of Canada, n.d.a). Individual medical schools, however, adapt the objectives to their local context.

1.4.ii The Informal Curriculum

The informal curriculum occurs outside of the formal curriculum and the teachings can be inconsistent with the formal teachings (Davies, 2017). In medical education, the informal curriculum involves unscripted interactions between the students, peers, faculty and members of all the different healthcare professions (Hafferty & Franks,

1994). A systematic review reporting on the informal curriculum in family medicine suggests that residents⁶ learnt about cultural competence, dealing with uncertainty and medical professionalism in this educational space (Rothlind et al., 2020). In my research, medical students took part in the informal curriculum, for example during shadowing⁷ experiences with physicians and being part of speciality interest groups.

1.4.iii The Hidden Curriculum

The hidden curriculum has both positive and negative effects on student learning and has been described as most effective and insidious when its presence goes unacknowledged (Hafferty & Castellani, 2009). The concept of the hidden curriculum is often intertwined and described as the informal curriculum, medical culture, or institutional values, and is associated with lapses in professionalism (Martimianakis et al., 2015). Martimianakis et al., (2015) describe the hidden curriculum as individual behaviours that “...are a product of complex social-political relations involving institutions and organizations” (p.88). It “hides in the gap between the ideal and the real practice of medicine, and it provides the lessons that students and educators need for the everyday work of medicine” (Hafferty & O’Donnell, 2015, p. 60).

There have been concerns that the use of the terms “hidden” and “curriculum” may result in the unconsidered being left invisible (MacLeod, 2014). Further, if the practices that serve to undermine the ideology of being a “good doctor” are considered to be part of a hidden curriculum, the assumption that it is hidden implies it is no one’s

⁶ Residents are postgraduate learners in medical education. They have graduated from medical school and are now doing their specialist training.

⁷ Shadowing experiences involve students receiving permission from faculty and non-faculty physicians to follow them during their clinical duties on hospital wards and in clinics.

responsibility and cannot be changed (MacLeod, 2014). Hafferty and Martimianakis (2018, p. 527) argue that, “there can never be a singular understanding truth about the hidden curricula phenomena.” There is the risk that blaming unprofessional behaviours on the concept of a hidden curriculum would emphasise medical students’ behaviours rather than addressing the implicit structural causes of unprofessional behaviours (Hafferty & Martimianakis, 2018; MacLeod, 2014).

The hidden curriculum can have both positive and negative effects on the students developing professional identity. The positive effects include teaching about altruism, ethical care, and patient-centered care (Karimi et al., 2014; Karnieli-Miller et al., 2011) and the negative effects include diminishing confident attitudes and productivity (Spady, 2010).

The formal and informal curriculum promote the ideology of how to be “the good doctor”. However, competing with that teaching, is the hidden curriculum that happens through both the formal and informal curriculum. The hidden curriculum is the daily interactions which shape learning in implicit ways, the unintended learning that occurs in educational settings, that can sometimes support or resist the orthodoxy of how to be a “good doctor”. The hidden curriculum can be tricky and insidious as it can support the ideology of “the good doctor” in a way that goes against (either resists outright or does not resist outright but reshapes and transforms) the official orthodoxies or stated rules about how to be “the good doctor”. This is done by contradicting or reshaping the behaviours; including doing specific actions or having specific attitudes that seem to contradict the official orthodoxy but are felt by the students to actually support the orthodoxy. I show this in my thesis as the students experience unprofessional behaviours

like bullying: this is framed as developing thick skin as a way to support the quality of endurance deemed to be important to “the good doctor”, but it in fact perpetuates the counter-orthodoxy of bullying as a normative and desirable trait. The complexity of how the ideology of “the good doctor” can be perpetuated but also ignored, contradicted, or otherwise resisted via the teachings of the hidden curriculum will be illustrated throughout this dissertation.

The discourse in medical school is formed through language that describes “hidden cultural scaffolding and social processes that shape practice and knowledge” (D. R. Gordon, 1988, p. 20). The hidden curriculum has been described as existing within the structures and culture of an organization. It is the “espoused values” and “underlying assumptions” that exist and are taken for granted (Hafferty & O’Donnell, 2015). The separate yet mutually reinforcing educational spaces of “formal/informal” curriculum and “hidden” curriculum unconsciously influence the behaviour, ideas, and beliefs of learners about the culture of medicine (Hafferty & O’Donnell, 2015).

The hidden curriculum can be aligned with Bourdieu’s (2000) concept of doxa. Doxa is “a set of fundamental beliefs which does not even need to be asserted in the form of an explicit, self-conscious dogma” (p.16). Doxa refers to the assumptions and beliefs that are unquestioned and are taken for granted as the “way things are” (Deer, 2012). Doxa, the set of taken-for-granted normative assumptions, is how power is reproduced without question. Doxa is responsible for the stability of the social structure as it is reinforced and reproduced. Doxa can be a powerful symbolic force. Students in the UGME field reproduce and reinforce doxa through their perceptions and the actions of

their habitus. They also may transform doxa, in their efforts to resist orthodoxy. In the medical education field, the doxa of the field is conveyed via the hidden curriculum.

In medical education, the hidden curriculum is well known to be one of the most powerful factors in the learning environment that can influence students' professional identity (Hafferty, 1998; Hodges, 2016). The hidden curriculum is produced by the informal interactions between students, faculty, and others within the organizational structure and culture and is intrinsic to the institution (Gaufberg et al., 2010; Hafferty & Castellani, 2009). Hafferty (1998) describes the hidden curriculum as the understandings and rituals that are taken for granted in medical education. Douglas (2002) shows that taboos exist to exert control over social boundaries, and the hidden curriculum in medical education exists to protect physicians' power and autonomy in health care (Douglas, 2002; Ong, 1988). This hegemonic action of the hidden curriculum perpetuates the power of physicians over junior staff and patients. Apple (1995) contends that the function of schools, including medical schools, is to "...teach norms, values, dispositions, and culture that contribute to the ideological hegemony of dominant groups" (p.38).

Power works by making people categorize themselves, which influences how they come to understand where they belong (Goldie, 2012). Individuals in health care learning environments are exposed to the norms about identities created by the dominant discourse and contained in the doxa. The doxa (the unofficial rules, implicit values, benefits, and attitudes) are subsequently reproduced and reinforced in day-to-day interactions. Individuals are encouraged to self-discipline and perform self-surveillance (Foucault, 1982a; Hodges, 2004; Hodgson, 2005), as will be illustrated throughout this dissertation.

My central point on this is that student identities are shaped within the regimes of power and discourse that exist in the hidden curriculum.

1.4.iv The Hidden Curriculum and Professional Identity.

The hidden curriculum impacts professional identity development. One Canadian study reports that institutional policies do not support medical students with disabilities as they try to construct the required identity of “the good student” (Stergiopoulos et al., 2018). The pressures of being in clinical service do not allow time for students’ reflection on how “to be”, an important aspect of identity construction development (Stergiopoulos et al., 2018). The hidden curriculum is described as a “sharp scratch”, similar to warning a patient before venipuncture, it alerts but does not prepare the learner for what follows in medical school (Nunez-Mulder, 2019). Various learning processes are identified in the hidden curriculum. These include the loss of idealism, adoption of a “ritualized” professional identity, emotional neutralization, change in ethical integrity, acceptance of hierarchy, and the learning of less formal aspects of “good doctoring” (Lempp & Seale, 2004).

There is a robust scholarship on the hidden curriculum in the upper levels of medical education. See for example, Angoff et al. (2016), Hill et al. (2014) and Todhunter et al. (2011). It has been widely researched and established that medical students’ professional values and empathy erode as training proceeds (Becker et al., 2007; Benbassat, 2014; Christakis & Feudtner, 1993; Neumann et al., 2011), leading to the declaration, “the Devil is in the third year” (Hojat et al., 2009, p. 1182). Professional identity formation starts early in medical school (Cruess et al., 2015), a time when

identity is also highly malleable (Hodges, 2016). Therefore, the focus should also be on the impact of the hidden curriculum on pre-clerkship students.

1.5 Rationale for the Study

My insider status of having a medical background and formerly working at the medical school in an administrative role influenced my thesis topic, study design and data analysis. My interest in the topics of the hidden curriculum and professionalism was borne through my own work experiences. My previous job at the medical school focused on the pre-clerkship phase of training. I often received reports of a lack of student attendance at classes, and on occasion there were reports of unprofessional behaviour. I was interested in knowing how students developed in their learning environment, what the influences were and why they were important. Given my insider status, I had to aware of my own pre-conceived ideas, and self-reflexivity was important. I was conscious that I needed to be constantly documenting my thoughts and experiences so I would be able to account for my final data analysis of my research.

My research addresses the gap in the scholarship on the hidden curriculum by providing a detailed account of the complex factors that shape medical professional identity in the pre-clerkship years. The preclinical years are when the essential prerequisites for clinical thinking and professional epistemology are learned (Hafferty, 1998). This includes learning what constitutes valid knowledge, what the rules of social intercourse are, and what the moral orientation of professionals should be (Vinson, 2018). Students learn to “to play the part of a physician in the drama of medicine” (Becker et al., 2007, p. 89). Thus, having the students, as well as administrative staff and faculty,

involved in my research with pre-clerkship students added contextual richness to support my findings.

Identity is constructed in the meaning-making processes that medical students engage in with their peers, faculty, administrative staff, and the local health care system. The learner becomes committed to medical education and adopts and maintains a new medical student identity. Medical students become immersed in a new environment, culture, and way of life in medical school. They move from their old identities and become redefined as medical students and future physicians. Medical students are part of a culture-sharing group, one in which the medical school environment, including the curriculum, influences the ways the students talk and behave, their rituals (like the white coat ceremony⁸), their ways of communicating, and their patterns of dress (Creswell, 2015b). Self-identifying as a medical student involves a transition for the learner who increasingly feels as though they are a legitimate participant in the medical education field.

Transitions in identity continue to take place throughout training and the establishment of medical practice. The major transitions are moving from layperson to pre-clerkship student, then to clerkship student, then to resident, and finally to independent practitioner. With a few exceptions, there is a lack of research on the experiences of first-year medical students as they transition from layperson to medical student. A Portuguese survey on first-year medical students' wellbeing in the transition

⁸ The white coat ceremony is the medical students official welcome to medical school. Medical students are welcomed by members of the medical school and representatives of local medical associations. Medical students are given their short white coats at this ceremony.

from high school to medical school reveals that students with better established self-directed learning skills coped better with the large volume of work (Barbosa et al., 2016). This study does not focus on identity, but rather on how achievement and success in medical school can help in building confidence and in future performance (Barbosa et al., 2016). A Norwegian study conducted focus groups with 12 students at the end of their first year to determine what factors impacted their professional identity (Schei et al., 2018). Students in this study rationalized their large volume of work, lack of supervision, and lack of opportunity for critical thinking and reflection (Schei et al., 2018). The result of this rationalization is the belief that poor teaching and a lack of teaching were acceptable and expected as they learned to fit into the medical culture.

In Canada, an analysis of McMaster University students' narratives of their personal development and professional competencies as a doctor at 4, 6, 8, 10, and 15 months of medical school reveals that role models and patient encounters are important influencers on professional identity formation (A. Wong & Trollope-Kumar, 2014). At the University of British Columbia, researchers examined narrative reflections to look at the impact of the transition of third-year medical students into clerkship (Jarvis-Selinger et al., 2019). The study reveals how the students went through phases of "being" and "becoming" in the clinical environment. The researchers used the reflections to identify the concepts of context, focus, catalyst, and process in the development of their emerging identity. The students' experiences stimulated reflection and helped the students to process who they were becoming. These examples illustrate the gap in the literature on the early years of medical school and I suggest my research will help to fill this gap in the literature on the transition of the layperson into medical school.

Physicians have been stereotyped as having a tough competitive mind and a caring aptitude (Bleakley, 2011a). The juxtaposition of the virtues of being powerful and competitive in practice (promoted through entrance requirements) and being caring and collaborative concerning patients (promoted through clinical skills training) was an important focus of this study. In my research, I focused on students' experiences as described in focus group discussions held throughout their two pre-clinical years. As I show, the UGME field including the formal, informal, and hidden curriculum, all influenced medical students' professional identity.

In the UGME learning environment, I show how informal learning shapes students' perceptions and actions. I show how the medical school unknowingly exposed medical students to the doxa of medicine, including perpetuating a specific ideology of "the good doctor" that contradicts the official ideology encompassed and espoused through the CanMEDS roles framework. The students tended to favour medical expert teachings over the nonmedical expert roles. The students prioritized clinical learning in the UGME field, to gain the precious symbolic capital required for the transition to residency (Balmer et al., 2015). They were competitive and at times unprofessional to faculty members and colleagues.

1.6 Aims and Objectives.

My thesis research looked at the UGME field and the impact of doxa on the developing habitus of medical students. Medical students competed in the field to gain symbolic capital, and in the process reified doxa, perpetuating a specific orthodoxy of "the good doctor".

My research examined the complex and multiple relations of power, influence, and resistance, and the role these relations played in constructing the identity of a medical professional. My study aimed to identify how the medical school environment shapes the professional “good doctor” identity of the pre-clerkship medical students. I undertook a critical ethnographic case study to describe in detail a hidden curriculum in the pre-clerkship UGME environment. In particular, I sought to reveal what is going on and is not acknowledged in UGME, and the reasons these practices persist. I explored the mixed messages regarding professionalism, in particular behaviour, language, and actions the students came across and their reactions to these. I use the findings and implications of my thesis to construct a conceptual teaching model that can address the hidden curriculum in pre-clerkship and help professional identity development and professionalism amongst medical students.

1.7 Outline of Thesis

In this thesis I present my key thematic findings supported by Bourdieu’s and Foucault’s concepts. I take Creswell and Poth’s (2018) approach to “Turning the Story” (Creswell & Poth, 2018, p. 288) and use my findings supported by the literature to frame pre-clerkship medical students' experiences as they learn to be a “good doctor”.

The chapters that follow will examine the impact of the UGME field and in particular the subfields where the students internalise how to be a “good doctor”. I have organized the dissertation to show how in the different subfields, the orthodoxy of “the good doctor” was promoted through CanMEDS roles and taught in the formal curriculum.

However, the counter-orthodoxy is embedded in both formal and informal curriculum, which opposed the official ideology of “the good doctor”.

In chapter 2, I describe my theoretical framework. I fully introduce and explain the concepts of Bourdieu and Foucault, whose theories I use to analyse my data. I provide a concept map as a visual aid to explain my application of Bourdieu’s concepts to my examination of the hidden curriculum in the UGME field.

In chapter 3, I present the concept of “the good doctor” and what it means to be professional. In chapter 4, I outline my methodology used for the research. I describe my data collection and analysis processes. In the chapters following, I then begin to present my results, supported by the literature and theory.

In chapter 5, I write about how students perform being a doctor by using cultural artefacts like the white coat. In chapter 6, I describe how students develop the “medical gaze” in UGME. I show how in the various subfields of UGME – in particular in clinical skills training and the anatomy lab – students learn to dehumanize the body. In chapter 7, I highlight student resistance to various aspects of the curriculum, such as elements of the clinical skills and research courses. In chapter 8, I highlight the power and privilege of the medical profession and the acceptance of the ideology of the doctor being at the top of a hierarchy of health professionals. The affirmation of these ideologies of power shape, and are shaped by, the student’s emergence of a professional identity as “the good doctor” in training. I look specifically at the subfields of Interprofessional Education (IPE) and aspects of the informal curriculum. At the end of the thesis, chapter 9, I summarise my findings, and I suggest the use of a “pedagogical space” model to help promote critical reflection and professionalism in medical students.

Chapter 2 Theoretical Framework

We might as well ask what is it ‘to know’ in this way, ‘to construct’ knowledge in this way and ‘what use’ can be made of it. (Grenfell, 2014, p. 228)

In this chapter, I present my theoretical framework. My research employed a post-structuralist framework primarily using Bourdieu and Foucault’s theoretical perspectives. I use the theoretical frameworks of Bourdieu and Foucault to provide an in-depth understanding of the culture of the medical school and to explain what is hidden and taken for granted. I provide detailed accounts of Bourdieu’s concepts of *doxa*, *habitus*, *fields*, and *symbolic violence*. I introduce Foucault’s use of power and show how it is applicable to my research. This may help readers from other medical schools determine whether my findings are transferable to their local context (Rees & Monrouxe, 2010). I provide a conceptual map of Bourdieu’s concepts to provide a visual aid to make understandable the complexity of the relations between the students and the medical field. I also used Foucault’s theories on power to show how the medical school exerts disciplinary power on the students.

2.1 Post-structuralism

My research used the post-structuralist frameworks of Bourdieu and Foucault’s theoretical perspectives. Post-structuralism represents the awareness that the ideas learned by people are produced by dominant institutions. The framework calls these normative views into question (Belsey, 2002a, 2002b; Mayan, 2016). Post-structuralism provides the opportunity for reflection on language discourse and the surrounding environment

(Belsey, 2002b). A post-structuralist perspective helps us reconsider educational discourse that tends to be taken for granted (Ricci, 2002).

Post-structuralism as a genre of theory is most frequently associated with the work of Michel Foucault (e.g., 1975). When analyzing education using a Foucauldian perspective, educators are perceived as practicing “disciplinary power” that operates from within the institution to control student behaviour, including learning and assessment (Rabinow & Sullivan, 1987).

Researchers studying medical education, have previously used poststructuralism. For example, Beagan, (2003b, 2005) reports on the inequalities faced by marginalized populations in medical learning environments. B. Good (1993) wrote about his experiences with medical students at Harvard medical school and shows the curriculum teaches students “formative practices” (p.80). The students learn how to construct and present information in predetermined formats to produce an account of illness, thus objectifying the patient.

Previous research draws on post-structuralism to examine professional identity in various professions including medicine. Bleakley (2014) presents new forms of medical identity construction through different theories such as “becoming” (Deleuze, 1977, 1987), the Actor-Network Theory (Latour, 2005), and Communities of Practice (Lave & Wenger, 1991). These theories acknowledge the impact the learning environment together with its artifacts has on the development of the learner’s identity. Other researchers have used the work of Bourdieu to examine how medical education is infused with power and how that power shapes normative assumptions and actions (Balmer et al., 2017; Brosnan & Turner, 2009; Nimmon & Stenfors-Hayes, 2016).

My research is informed by specific theories within the genre of post-structuralism that attend to relations of power. These include feminist theory (Babbitt, 1993; Harding, 1993), post-colonial theory (Said, 1978), and critical theory (Bourdieu, 1977; Freire, 1970). I used primarily the work of Pierre Bourdieu (1977, 1984, 1984, 1996). Of the post-structuralist critical theorists who examine culture in relation to power, Bourdieu's work is particularly applicable to the education context (e.g., 1996). Brosnan (2009), and Nimmon and Stenfors-Hayes (2016) use Bourdieu's theoretical framework to successfully examine medical education in general.

In the next section I review the work of Bourdieu in more detail, referring to other scholars who have applied the work of Bourdieu to medical education and to explain my own application of Bourdieu to understanding professional development in the pre-clerkship years.

2.2 Bourdieu

Bourdieu's theoretical framework is an appropriate fit for my topic because his concepts of *doxa*, *habitus*, *field*, *capital*, and *symbolic violence* are useful for analyzing the culture of medical education and the impact it has on the development of students in the field. Working with Bourdieu's concepts, my theoretical approach focuses on how medical students make sense of their non-consciously accepted attitudes and values as well as the embodied dispositions that organize how those students respond to the world around them.

2.2.i Doxa

Bourdieu considers doxa to be the acceptance or naturalization of certain ideas that are taken for granted and not questioned (Bourdieu & Eagleton, 1992). The dominant

ideology is reproduced as the natural way of being in society. Bourdieu calls this natural way of being “doxa”. Doxa is lived, practised and expressed in symbols and rituals, such as the white coat ceremony (Maritz & Prinsloo, 2019). Doxa can be seen as a framework that medical students use to make sense of their subconscious acceptance and internalizing of attitudes, knowledge, beliefs, and values of the institutional and organizational culture of the learning environment without knowing they are doing so (Nimmon & Stenfors-Hayes, 2016). Taken-for-granted truths are internalized and subsequently reinforced and reproduced (Bourdieu & Eagleton, 1992).

Nimmon and Stenfors-Hayes (2016) examine how the doxa of medical school education and training creates a medical habitus that affects physician perceptions of power in patient encounters. The researchers show that even though all physicians went through the same training, each individual responds differently to their context, training, social field, and capital when dealing with patients. The “style” of treatment is different and dependent on individual experiences (Nimmon & Stenfors-Hayes, 2016; Sinclair, 1997a).

The institutional management and culture of the doxa of medical education refers to the “hidden curriculum”. Hafferty (1998) describes the hidden curriculum as the understandings and rituals that are taken for granted in medical education. Thus, the hidden curriculum can be understood and examined using the framework of the concept of doxa. A focus on the hidden curriculum alone is useful for describing what it is; a focus on doxa, by contrast, enables us to see why the hidden curriculum is the way it is, by focusing on power in relation to culture. The hidden curriculum is not articulated but is accepted in practice. This awareness of the arbitrariness of the hidden curriculum or doxa

is orthodoxy, which is often prescribed in the form of written texts. The prescribed orthodoxy or ideology results in the “‘rules of the game’ being known and played accordingly” (Bourdieu, 1977; Deer, 2012, p. 118). Challenging the doxa to acknowledge competing beliefs and actions arise as *heterodoxy*, *counter-ideology*, or *counter-orthodoxy* (Deer, 2012). In my thesis, I mainly use the term counter-orthodoxy to describe the resistance to and rejection of the orthodoxy. Some authors following Bourdieu would use the term heterodoxy to describe this counter-ideology or counter-orthodoxy. I, however, choose to mostly use counter-orthodoxy rather than heterodoxy because it more firmly illustrates that it is an explicit rejection of the orthodoxy.

In my research, I explore the hidden curriculum as doxa to make visible what ideas are being perpetuated and reinforced in medical students’ learning and why.

2.2.ii *Habitus*

Habitus was used by Bourdieu to describe how a person thinks about the world and how a person reacts to the field around them (Bourdieu, 1977; Maton, 2012). The reproduction of the understood doxa in medicine, including in medical school, reinforces normative actions and beliefs. The doxa influences the development of medical students’ dispositions in the field. It develops the habitus of students. Bourdieu’s concept of habitus describes a “flexible disposition”, a “know-how”, or an action that does not require knowledge or conditioning. The dispositions of habitus are formed through lived experiences in a specific field (Emmerich, 2013). Bourdieu wanted to differentiate habitus from “habit”, which suggests a pre-conditioned, learned behaviour (Crossley, 2013). Bourdieu saw habitus as being flexible and not dependent on prior knowledge or

expertise. Habitus formation begins at birth, through lived experiences, and it determines the way the individual reacts in different situations.

The doxa of the medical school is enacted through the dispositions of the habitus. The development of the student dispositions in the UGME field makes up the structure of the medical habitus (Luke, 2003; Sinclair, 1997a). Bourdieu describes dispositions as, “An organizing action, with a meaning close to that of words such as structure; it also designates a way of being, a habitual state (especially of the body), and in particular, a predisposition, tendency, propensity, or inclination” (1977, p. 214).

Students learn or adopt sets of “dispositions” that structure the way physicians think and act (Sinclair, 1997a). Students, therefore, take on a “doctorly way of being” (Rice, 2010, p. 288), the physician’s habitus, in order to look and behave like a doctor (Luke, 2003; Rice, 2010). Thus, this habitus can be used to explain the development of the doctor’s professional identity amongst medical students. The habitus does not act alone but develops in relation with the field and the available capital in that field.

Bourdieu and Wacquant (1992, p. 126), write there is “an obscure and double relation” between the habitus and the field. The habitus represents the dispositions or ways of being in a field with its available capital, with capital being the “generative formula of the habitus” (Bourdieu, 1984, p. 208). These three interlinking concepts of habitus, field and capital are described as “thinking tools” (Wacquant, 1989, p. 50), to show that the dispositions of the habitus are formed in relation to one's position in the field (Bourdieu & Wacquant, 1992, p. 127; Maton, 2012, p. 51).

Students’ dispositions respond to changes in the UGME field (Maton, 2012). The habitus operates within a specific context, a field where the dispositions of the habitus

reinforce the power of doxa (Deer, 2012). For example, I will show in my thesis how the medical student with the good science background, confidently presents PowerPoint presentations, while the non-science medical student is left to struggle with presentations.

Bourdieu describes an individual's habitus as being "structured and structuring the structure" (Bourdieu, 1984, p. 170). Maton refers to Bourdieu's concept of the "structure" in this instance as consisted of "...a system of dispositions which generate perceptions, appreciations, and practices" (2012, p. 51). An individual's dispositions are "durable" in that they last over a lifetime and "transposable" in that the habitus, the way of thinking and acting, can become active in different social contexts or fields. For example, I show in my thesis how the students are told they are privileged in their white coat ceremony. This identity of being privileged and of having a high status is reinforced and replicated in public health care settings, as students can access patients on hospital wards for examination.

Habitus is the link between the individual's emotional being and external social processes (Gale & Lingard, 2015). The habitus can be used to explain how identities are formed and modified by external structures of power, resistance, and change (Underman, 2015). Thus, habitus can be used to explain the development of professional identity amongst medical students.

A critique of the concept of habitus, claims it is "...overly deterministic construct that leaves little room for individual agency, innovation, and change" (Edgerton & Roberts, 2014, p. 199). However, Bourdieu does acknowledge that the habitus can be altered to help achieve success in the field (Bourdieu, 1990).

In my research, I paid attention to what people said in the focus groups and their reactions to their experiences in the learning environment. Students' actions in the UGME field develop along with their dispositions in their habitus; this is how they view their environment and the actions they must take as they progress in their career. Their habitus develops in medical education through their interactions with people (such as faculty and patients) and artifacts (such as medical instruments). I show how their medical habitus develops as they accumulate symbolic capital and reproduce and reinforce the doxa and equally how the doxa shapes them and their habitus.

2.2.iii Medical Habitus

The concept of having a medical habitus is described as “acquiring a set of dispositions needed to practice successfully, behave and look like a doctor” (Brosnan, 2009, p.59). Being involved in medical education gives students the practical sense on how to succeed and thus helps create the medical habitus Brosnan (2009, p. 58).

Balmer et al (2015) show how medical students use their dispositions to gain educational and cultural capital to improve their positions in the field. Balmer et al. (2017) show that even though the medical education field impacted students' habitus, the trajectory of their career path is determined by their dispositions. In another study, interviews with 15 residents shows how family background is helpful in the formation of the early habitus and gaining cultural capital, which helps with admission to medical school (Olsson et al., 2019). However, the continuing development of the residents' habitus in medical school eventually determines their specialty choice (Olsson et al., 2019).

Luke (2003, p. xii) describes the medical habitus as a concept that can be used to explain how medical students come to personify medical culture, which "... teaches doctors ways of negotiating their identities within the medical hierarchy and structures." The dispositions that medical students acquire can include specific clothes, language, status, and money (Jenkins, 2014; Sinclair, 1997a).

The specific vocabulary and medical "jargon" used is learned by students and reinforced throughout their training, thus supporting the durability of the habitus (Sinclair, 1997a). Students' social identity is established and maintained using medical language (Sinclair, 1997, p.23). Bourdieu recognized the power that language possesses as prescribed by the governing institution, in this case, the medical school (Nimmon & Stenfors-Hayes, 2016). Bourdieu and Eagleton (1992) state that doxa and in turn dispositions are reproduced and reinforced through the body and language.

Status and economic dispositions reflect the "prestige" of entering medical school and the expected future earnings (Sinclair, 1997, p. 28). Thus, the medical habitus instills a set of dispositions that give the physician the mastery of medical practice (Emmerich, 2013). Case (2014) proposes that the hidden curriculum is performative and includes bodily techniques and ways of being that are learned and rehearsed as part of the medical habitus. Luke (2003) describes how students learned where to stand and how to conduct themselves on ward rounds until these behaviours became "normal" as part of their medical habitus.

2.2.iii Fields

In medical education, the field where the doxa is reproduced exists both in medical schools and health care facilities. A field is described as a social space that is

human-constructed and has its own sets of beliefs and rules (Bourdieu, 1969). Fields structure the habitus as “‘at home’ in the field it inhabits,” where it is “endowed with meaning and interest” (Bourdieu & Wacquant, 1992, p. 128).

Bourdieu often uses the analogy of a football field to describe the social field, as individuals know the rules of the game, players know their position and the play happens in defined boundaries (Thomson, 2012). The state of the field, “whether it is wet, dry, well grassed or full of potholes” affects what “players can do and thus how the game can be played” (Thomson, 2012, p. 66).

For medical professionals, the field can be huge; doxa exists in popular culture through television shows, such as the American television series *ER* and *The Good Doctor*, and other social spaces where the ideologies of what it means to be a doctor get created, reinforced, resisted, or ignored⁹. Bourdieu conceptualized a field as a space that determines the individual’s actions (Jenkins, 2014). Thus, the field is the space where individuals’ dispositions develop and become part of their habitus, “Habitus disposes actors towards certain practices, which are mediated by constraints, demands and opportunities in a field of practice” (Luke, 2003, p.65). The field is not only a structured space but also a structuring environment that influences and shapes roles and identities (Maritz & Prinsloo, 2019).

2.2.iii.a Subfields. It is, however, possible for individuals to participate and compete in more than one social field at a time, such as classrooms and clinic teaching.

⁹ There is a massive network of social spaces in which medical professionalism is constructed and shaped; however, I am limiting my focus to how it is shaped through the formal, informal, and hidden curriculum.

Bourdieu (1990) recognizes that the social world is made up of smaller fields known as subfields. The medical students in this study were part of various subfields such as the anatomy and clinical skills labs. Each subfield has its own rules and regulations but acts collectively to support the doxa of the larger field (Thomson, 2012, pp. 70–71).

2.2.iv Capital

Bourdieu (1996) explains that educational institutions, such as medical schools, are part of a larger system that reproduces existing power relationships. Fields such as medical schools comprise competitive markets where social goods are exchanged (Bourdieu, 1996); in Maton’s words, fields can be considered “networks of value” (2012, p. 62). Actions in the field reproduce the doxa and have been explained by the formula “[habitus] (capital)] + field= practice” (Bourdieu, 1986b, p. 101).

Individuals in fields are always in competition to improve their status in that field (Thomson, 2012). The field where the habitus operates is seen as a “network, or configuration of objective relations between positions” (Bourdieu & Wacquant, 1992, p. 97) operating as an arena “of production, circulation, and appropriation of goods, services, knowledge or status” (Swartz, 1997, p. 117). Legitimate capital lives within the doxa of the field. This capital is defined as “the set of actually usable resources and powers” (Bourdieu, 1984, p. 114). The acquisition of capital means having resources in that field. Thus, the interactions in a field are competitive, with individuals trying to maintain or improve their position in that field.

According to Bourdieu (1984) individuals can accumulate capital over time, and it can be transmitted and/or reproduced. Capital also exists in different forms such as educational background and financial background. Bourdieu (1998) writes about the

“symbolic capital” possessed by the individual or group, which gives them an aura of having “an almost magical power” (Bourdieu, 2009, p. 170). This magical power is recognized by others (Bourdieu, 1988). Bourdieu (1986a) writes that educational capital is “predisposed to function as symbolic capital, i.e. to be unrecognized as capital and recognized as legitimate competence, as authority” (p. 245).

Medical students struggle to acquire different forms of capital to gain prestige and be successful (Bourdieu, 1986a; Brosnan & Turner, 2009). In Bourdieu’s understanding of how power shapes culture, in the field there is a “game” where individuals compete for capital and where the definition of legitimate capital is defined (Brosnan & Turner, 2009). For example, in medical education, trainees “play the game” to accrue capital such as residency positions (Bosk, 2003; Hill et al., 2014). Bourdieu (1977, p. 164) calls this as orthodoxy, where the arbitrariness of the doxa is recognized but accepted in practice. The kind of capital medical students compete for, as I will demonstrate, includes learning experiences and opportunities to meet influential physicians. Having capital gives medical students access to particular fields, such as health care wards and clinics. The accumulation of capital increases the chances of success with highly valued residency placements. The accumulation of capital thus enables a student to improve their position in the UGME field by helping them to appear competent.

2.2.v Symbolic Violence

Symbolic violence has been described as one of Bourdieu’s more confusing concepts. The violence does not induce physical pain, and the social aspect of suffering is not explicit but is internalized by individuals (Bourdieu, 2005; Bourdieu & Wacquant,

1992; Schubert, 2012). Symbolic violence works in a “gentle” manner through the naturalization of domination and hierarchy (Schubert, 2012).

Bourdieu and Passeron (1977, p. 18) wrote that, “pedagogic action is objectively a symbolic violence to the extent to which it is an imposition of a cultural arbitrary by an arbitrary power”. The pedagogy of medical education, including the clothing, language, hierarchy, and status, can be used to show how medical students come to personify medical culture, which “teaches doctors ways of negotiating their identities within the medical hierarchy and structure” (Luke, 2003, p. xiii). Bleakley (2011b) explains that “the vicissitudes of a medical identity are ultimately tied with power” (p.7). The progression of training as a medical student and moving from supervised conduct to unsupervised independent actions leads students to accrue power as they assume the professional identity of a physician (Bleakley, 2011b). The medical profession is described as a “world of its own” where investments and power struggles are what are considered to be important (Bourdieu, 1984; Olsson et al., 2019).

Bourdieu and Passeron claim that pedagogical action is the “...chief instrument of the transubstantiation of power relations into legitimate authority or symbolic violence” (1977, p. 15). Bourdieu and Passeron argue that teaching content and curriculum is not neutral, with pedagogical action transmitting not content but rather the dominant culture as a “fait accompli” (Kupfer, 2015). The symbolic violence in this perspective determines which knowledge is superior or “valuable” and which is inferior or “non-valuable”. Thus, pedagogical action is internalized by the dominated, in this case, the medical student, in a process through which certain knowledge is prioritized, while the exclusion of “lesser value” teaching and content is legitimized (Kupfer, 2015). In my thesis, I also describe

symbolic violence in, for example, the way that gender roles are experienced, and non-medical expert sessions are scheduled at unpopular times in the curriculum.

Bourdieu's concepts of habitus, doxa, field, capital, and symbolic violence provide a useful framework for understanding the field of UGME (see Figure 2). In my thesis I show how the formal and hidden curriculum of UGME shapes the professional identity of the students. In particular, I highlight the practices that are reinforced and reproduced in UGME.

In the next section I take a closer look at the relevance of Foucault to my work.

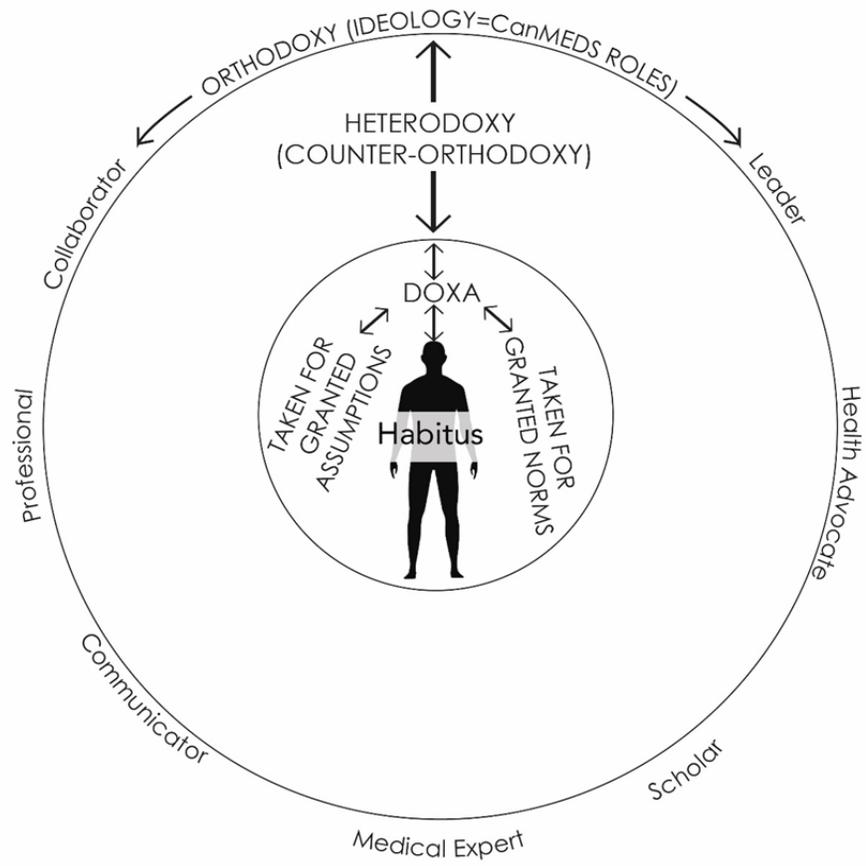


Figure 2

The Formation of the Habitus

2.3 Foucault

In my research, I use Foucault's views on surveillance and power to demonstrate the disciplinary action of the medical school.

Foucault believes that power and knowledge are intrinsically linked, and the dominant view is the one expressed in formal education. Foucault believes in not only sovereign power or top-down power, but also in capillary power (Bleakley & Bligh, 2009; Foucault, 1978, 1979). Capillary power refers to the influence that has worked its way into all systems of the institution. For medical education, this includes all areas, from admission into medical school to the curriculum and pedagogy, including how and what the students are taught. I show in my thesis how students are enculturated to ignore the humanistic aspects of medicine, thus promoting the development of a medical gaze (Foucault, 1973). The medical gaze refers to how doctors change the patient's story to fit a biomedical model, filtering out non-biomedical material. The "gaze" refers to the process of selecting relevant information to fit the biomedical model and ignoring the rest (Good & Good, 1993, p. 94; Misselbrook, 2013).

Foucault speaks about individuals' actions being subject to governmentality (Foucault, 1979). Governmentality includes not only political office but any authority figure in an institution. Governmentality refers to for example, the way authority-controlled populations support the neoliberal and capitalist economy. One aspect of governmentality is the categorization of people for control, which results in the subjectification of the individual. This individual subjectification results in the person adopting the identity of what they could be and how other people would view them.

Foucault shows that through governmentality and, ultimately, biopower¹⁰, which acts at the individual level, medical education tends to create “docile bodies”. Docile bodies are created to function as though under constant surveillance.

In medical education, the learners are under panopticon-like surveillance, with the panopticon functioning to create the impression of constant potential surveillance (Hyslop-Margison & Rochester, 2016). This surveillance acts as a hegemonic process as the students willingly succumb to the control. I show in my research how the students are disciplined as docile bodies, which directs them to self-regulate through reflection assignments and rehearsal for their clinical skills examinations. Currently, in medical schools, there is constant surveillance, as faculty assess students, students assess faculty, and regulatory boards govern curriculum and grant or withhold accreditation of the medical school. This surveillance ensures the hegemonic disciplinary control of learning the accepted values and teachings of medicine. Overall, these hegemonic actions ensure that the students develop into “the good doctor”.

In the next chapter, I continue a review of the literature about professionalism in medicine and the concept of “the good doctor”.

¹⁰ Biopower is the management of populations and discipline of individuals (Foucault, 1978). It allows for populations or individuals to be counted, analyzed, and categorised.

Chapter 3 The Good Doctor

Every established order tends to produce the naturalization of its own arbitrariness. (Bourdieu, 1977, p. 115)

There is no consensus on who or what “the good doctor” represents (Collier, 2012). The RCPSC focuses on the Canadian Medical Education Directives for Specialists (CanMEDS) roles as a framework that details what a competent doctor is supposed to be and do (The Royal College of Physicians and Surgeons of Canada, 2015). However, working in healthcare is not static and instead is characterized by simultaneous processes of patient care (L. J. Gordon, 2017). The views of learners and patients are often missing in the construct of “the good doctor” (Cuesta-Briand et al., 2014). Further, the external forces of capitalism and technology can impact the care received by patients (Collier, 2012). The construct of professionalism embodies what “the good doctor” should be, and as a professional “the good doctor” should be of service to the public (Crues & Crues, 2008).

In this section, I look at the roles of doctors as professionals, the relationship between professionalism and medicine, and the CanMEDS framework to consider the official and competing ideologies of what a competent professional doctor should be and do.

3.1 Defining a Profession and a Professional

An occupation that is considered a profession controls access to information that is considered valuable to the public (Goodlad, 1994). Freidson (1975) explains that a profession has defined knowledge, specific training and examinations required to enter

that occupation. The status of a profession is awarded to occupations whose members possess specialized knowledge and skills that allow them to perform tasks of great social value and whose labour sets them apart from other kinds of workers (Freidson, 1984). A professional traditionally holds a unique position by having specialized knowledge and a commitment to a high degree of service (Freidson, 1975; Hafferty, 2016; Hilton & Southgate, 2007). This unique place in society means that individuals in a profession, such as doctors, lawyers, and ministers of faith, are perceived as acting for the good of society (Freidson, 1973; Pellegrino, 2002). There is an implicit social contract between society and the medical profession regarding what are considered acceptable behaviours and practices (MacDougall & Langley, n.d.).

The social prestige associated with having this specialized knowledge and skills gives the profession and its members power and a monopoly over that knowledge. Access to and control of this specialized knowledge forms the basis of the concept of professionalism, and since knowledge is a form of power, being a professional can be considered a political phenomenon (Goodlad, 1994). This inherent political power allows the profession to dictate who can join and function within its domain (Freidson, 1984). There are several attributes that, taken as a whole, account for this prestige and respect, such as possessing a monopoly of knowledge that is inaccessible to laypeople, having a positive public image that stresses altruistic rather than self-serving motives, and having "the power to set their own rules as to what constitutes satisfactory work" (Haug, 1973, p. 196).

For example, Beck (1992, p.208) writes about the "*internal definition-making power of medical practice*" [italics in the original] and discusses the power of the medical

profession as it escapes criticism through the creation of new facts. The medical profession has been successful in having its worldview perceived as the correct stance, as it connects science, training, and everyday practice (Beck, 1992). In this way, the profession itself controls “cognitive development in the field of activity it monopolizes” (Beck, 1992, p. 211).

The professional is thought to bring unique attitudes, commitments, and concerns to their work, which is referred to as “professionalism” (Tawney, 1920). Professionalism is understood as the means to ensure that the conduct of workers is for the benefit of society (Tawney, 1920). Freidson defined professionalism as:

A process by which an organized occupation usually but not always by virtue of making a claim to special exoteric competence and to concern for the quality of its work and its benefits to society, obtains the exclusive right to perform a particular kind of work, control training for and access to it and control the right of determining and evaluating the way the work is performed (1973, p. 22).

However, the control that professionals have over their work has been criticized (Freidson, 1973; T. J. Johnson, 1972). Haug critiques a profession as only a “folk concept, a semantic technique for winning occupational status and minimizing occupational constraints” (1988, p. 49). These criticisms of professionalism extend to medicine.

3.1.i The Concept of Professionalism in Medicine

Professionalism in medicine, describes the qualities expected of the profession (Pellegrino, 2002). A Bourdieusian perspective frames professionalism as “a form of symbolic capital characteristic of a historically constructed field of power” (Noordegraaf

& Schinkel, 2011, p. 85). Professionalism is understood as a contract between society and the medical profession regarding acceptable behaviours and practices (The Royal College of Physicians and Surgeons of Canada, 2014). This metaphor of medicine having a social contract has been criticized as being a “contracted deliverable and bargaining chip” (Harris, 2017, p. 1236). Some argue that this contract was never debated and it is naïve to assume that ethical medical practice can exist in a consumer-orientated health market (Koch, 2019).

Members of the medical profession understand professionalism to mean being competent, having collegial peer relationships and having an empathetic doctor-patient relationship (Gallagher & Little, 2017; Wagner et al., 2007). Research examining professionalism in medical practice tends to focus on unprofessional behaviours such as incivility (Pattani et al., 2018), offensive and disrespectful communication, and making fun of colleagues (Reddy et al., 2012).

Regulatory bodies across the globe mandate specific professional attributes that medical students and doctors are expected to display, such as altruism, accountability, and integrity (American Medical Association & Council on Ethical Judicial Affairs, 2016; General Medical Council, 2013; The Royal College of Physicians and Surgeons of Canada, 2014). These attributes, however, have been criticized as being too vague and abstract to facilitate the teaching and learning of these concepts (Hafferty, 2016). Further, these attributes are based on western frameworks for medical professionalism and do not reflect the cultural values of non-western countries (Pan et al., 2013). For example, western frameworks dichotomize doctors’ professional and personal lives, while Taiwanese frameworks are influenced by Confucian cultural traditions toward

harmonizing these roles (Ho et al., 2011). Additionally, the use of “professional” along with other concepts such as values and attributes can be confusing to learners struggling to display professional values and attributes (Levinson et al., 2014).

Medical professionalism is described as a product of “deep learning and internalization, something that functions at the level of personality and self-identity” (Hafferty, 2016, p.59). Levinson et al. (2014) suggest that professionalism should be viewed as a competency. A competency is defined as “a set of knowledge, attitudes, and skills that can and should be subject to professional development” (Levinson et al., 2014, p. 20). A systematic review of the definitions and assessment of professionalism found behavioural competencies that were relevant to professionalism, including accountability and abiding by ethical principles (Wilkinson et al., 2009). Viewing professionalism as a competency allows unprofessional behaviour or “professional lapses” to be remediated. In situations of professionalism lapses by learners and doctors, policies need to be put in place for remediation. An understanding of why professionalism lapses occur can inform the appropriate action to be taken (Levinson et al., 2014). The Canadian Medical Association outlines what professionalism entails and how the ethic of service, clinical autonomy, and self-regulation can benefit society (Canadian Medical Association, 2018b). The development of these themes has evolved over the centuries from the original Hippocratic Oath (BC 460).

3.1.ii The Hippocratic Oath

The scholar Hippocrates (BC 460–377 BC) originally wrote about the duties of healers in patient care, with priority being given to rich noblemen (Clark, 2018). The original work is now too outdated to apply to the current postmodern world, but essential

elements such as altruism and ethical practice remain (Catto, 2014; Hilton & Southgate, 2007). The oath has been updated and adopted by the Canadian Medical Association as part of the Code of Ethics to maintain the “fundamental ethical principles of medicine, especially compassion, beneficence, nonmaleficence, respect for persons and justice” (MacDougall & Langley, n.d.). The Canadian Code of Ethics applies to both medical students and practicing doctors.

Criticisms of the Hippocratic Oath are plentiful, with scholars pointing out that social and legal responsibility and patient communication are ignored (Hanák et al., 2019; Jotterand, 2005; Loewy, 2007). However, the Hippocratic Oath provides a foundation for the development of bioethics in medicine, taking into consideration patient welfare and doctors being allowed autonomy and self-regulation (MacDougall & Langley, n.d.).

3.1.iii Self-Regulation

Self-regulation can be viewed from an individual level and at the level of medicine as an institution. Governance of the medical school is made up of a complex network of stakeholders, including public stakeholders, faculty, administrative staff, and student representatives. Governance in the medical profession relates to both personal and institutional regulation. Institutional governance of medical practice challenges the autonomy of doctors (deprofessionalization) (Haug, 1988) or, as Gleeson and Knights (2006) explain, leads doctors to adapt and accept change for their benefit or what they refer to as “strategic operators” (p.279).

3.1.iii.a Strategic Operators. The modern-day “governmentality” (Foucault, 1978) of medical practice has taken shape through the neoliberal management of medical care (Doolin, 2002). The challenge to medical expertise and authority has resulted in the

deprofessionalization of doctors (Racko, 2017). This can reflect training by competence-based education models, which represents the start of the deprofessionalization of doctors (Lombarts, 2015). Training is standardised and can result in the “McDonaldization” of medical education that is, “...commodified, standardised, packaged and delivered” (Bleakley, 2011a, pp. 181–182).

It has been argued that physicians as strategic operators operate “within the cracks and crevices” of management to reassert their professional identities (Gleeson & Knights, 2006, p. 289). Physicians may appear to comply with deprofessionalization, but they actually resist this process through the development of a new emerging professional identity. This resistance can take the forms of ignoring health managers’ guidelines and care pathways or gaining power through being part of administrative management teams (Numerato et al., 2012).

3.1.iii.b Self-regulation of Medicine as an Institution. As an institution, medicine is conferred autonomy to ensure the competence of its practitioners. Self-regulation is awarded, as it is thought that the complexity of the craft is understood best by its practitioners (Cruess & Cruess, 2016). Built within this self-regulation is peer review. “Peer review sans self-review” (Hafferty, 2016) is equivalent to a promise without action — the promise to provide quality patient care without actually doing so. Peer review supports the self-regulation of the medical profession, as expected behaviour and actions will be monitored (Emanuel & Greenland, 2005).

Self-regulation functions when there are established standards that a person must abide by to enter a profession. Learners are taught these standards, monitored for their actions, and reprimanded if there are violations of the standards. There are challenges to

the concept of self-regulation in medicine, as physicians do not practice in isolation; rather, they are reliant on teams and technology (Baron, 2015). The self-regulation of medicine as an institution should then progress to the self-regulation of individuals in medical schools or practice.

3.1.iii.c Individual Self-regulation. Self-regulation in the medical profession is required to identify learning needs and engage in continuing professional development to maintain competence in patient care (Duffy & Holmboe, 2006; Regehr & Eva, 2006). Medical students must be able to manage their learning needs to suit the context of their environment, whether it is clinical or non-clinical. In medical school, the self-regulation of learning is facilitated through specific assigned activities like reflection assignments¹¹ (Brydges & Butler, 2012).

Practicing physicians engage in self-regulation to maintain competency through continuing professional development activities. This self-regulation is a form of governmentality (Foucault, 1978), in which self-surveillance is tied to maintaining licensure to practice (The Royal College of Physicians and Surgeons of Canada, 2019). Physicians engagement in lifelong learning reflects the “...constructing and reconstructing of their identities as they engage with and critique new knowledge, skills, and practices” (Scanlon, 2011, p. 28). This continuous lifelong learning impacts the “becoming” of the individual’s professional identity, as the external environment influences the way professionals function (Jarvis, 2007).

¹¹ Reflection assignments are written assignments where the students write about their experiences in clinical or rural settings (Undergraduate Medical Education, Faculty of Medicine, Memorial University, 2018a).

Self-regulation of the individual has been referred to by Foucault as the “technology of self”, as the person disciplines themselves to the required identity of the doctor (Foucault, 1973; Jaye & Egan, 2006). Medical students, through the negotiation of the unwritten doxa, decide on their actions through engagement or resistance.

3.2 Professional Identity

Medical school has been described as an example of Goffman’s “total institution”, where the person not only learns doctoring skills but is remade as a person (Goffman, 1961; Prentice, 2007). The health care environment itself can influence learners’ professional identity, as students learn to navigate the existing hierarchy of power and culture of the medical field (Lawson et al., 2017).

Professional identity has been described as the way an individual perceives themselves in a social context (Wilson et al., 2013). Social memberships, including interactions with peers, help form identity through lived experiences (Wilson et al., 2013). Individuals place value on social memberships and define themselves as part of their group affiliations (Blouin, 2018).

Professional identity is traditionally been thought of as the actual “being” of a profession (Cruess & Cruess, 2016). Bleakley (2014) expands this notion and considered the medical identity as more dynamic, with the learner “becoming” within the field. The development of the professional in this formulation is not static but rather evolves in the context of historical, social, and cultural histories (Bleakley, 2014). This “becoming” is subjected to changing environments, such as increased access to medical education by women or differences in training structures through curriculum design. Thus, the “becoming” of the professional identity of a physician is dynamic and responds to the

environment (Deleuze, 1994, as cited in Cristancho & Fenwick, 2015). “Becoming” is more than just “being” and includes the expansion of the self in its relationship with others and artifacts (Deleuze, 1994, as cited in Cristancho & Fenwick, 2015).

The construction of a professional identity is part of individual identity development (Holden et al., 2012). It includes the ways individuals see themselves. The professional identity represents a structure of meanings in which individuals identify their motivation and competencies with their career roles (Skorikov & Vondracek, 2011). Professional identity is influenced by an individual’s own identity, language, race, and religion as well as by technological and societal factors (Wilson et al., 2013). In short, professional identity is influenced by their “habitus” and determines the values and behaviours as well as how the individual’s professionalism is performed. I return to this point below.

3.2.i Professionalism and Professional Identity

Wilson et al. (2013) defined the difference between professional identity and professionalism and show how the two are linked: “Professional identity is how an individual conceives of him - or herself as a doctor, whereas professionalism involves being and displaying the behaviour of a professional; in the case of doctors, this includes ethics, expertise, and service” (p.369).

Hafferty (1998) calls for a dedicated process to ensure that new physicians and medical students develop an appropriate professional identity worthy of their status as a professional working in the health environment. A physician’s professional identity is described by Cruess & et al. (2014) as, “a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are

internalized, resulting in an individual thinking, acting and feeling like a physician” (p.1447).

Medical education can be described as “...a form of professional socialization and moral enculturation whereby the profession transmits normative expectations and behaviour to its students” (Jaye et al., 2006, p. 143). This professional socialization is a lengthy and complex process through which students acquire their new professional identity. It is facilitated by informal and formal teaching, peer relations and subcultures, and professional rituals (Vinson, 2018). This socialization involves learning new knowledge and skills and an altered sense of self. This takes place at a nonconscious level that Bourdieu would refer to as the “habitus”. Thus, in the case of medical students, their professional socialization will be the development of their “medical habitus” (Luke, 2003; Maton, 2012).

Part of the goal of medical education training is to have professionalism become part of the medical habitus (Antiel et al., 2013). For example, Monrouxe (2010) wrote about the need for a physician to have a strong professional identity “ethically and practically ...to practice with confidence ...even if medical students learn all the knowledge and skills required of them, they will find it hard to be successful as doctors until they have developed their professional identity” (p. 41). Identities are created and recreated as individuals participate in daily activities and use artifacts within power relations (Monrouxe, 2010). These power relations are communicated and conveyed through the hidden curriculum. In medical education, identity reflects how physicians perceive and act in the profession within changing and sometimes challenging environments. Professional identity includes the physician's understanding of what being

“the good doctor” means and how they should conduct themselves (Bennett et al., 2017; Coulehan, 2005).

3.3 The Professional, Symbolic Capital, and the Medical Habitus

As discussed above, medicine as a profession is powerful, as it is associated with autonomy and the regulation of specialized knowledge. The acts of professionalism are considered a form of symbolic capital (Noordegraaf & Schinkel, 2011). Symbolic capital can be arbitrary, but it gives the holder assets, values, advantages, or disadvantages in the field. Medicine as an institution was able to set up requirements for entry through education that transmitted the profession’s cultural capital, its medical expertise, and that hence contributed to the (re)production of such cultural capital as symbolic capital (Noordegraaf & Schinkel, 2011, p. 88).

Symbolic capital can be objects and artifacts, like stethoscopes, or it can be embodied. Embodied symbolic capital affects the individual’s consciousness, predispositions, and physical features such as their stances and language. Educational capital as symbolic capital can become institutionalized, which supports the embodiment of habitus, and makes understandable the dominant ideas of the surrounding fields (Bourdieu, 1984, p. 71). Medical students’ acquisition of symbolic capital is similar to the formation of their habitus, as it is the integration of mind and body, adapted to UGME fields and transposable beyond those fields. Habitus assesses how to express certain dispositions and how the requirements of the field are “tattooed” onto the body (Luke, 2003, p. 61). This includes walking, language, and body language. Bourdieu and Paaserson (1977, p. 31) describe having social capital as similar to the developing habitus:

Pedagogic action (PA) entails pedagogic work (PW), a process of inculcation which must last long enough to produce a durable training, i.e., a habitus, the product of the internalization of the principles of a cultural arbitrary capable of perpetuating itself after the PA has ceased.

This process gives rise to medical students as professionals imbued with a medical habitus who are able to recognize situations relevant to the medical profession and to act “naturally” based on professional dispositions gained during their training (Noordegraaf & Schinkel, 2011, p. 88). A professional medical habitus thus consists of predispositions that simultaneously reproduce and influence medical practices both within UGME sub-fields (for example, the clinical skills lab) and within the larger field of power in which professional UGME sub-fields are situated (the medical school) (Noordegraaf & Schinkel, 2011, p. 87).

In my research, I show how through the process of entering medical education, the students learn about the desired values, characteristics, and knowledge associated with the profession of medicine. The students compete for symbolic capital in the UGME fields. The medical students are actors in the field who act in “history objectified in the form of structures and history incarnated in bodies in the form of habitus” (Bourdieu, 2000, p. 152). The students’ embodied habitus will determine how they conduct themselves through their structured and structuring dispositions. This will be seen as a “distinction”, indicating a competent student who is aware of the medical fields (“legitimate culture”) and can navigate the fields with confidence as they know “the rules of the game” (Luke, 2003, pp. 56–58). This gives rise to medical students as professionals imbued with a medical habitus. They can recognize situations relevant to their profession and act

“naturally” based on professional dispositions gained during their training (Noordegraaf & Schinkel, 2011, p. 88).

Medicine is a highly structured and hierarchical professional field, and within the fields are subfields of struggle and structure that encourage practices in specific ways that alter the habitus. The strategies that the habitus uses are “coherent and systematic, but they are also ‘ad hoc’ because they are triggered by the encounter with a particular field” (Chan, 1997, p. 115). This links the UGME field’s practices, the habitus, and the professional development of medical students. In Canada, the regulatory body RCPSC prescribes the orthodoxy of what “the good doctor” should be via the CanMEDS roles.

3.4 The CanMEDS Roles: The Orthodoxy of Being the Good Doctor

The slogan of the CanMEDS framework as displayed on the RCPSC website is “Better standards, better physicians, better care” (The Royal College of Physicians and Surgeons of Canada, 2014). The initial CanMEDS roles were generated out of a project established by the group Educating Future Physicians for Ontario and were originally described in their document “Summary: What people of Ontario Need and Expect from Physicians” (Educating Future Physicians for Ontario, 1992, as cited in Neufeld et. al, 1998). The result of the project was the development of eight roles that were seen as the roles of physicians (Neufeld et al., 1998). These roles were based on research done with the public and supported by the literature (Neufeld et al., 1998).

The roles were further developed, and in 1998 the RCPSC adopted a framework for the core competencies for all specialty training, entitled the *CanMEDS roles*. A decade later, these roles were reviewed, revised, and revalidated, and a new edition of the

CanMEDS roles, now referred to as competencies, was released as CanMEDS 2005 (Frank & Danoff, 2007). The CanMEDS were reviewed once again in 2015 to introduce milestones as part of competency-based medical education (The Royal College of Physicians and Surgeons of Canada, 2015). This “breaking up” of competencies into different achievable milestones increased the disciplinary power of the prescribed roles that medical students must adhere to in order to have a successful UGME career (Chen et al., 2015).

The creation and promotion of the CanMEDS roles functions to solidify the official ideology of “the good doctor” for emerging Canadian physicians. A Foucauldian discourse analysis of the Canadian CanMEDS roles framework showed how the physician as a person was left out (Whitehead et al., 2014). Dutch medical schools adopted the CanMEDS “daisy” framework to include “a sense of the person” (Whitehead et al., 2014, p.789), which is drawn as a flower stalk that nourishes and sustains the daisy. The Dutch model emphasizes that students need to be aware of their behaviour, as it can impact their professional work, and the importance of self-reflection is emphasized throughout all years of the Dutch UGME curriculum (Mak-van Der Vossen et al., 2013).

Teaching in Canadian medical schools revolves around the CanMEDS roles. Students are taught the importance of the CanMEDS roles, and the roles are foundational to learning objectives and assessments.

3.5 Summary Comments

In this chapter, I have shown how the orthodoxy, the CanMEDS roles, translate to being a professional doctor. I described the responsibilities of being a medical professional and the expected professional identity.

In the next chapter, I describe the methodology used in my research. I explain my methods, including the recruitment of participants, data collection and analysis.

Chapter 4 Methodology

One cannot grasp the most profound logic of the social world unless one becomes immersed in the specificity of an empirical reality. (Bourdieu, 1993, p. 263)

The methodology I used was a combination of critical ethnography and case study. The method of data collection was a blend of observation, focus groups, and reviewing publicly available text. In this chapter I discuss my research methodology, including data collection, analysis, issues of consent, limitations of my study and being an insider. In each section, I discuss the rationale for my methodological choices.

This research combined two methodologies: critical ethnography and case study research. Critical ethnography “asks what could be”, while conventional ethnography describes “what is” (Thomas, 1993, p.3, as cited in Agar, 2008, p.27). Case study research asks about the “how” and “why” of everyday acts (Yin, 2017, p. 11). Ethnography can be considered as a subset of case study research (Cleland et al., 2021). Case study research is bounded by time, place and a unit of study, while ethnography focuses on the cultural practices of groups (Cleland et al., 2021). In my research I seek to understand “what is going on” and the “why” this occurs, thus an ethnographic case study research design was deemed appropriate. Ethnographic case studies have been previously used in health research (Greenhalgh et al., 2019; McCullough et al., 2015; O’Leary et al., 2020; Storesund & McMurray, 2009) and are well suited to my research as I looked to analyze the sociocultural context of undergraduate medical education learning.

The research methodologies used in this study are suited to the abstract nature of the hidden curriculum and the cultural context in which power relations occur. This research looks at the medical students’ experiences of the effects of a powerful but hidden

curriculum that influences their professional identity development of “the good doctor”. A qualitative paradigm was appropriate to use, as it allows for the exploration of the how, what and why of occurrences (Green & Thorogood, 2014). An ethnographic case study enabled an in-depth examination of the lived experiences of medical students, as they navigated through the pre-clerkship phase.

4.1 Ethnographic Case Study

Case studies are used to understand reality and the surrounding conditions creating that reality (Yin & Davis, 2007). An ethnographic case study has been described as “...an intensive, holistic description and analysis of a social unit or phenomenon... Concern with the cultural context is what sets this type of study apart from other qualitative research” (Merriam, 1988, p. 23). Ethnographic case studies have previously been used in medical education research. One example is a comparative study that examined culture in the training programs in both a Thai university and a Canadian medical school (A. Wong, 2011). In that study, the use of a case study design allowed a case to be defined as residency training programme in each country. In Wong’s study, qualitative data collection included observation field notes and the review of documents such as curriculum schedules and evaluation records. Data analysis included the identification of major themes and subthemes.

The use of multiple sources of evidence is recognized as a hallmark feature of a case study (Anthony & Jack, 2009). The qualitative case study is thus appropriately described by Boblin et al. (2013, p. 1267) as an, “exploration of a bounded system or case over time through detailed, in-depth data collection involving multiple sources of

information, each with its sampling, data collection, and analysis strategies”. Using a case study has advantages, such as helping the researcher examine multiple perspectives related to a single context or phenomenon (Starman, 2013). For example, a case study research design was used in nursing research examining the transition of nursing students into higher postsecondary education (Cronin, 2014). In that case, the use of the case study research methodology allowed the perspectives of the students and the interactions in their working environment to be seen. An important factor was the context in which the research took place, because at that time the U.K. was experiencing austerity measures. The result was an exposition of the tensions between learning and service commitments on the clinical ward (Cronin, 2014).

4.1.i Justification for Using a Case Study in My Research

Ethnographic case studies have been previously used in health research (Greenhalgh et al., 2019; McCullough et al., 2015; O’Leary et al., 2020; Storesund & McMurray, 2009) and are well suited to my research as I looked to analyze the sociocultural context of UGME learning. A case study is a research design that can incorporate many different qualitative and quantitative research methods. It is chosen based not on the choice of methodology, but rather on what is to be researched (Starman, 2013). In my research, a case study was an appropriate design framework as I was looking at a specific university class at a specific time in their training, including various aspects of the context of their training (including curriculum design, policies, and the administration of UGME) as well as the perspectives of the faculty and staff involved in their training.

I used the case study to answer the how and the why questions regarding the students' experiences in UGME. This design accommodates situations in which I have no control over the events,¹² and it requires a focus on phenomena that occur in a real-life context (Amerson, 2011; Boblin et al., 2013). The case study has been described as one of the most powerful research strategies for explaining real-life, causal links, and it enabled me to appreciate the subjective richness of individuals recounting their experiences and perspectives in context (Yin, 2009).

The medical school learning environment and the curriculum can be viewed as “fluid” with students' days being different, moving from classroom-based lectures to anatomy dissection labs, to physician offices, and to practicing clinical skills with standardised patients. The use of a case study research design helped me cope with this fluid environment, as it allowed me to listen to the voices and perspectives of the research participants and the relevant groups (faculty and administrators). Importantly, I was able to take into consideration the context in which these interactions happen.

Yin (1981, p. 59) describe the case study as being “ a research strategy, the distinguishing characteristic of the case study is that it attempts to examine: (a) a contemporary phenomenon in its real-life context, especially when (b) the boundaries between phenomenon and context are not clearly evident.” Given the unpredictable nature of the hidden curriculum a case study research design was appropriate.

¹² Events could include things like the scheduling of their teaching sessions, the organisation of their Monte Carlo charity event and their assessment of topics.

4.1.ii Critical Ethnography

According to Agar (1996), “Ethnography is not simply data collection; it is rich in implicit theories of culture society, and the individual” (p.75). Further, critical ethnography goes further than just describing cultures, as it also attempts to change them (Thomas, 1993, p. 4).

The ontology of critical ethnography relies on the understanding that there are realities that exist beneath surface appearances that may reveal the oppressive side of social life. The accepted ideas of what constitutes the norm create ideologies that serve to stratify people and consequently distribute power and resources in unfair ways (Thomas, 1993). Thomas (1993, p.4) writes that critical ethnography strives to be both hermeneutic and emancipatory. It is hermeneutic in that it attempts to prevent misunderstanding, and it is emancipatory in that it alerts the researcher that “things are not always what they seem” (Thomas, 1993, p. 4).

Bourdieu and Coleman (1991) argue that institutions of power lie behind behaviour and cultural meanings that construct and limit choices, confer legitimacy, and guide our daily routine. This power is symbolic as it relies on shared beliefs and ways of expressing those beliefs (Bourdieu & Coleman, 1991). Symbolic power can be violent because it appropriates preferred meanings and represses alternatives (Bourdieu, 1977). Critical ethnographers resist symbolic power by showing how it restricts alternative meanings, conceals the deeper levels of social life, creates misunderstanding, and prevents action. According to O’Reilly (2008, p. 53) “they also look for the meanings of meanings and how they connect to broader structures of power and control”.

4.1.iii Justification for Using Critical Ethnography

The critical ethnographic approach has been used in adult education research, including health professional education (Carspecken & Walford, 2001; Holmes & Smyth, 2011; MacLellan et al., 2016). Porter (1993) use a critical ethnographic approach to examine racism and professional relationships in an Irish hospital. That study highlights the social structures, including human agency, present within the clinical ward that resulted in ethnic minority doctors using their “professional” status as a means of power in the ward (Porter, 2001).

Critical ethnography has also been used to uncover a hidden curriculum surrounding medical sex education and perceptions of normal sexual behaviour (Murphy, 2016). In Murphy’s study, the author was a participant observer in the *Social Aspects of Medicine* course. Interviews were also done with students, faculty, and administrative personnel reveal that heterosexually “normal” messages are transmitted at the expense of non-heterosexuality. These examples informed my decision to use a critical ethnographic method to examine the hidden curriculum and medical students’ professional identity development in UGME.

4.2 The Field Site

Memorial University’s medical school was established in 1967 with the first medical students being admitted in 1969 (Faculty of Medicine, Memorial University, 2019d). The Faculty of Medicine at Memorial University supports a professional learning environment through the establishment of policies and resources for staff and learners (Faculty of Medicine, Memorial University, 2019b).

4.2.i The UGME Field

Medical students are expected to learn how to become a physician based on the overarching framework of the CanMEDS roles. The roles are structured with the medical expert as central and supported by the non-medical expert roles. As discussed earlier, this structure is conveyed pictorially using the image of a daisy, with the medical expert as the centre of the daisy and the non-medical expert roles represented by the various petals. The students are expected to develop into these roles as part of their professional identity.

There are four courses in the pre-clerkship curriculum in UGME, the Patient course, Physician Competencies course, Community Health course, and Clinical Skills (Faculty of Medicine, 2017). The Patient course deals with normal growth and development, acute illnesses, and chronic diseases. The Physician Competencies course integrates the non-medical expert CanMEDS roles in teaching about research, ethics, and health care systems. The Community Health course teaches about the determinants of health, health promotion, and health systems. Students are also taught to appreciate the role of the family physician in patient management. In the Clinical skills course, the students are taught history taking and the examination of body systems in healthy patients and patients with known illness (Undergraduate Medical Education, Faculty of Medicine, Memorial University, 2019).

4.3 The Curriculum

In North America, undergraduate medical education curriculum generally follow the traditional format of two years of basic science followed by two years of clinical experience (Buja, 2019; Flexner, 1973). Brauer and Ferguson (2015) suggest that Bloom

et al.'s (1984) taxonomy of the domains of learning — cognition (knowledge), psychomotor (skills), and affective (attitudes) — should be featured throughout the curriculum rather than separated into discrete time frames. The overall structure of the curriculum at the medical school of my field site was a spiral curriculum, which is defined as, "...one in which there is an iterative revisiting of topics, subjects or themes throughout the course" (Harden, 1999, p. 141). A spiral curriculum is supposed to encourage cohesion between academic departments and break down barriers that may have developed between courses and departments (Harden, 1999). At the medical school of my field site, the pre-clerkship years (Years 1 and 2) are divided into three phases. Phases 1 (September to December) and 2 (January to June) occur in the first year, and Phase 3 is during the second year.

4.4 The Medical School Pedagogy

The medical school curriculum at my field site operates through various learning and teaching methods to integrate the CanMEDS roles. The curriculum operates on weekdays with students expected to be available between 9 am and 4 pm for instruction. The assessment of the student learning is done through multiple choice question (MCQ) exams, written assignments (including reflection assignments), and Objective Structured Clinical Examinations (OSCEs) of clinical skills. The teachings are lecture, lab, tutorial, or clinic-based, and there is also time allotted in the schedule for self-directed learning, and three hours per week for personal time. There are guidelines on attendance to teaching sessions, some of which are considered to be mandatory (Faculty of Medicine, Memorial University, 2018). The medical school supports blended learning by offering lectures, self-directed teaching modules, and case-based learning. Independent learning is

supported through the availability of lecture capture. Lecture capture involves the recording of live audio and visual aspects such as Power Point slides used in the class for viewing at a later date (Ikonne et al., 2018).

In the next sections, I describe data collection methods and recruitment of student participants. Ethics approval was granted for my research by the Interdisciplinary Committee on Ethics in Human Research. (See Appendix A).

Faculty recruitment and data collection and recruitment and data collection methods for administrative staff are also explained. Faculty members and administrative staff were interviewed only to contextualize the research, rather than themselves being the main sources of data. Data collection took place over two academic years, from September 2017 to June 2019. To gain access to the UGME field, I contacted the gatekeeper. Gatekeepers are sponsors or individuals who enable access to a group under study. They are the key people who give permission or grant access (O'Reilly & Bone, 2008). The gatekeeper to access the UGME environment was identified via the Faculty of Medicine website as the Associate Dean of UGME. The gatekeeper was contacted, and permission was granted prior to data collection.

4.5 Students

A longitudinal study was used to explore the student experiences and views of being in medical school. I sought to capture changes occurring in students' perceptions, attitudes, and expectations in relation to moving from being a layperson in society to a medical student and the professional expectations and responsibilities that come with that role (Corden & Nice, 2007; Faculty of Medicine, Memorial University, 2017a).

4.5.i Recruitment for Students

Data collection was set to begin in September 2017 at the same time classes began. Therefore, I used criterion sampling of medical students (Creswell, 2016). In this ethnographic case study where pre-clerkship students were going to be followed for two years, the inclusion criteria of being a full-time registered student in the Fall semester 2017/18 of Memorial University medical school was used.

4.5.ii Recruitment for Student Focus Groups

Participation in the focus groups was voluntary. The class was approached during orientation in the first week of school. I received permission from a speaker in their Orientation to use the last five minutes of their session to speak to the class. I read from a prepared script (see Appendix B) detailing information on the research study, the voluntary nature of the study, and their ability to withdraw at any time. The students were informed that the focus group sessions were going to be audiotaped, and they were provided with a written summary of the session. Flyers detailing the research (see Appendix C) were placed on bulletin boards in the medical school and were distributed while I was speaking to the class. I continued to recruit students throughout the first semester using snowballing¹³ techniques to ensure that I had enough participants for robust data and to account for participant attrition.

In the first year of the study, I recruited 31 (38.5% of a class of 80 students) students with an average of 23 people attending each set¹⁴ of focus group sessions. Of the

¹³ Snowballing is a “referral” model of using one research participant to help recruit another research participant, who then can help recruit another person (Geddes et al., 2018).

¹⁴ A set of focus groups being the total number of individual focus groups in a particular time. For example, in March 2018, I had a set of focus groups. This set of focus groups had 5 individual focus groups.

31 volunteers, there were 23 females, and eight males¹⁵. All self-identified their gender on the consent form. The mean age was 25.4 years, and the majority were from a science background¹⁶.

Attrition in the second year of the study reduced participation to 25 students, with an average of 21 students attending each set of focus group sessions. Each set of focus groups could have a different number of individual focus groups depending on the number of students volunteering at that time. For example, in March 2018, I had 23 people volunteering so I had five focus groups. In September 2018, I had 18 people volunteering so I had four focus groups.

The students chose the focus group which was most convenient for them to attend. This resulted in different groups of individuals attending each focus group over the two-year period.

4.5.iii Data Collection and Student Focus Group

Focus groups were conducted with the students over a two-year period meeting approximately every six weeks. I conducted a total of 52 student focus groups over the course of the two-year period. Focus groups were used to engage the student research participants in a discussion regarding their past and current experiences and their future intentions.

¹⁵ This was expected as there has been an effort to increase the female medical workforce in Canada (Canadian Medical Association, 2018a). My research participants told me approximately two-thirds of their class was female.

¹⁶ Six students (19%) in my research were from non-science backgrounds. For reasons of confidentiality, I am not able to provide details on what types of non-science background were represented amongst my research participants.

Individual interviews tend to produce more novel ideas than focus groups (D. Morgan, 2004). For this research, my goal was to foster group interactions on students' perceptions of the medical school environment rather than individual perceptions of their experience. However, I made use of quotes from individual participants to illustrate focus group discussions. It is in the interactions between individuals in the focus groups that the collective negotiation and consensus around what is and what should be (counter-ideology; ideology) is best revealed. This includes where students within the group challenged or identified counter-narratives with respect to statements made by their peers (Silverman, 2004). Focus groups enabled students to explore and explain their opinions in ways that would be less accessible had they been interviewed individually. Focus groups have been described as "more naturalistic" than individual interviews as they encourage more communicative processes (Silverman, 2004). As D. Morgan (1997) writes, "The hallmark of focus groups is their explicit use of group interaction to produce data and insight which would be less accessible without the interaction in a group" (p.2). The creation of a "synergistic effect," where interactions between participants allow the production of more elaborate and detailed accounts than individual interviews, was beneficial in my research (Silverman, 2004). This interaction helped to focus the research on culturally important norms (D. Morgan, 1997; Sobo, 2009). Also, issues arose I was not aware of or had not previously considered. In the focus groups I facilitated "interaction among the participants...and the information obtained (will be) enriched through the collective recall of experiences. Conversations between individuals as they prompt one another became as important as are the comments between the individual and

(myself)” (Freeman, 2013, p. 141). I engaged the student participants in discussions about their past and current experiences and their future intentions.

The participation of the moderator of a focus group can be disadvantageous to the discussion and might unknowingly disrupt group dynamics (Hesse-Biber & Leavy, 2004). My previous experiences working in UGME may have inevitably shaped my questions, responses, and possibly even body language, which may have had an impact on my interactions with the participants. Thus, I needed to exercise reflexivity during my data collection and analysis. Self-reflexivity is a way for a researcher to enhance their awareness of their opinion on the research topic and thus be receptive to viewing that topic from a different perspective (D. Hays & Singh, 2012; Horner, 2002). The conditions that researchers should keep in mind as they carry out their research include not judging their participants in the study and recording all that is said or observed (D. Hays & Singh, 2012).

Research based on focus groups should, ideally, consist of four to six focus groups, as beyond this data become saturated (that is, no new ideas are generated) (D. Morgan, 2004). Ideally, each of my focus groups should have had no fewer than four and no more than six participants, as this would have allowed me to have sufficient engagement with the students to ensure that all students could have a voice (Silverman, 2004). This, however, was not the case at times. On four occasions, I had eight people in a focus group and on two occasions there were three people in the focus group. I was hesitant to cancel the focus groups based on student attendance, as I was aware of their busy schedule. In my reflection notes, I was aware of the power students had over my data collection. If the students did not attend the focus groups, my research would not be

successful. Thus, in the interest of continuing my research, I did allow focus groups to continue with as few as three and as many as eight participants. There is research which suggests that focus groups can continue with four to 12 participants (Glenton & Carlsen, 2019). However, I documented in my reflection notes, following a focus group with eight students, that it was difficult to keep track and control of the conversation with this many, as people were speaking between themselves.

Once the final number of volunteers was known, participants were advised of the dates of the focus groups and asked to indicate their preferred time and date. It was expected that attrition would take place as the semesters proceeded. I used small teaching rooms in the medical education building to carry out the focus groups. This location was familiar and accessible to the students as it was close to their lecture theatres. I attempted to create a hospitable non-threatening environment to encourage students to share their experiences. The aim was to create “power equality” in the room by empathizing with the students in the hope that they would share their thoughts and experiences (Karnieli-Miller et al., 2009). I provided a pizza lunch for participating students, as the sessions took place during their lunch hour. I chose lunchtime because the students were guaranteed to be at the university for classes in the morning and afternoon sessions. However, I did not take into consideration other competing activities the students were involved in such as, student-led interest groups, the annual “Monte Carlo” charity event,¹⁷ and Student Affairs sessions.¹⁸ The focus group sessions lasted approximately 45 minutes, which left students with enough time to prepare for their afternoon classes.

¹⁷ Students reported to me that the Monte Carlo charity event was very time consuming for them.

¹⁸ The Student Affairs office sometimes held information sessions for the students during lunch.

For the focus groups, written consent was obtained at the first meeting, and then verbal consent was given at subsequent meetings. At each meeting, participants were reminded about the research focus, that participation was voluntary, and that they were free to withdraw at any time. They were also informed that withdrawal would not result in the destruction of their previously collected data. Regarding longitudinal focus groups, Corden and Nice (2007) write that not using data, "...would be wasteful both in terms of resources expended already and, importantly, in terms of the loss of insights from the data collected thus far" (p.563).

A discussion guide (see Appendix D) was prepared for each focus group based on recommendations from Stalmeijr et al. (2014). I began each focus group with introductions, moving onto transition questions, then key questions, and finally ending questions. The session concluded with a summary of the discussion and arrangements for the next meeting. I maintained a journal of my reflections following each focus group meeting, to use during data analysis.

The focus groups were audiotaped and transcribed for analysis. A transcriber based at Memorial University was used, rather than transcribing the interviews myself. The transcriber understood the need for confidentiality. I was able to immerse myself in the data by reading the transcription while listening to the audiotapes and at the same time checking my reflection notes on the focus group. At the end of each focus group, a summary of the session was sent to the attendees for their review. There were no issues arising out of the focus group summaries.

A nominal “gift” of a \$10 Tim Hortons¹⁹ card was given each time the students attended the focus group. The issue of paying or the giving of incentives to participants of research has been debated. In quantitative studies using surveys and questionnaires, monetary incentives have been shown to increase participation rates (Singer & Cong, 2013; Singer & Kulka, 2001). Thompson (1996, p. 3) suggests that providing compensation is the “beginning of a way to equalize” the uneven power relationship between the interviewer and interviewee. Also, providing an incentive to participate would “... avoid the bias which might have resulted from the omission of those who declined to participate because they put a greater value on their time, energy, and views” (Thompson, 1996, p. 5). Head (2009) notes that the amount “paid” to participants should be given “fair return” for their time and not set at “coercive levels”. There are currently no guidelines for judging what constitutes overly coercive incentives, though research ethics policies do provide some guidance (TCPS 2, 2014). At the time of this data collection during the students’ pre-clerkship academic years 2017/18 and 2018/19, \$10 was enough money to purchase a single medium cup of coffee or tea each day for five days of the week. Thus, I considered this an appropriate amount to be given. The provincial Health Research Ethics Board in St. John’s N.L. does not bar the use of incentives for recruitment to research studies.

Interviews including focus groups can act as an intervention through “...reflexive consciousness from participants...expression of feelings and ideas in confidence” (Nicolson, 2003, p.141). The interview then becomes an encounter similar to a counseling

¹⁹ Tim Hortons is a coffee restaurant, with a branch in the local hospital near the medical school.

interview, where all participants are engaged in the content and construction of the meeting through mutual engagement (Nicolson, 2003). My reflection journal reveals that students told me they enjoyed coming to the focus groups. I believe the experience of taking part in the focus groups allowed them to verbalize any difficulties they were having without being judged. In this light, the focus groups could have also acted as an intervention or a stress reliever for the students (Swenson et al., 1992).

I now turn to a discussion of the recruitment of faculty and data collection using interviews.

4.6 Faculty

Faculty members who teach or hold administrative roles in the pre-clerkship curriculum were emailed to take part in focus groups. These focus groups were to be held at the end of each phase. My attempt to organize a faculty focus group was futile because of scheduling conflicts. Thus, I revised the method and instead held individual interviews with interested faculty members. Ethics approval was sought and gained for this amendment to the original study design. In total, 26 semi-structured interviews were undertaken with faculty members. This included four faculty members who held administrative positions, 12 non-clinical faculty members, and 10 clinical faculty members.

4.6.i Interviews with Faculty

In-depth interviewing has been described as a means of qualitative inquiry that uses questions to gain in-depth responses about peoples' experiences, perceptions, opinions, and knowledge (Patton, 2002). By conducting interviews, the researcher attempts to understand what the participant means by what they say. It is understood that

an in-depth interview can never be “neutral, objective, and unbiased acts... [as there is] mutual construction of the topics under discussion” (Nicolson, 2003, p. 144). Through in-depth interviews, I gained access to faculty’s experiences and the challenges they faced in providing undergraduate medical education. The faculty interviews helped me contextualize the students’ experiences and build an overall view of the students’ world in medical school.

Faculty members who were involved in administrative and teaching roles were identified through the Faculty of Medicine UGME website. Faculty members who were teaching the students were identified from the teaching schedules available on the UGME website. The relevant contact information was also available on the website, and this information was used. There are over one hundred teaching faculty in the pre-clerkship program in this medical school. Faculty members are either clinical or non-clinical, and may meet the students in lectures, tutorials, or clinical skills sessions. Those faculty members who responded to the email invitation were interviewed at a convenient time and place (either in their office or in a small learning room in the medical education building). Prior to asking for consent from to be signed, faculty members were made aware that the interview was voluntary, and being audiotaped, and that every attempt would be made to de-identify them (see Appendix E for faculty members discussion guide). The interviews lasted generally from twenty to thirty minutes. A summary of the interview was sent to the faculty interviewee for their review. There was one interview summary that the faculty member corrected, as I had misunderstood the faculty member’s views on the UGME curriculum. This did not alter my research findings.

I continue in the next section to describe data collection and recruitment for administrative staff.

4.7 Administrative Staff

Focus groups with administrative staff involved in the organization and delivery of the pre-clerkship curriculum were carried out. I identified administrative staff from the Faculty of Medicine website. The recruitment process was by email invitation, with email addresses being accessed via the Faculty of Medicine's publicly available staff contact information. I had 12 administrative staff volunteering for my research focus groups. I had four focus groups with administrative staff: one in Phase 1 (first-year), one in Phase 2 (first-year) and two in Phase 3 (second-year). I considered it important to include administrative staff in my study, as they were involved in organising the learning environment the students experienced and had information that would be helpful to contextualize student experiences. I aimed to have four to six volunteers in each of the focus groups. However, in my final focus group in June 2019, only three out of the four volunteers attended.

The research participants were advised that the focus groups were to be audiotaped (consent was obtained), and the data were anonymized and kept confidential (see Appendix F for Administrative Staff focus group guide).

4.8 Anonymizing participants

The students were anonymized by assigning everyone a different name. I did not want to inadvertently reveal identities or create an assumption of an identity based on the name chosen, and so names were used that are widely recognizable or commonly used in the Newfoundland context. This was done randomly using the Top 100 trending baby

names found on a public website (Baby Names, 2020). This website was useful as the names were placed in sequential order of popularity, so my first female volunteer was allocated baby name number one from the website. If a name was exact or similar to a participant's names (e.g., Elizabeth and Beth), I used the next available name on the list. I took the risk of unknowingly using a non-research participant medical student's name or unknowingly using students' middle names or names of their significant others, like a parent or sibling. If this happened, it was not my intention. The students were identified by their pseudonym and their phase of training in pre-clerkship (Phase 1, Phase 2, or Phase 3).

Faculty volunteers were assigned numerical codes, so the first faculty member I interviewed was assigned code *Fac 01*. The faculty were from clinical, non-clinical, or administration in their roles at the medical school. Some faculty held dual roles in the medical school, both administration and teaching. In these cases, I chose to describe the faculty member in the role where they spent the most time, engaged with the students (teaching) or the medical curriculum (administration). The administrative staff who attended the focus groups were not individually anonymized. Any issue I reported from an administrative focus group only had the focus group number. I did four focus groups with administrative staff, so the focus groups were numbered FG 1, FG 2, FG 3, and FG 4.

4.9 Documentary Sources

Documents publicly available from the Memorial University Faculty of Medicine website were used to inform the research. These documents included the student

handbook, faculty handbook, the student curriculum schedules, and the minutes of UGME Governance meetings

Documents have been described by Riles (2006) as "...artifacts of modern knowledge practices that define ethnography itself" (p.7). The ability to study documents helps the ethnographer "to know" (Riles, 2006). Textual records embody individual actions, interactions, and encounters within social settings (Flick, 2014). As Boblin et al. (2013, p. 1272) write, "In case study research, researchers use documents as a source of contextual information about events that cannot be directly observed; documents also are used by researchers to confirm or question information from other sources". Public documents have been described as "cultural artifacts" used to inform ethnographies. People's names were not used, and any information taken from the minutes was anonymized as much as possible. The information gained from the minutes helped provide information about the ongoing environment and culture of the institution and the UGME curriculum.

The use of text data can complement qualitative research in which qualitative text analysis has a complementary role in the main data collection methods (Perakyla & Ruusuvoori, 2011). Further, written texts can represent the local cultural, social, and political construction of those who cannot be interviewed or take part in focus groups (Onwuegbuzie et al., 2009).

Other organizations' websites were used to provide context for medical training in Canada and specifically in Newfoundland and Labrador. These organizations included the RCPSC and The College of Physicians and Surgeons of Newfoundland and Labrador. These organisations' websites provided the standards and expectations for

professionalism for registered physicians in Canada. There are other regulatory bodies involved in Canadian medical education, like the Association of Faculties and Medical Colleges, the Medical Council of Canada and the Committee on Accreditation of Canadian Medical Schools (*About CACMS | CACMS*, n.d.; Association of Faculties of Medicine of Canada, 2019; Medical Council of Canada, n.d.b). However, the underlying ethos of these organisations aligns with the RCPSC aims and objectives for medical training in Canada. Thus, it was decided to mainly use the overarching regulatory body, RCPSC documents.

4.10 Observation

There are numerous governance meetings that take place involving the UGME curriculum. I chose to attend those meetings that would directly help me to put into context the orthodoxy and expectations of the student's curriculum. This meant I went to those governance meetings that discussed content relevant to the students in my research (for example, I went to Phase 1 meetings when my research cohort was in Phase 1). I attended other meetings like the Undergraduate Medical Studies²⁰ (UGMS) committee meetings if I was aware that there were going to be discussions about changes in the structure of the UGME curriculum.

The classes that I chose to observe related to topics that would help me to answer my research objectives. For the observation component of the research, consent, and permission to attend the meetings or lectures for observation only were gained from the chair or faculty member in charge of that meeting/lecture. I provided a script for the chair

²⁰ UGMS is a senior level governance meeting and includes representatives of both pre-clinical and clinical phases.

of the meeting or teaching faculty member to explain my presence as a researcher, my research topic, and why I was at the meeting to observe. It was stated that all data would be anonymized, and that I would not use personal identifiers. Further information regarding consent and privacy is given below.

As described by Gold (1958), my role as an observer was one of “formal observation” rather than participant observation, as I am no longer attending these events as part of my previous job. I was recognized but only regarded as a researcher in the field (Angrosino, 2007). The benefits of observation-based research have been described as the ability of ethnographers to have a more peripheral role in their communities under study, to recognize that it may not be possible to combine observer and insider status to develop an objective understanding and that the community under scrutiny may not be collaborative partners (Bratich, 2011). Observing people in their natural environment not only helps avoid problems of bias in self-reported accounts, as it can also reveal insights not accessible with other data collection methods, such as structures, processes, and behaviours the interviewed participants may be unaware of themselves (D. Morgan, 1997).

The nonparticipant-observer role usually involves the intensive observation of a field setting without contributing to that field. My goal of non-participant observation during meetings was to develop an understanding of how the medical school functions and the impact it has on the students (Stahler & Cohen, 2000). Utilizing a nonparticipant-observer approach to gain an understanding of the medical school environment was viable, as my presence did not alter the culture, including the curriculum, or the governance of the medical school.

Sometimes, the mere presence of observers in a field can lead to a change in behaviour of those being observed to meet the expectations of the observer. This is known as the Hawthorne effect (Stahler & Cohen, 2000). To attempt to counter this, attendees at meetings were reminded that I no longer work in UGME, that my presence is solely that of a researcher observer, and that any data will be kept confidential and anonymized. There was the challenge of blending in to the meetings as I previously attended these meetings as part of my job (Handley et al., 2020). However, I was not part of the roundtable meeting, and no questions were directed to me. My position in the room was normally in a corner where I could observe and make my notes.

Data collection during the observation was in the form of fieldnotes. Fieldnotes have been described as “accounts describing experiences and observations the researcher has made while participating in an intense manner” (Emerson, 2011 p.4). It has been suggested that fieldnotes are, in reality, the ethnographer’s interpretation of the research participants’ experiences and affairs (Emerson, 2011). The value of fieldnotes does not depend on quantity of notes, but rather on their details and quality. Thus, in one guide to fieldnote writing, Suelzle and Pasquale (1981) warn that: “adjectives and adverbs are possibly the worst offenders (‘aggressive’, ‘active’, ‘passively’, ‘enthusiastically’, and so on). You must tell in what way(s) the individual exhibits these types of action” (p.156). This advice was useful for my description of events and experiences.

I used a guide provided by Farrell et al.(2015) to document my experiences with focus groups and observation. The information I recorded as field notes included: what were the key issues for reflection in this experience, what factors were influencing my actions in this experience, were the students' views fully explored, and what was my

action plan in this experience. In gathering this information, I was able to introduce my own experiences in the final analysis of the data.

As my research progressed, my assumptions and “emic” perspectives were challenged, forcing me to be reflexive and adjust my research paradigms. There was a strong possibility that I was a “privileged observer” because of my past knowledge working in the UGME office (DeWalt & DeWalt, 2011). The notion of a privileged observer status was discussed concerning a nurse researcher doing ethnographic research investigating her patients undergoing fertility treatment (Allan, 2006). Allan (2006) found that keeping a reflective diary helped in distinguishing her emotions and documenting what participants of the research said and felt. Thus, at the end of each encounter, I tried to critically reflect on the day’s events, including any meetings, student lectures attended, or focus group facilitation.

4.11 Being an Insider

I am a registered physician in the United Kingdom; however, I do not practice here in Canada. This occupational knowledge provided me with an “insider status” as I was aware of most of the medical jargon and artifacts the students discussed. Merton (1972) was an advocate for insider research as “the Outsider has neither been socialized in the group nor has engaged in the run of experiences that makes up its life, and therefore cannot have the direct, intuitive sensitivity that alone makes empathetic understanding possible” (p. 15). There is no definite consensus to whether insider research is better than outsider research as researchers move continuously between the insider/outsider dichotomy (Mercer, 2007).

I previously worked in the UGME office in an administrative role for two years, which put me in contact with faculty and administrative personnel. This insider knowledge also gave me the understanding about “how things work[ed]” in UGME (Cleland et al., 2021, p. 7). Having this insider knowledge helped in choosing my thesis topic, my data collection and analysis. My previous clinical experiences and experience working in UGME helped to build my interest in professionalism in medical education and the medical profession. I was very interested in elucidating how and why the hidden curriculum occurs and how this impacts the professional behaviour of medical students. These work experiences gave me an “insider” role where I was native to the setting and familiar with health care environments, the workings of the UGME curriculum and the governance structures. Former coworkers may have felt worried and believed they had no option but to take part in the study due to the pre-existing relationship. They may have also feared adverse consequences for their role at work if they did not participate (McDermid et al., 2014). The participants were assured that they were under no obligation to participate in the research. Participants who did volunteer were told that all data would be anonymized and kept confidential.

There was also the possibility that during my interviews, my familiarity with UGME may have led to less probing and less challenging questions (Brannick & Coghlan, 2007; Hellowell, 2006). Mercer (2007) considered insider research to be, “like wielding a double edge sword” (p. 7), as what can be gained in terms of knowledge and familiarity with the context may be lost in terms of an insider’s inability to “make the familiar strange” (p. 7). Thus, I had to ensure that I had a list of questions and topics I wanted to discuss, and my post-attendance summaries, were confirmed by the

interviewees. I always had to be conscious of my data collection with former colleagues, both faculty members and administrative staff, to ensure that they did not take it for granted that I was aware of their experiences.

In my data analysis, I really had to look at the data from a distanced perspective, considering the bigger picture and the previous literature I had read. I exercised self-awareness of my own emotions and my feelings about the curriculum, the interviewees, and the medical school governance, using means such as keeping a personal journal and regularly consulting with my research supervisor.

There are criticisms of insider researchers' data analyses. I am aware that given my previous experience working in the Faculty of Medicine, I do have "conceptual baggage" (Kirby, 1989), which I accounted for in the analysis and presentation of my data. The analysis of my data had to be meticulously interpreted to ensure credibility. I was at risk of drawing premature conclusions based upon my own preconceived ideas (Fleming, 2018). I sought to overcome this by periodically reviewing my data transcripts with my supervisor, who gave useful points of view. Having my supervisor reviewing and discussing my transcripts gave an etic (outsider) perspective to the data analysis. Using both emic and etic perspectives in the data analysis allowed for balanced perspectives and conclusions to be drawn from the research findings (Cleland et al., 2021).

4.12 Data Analysis

I focused on a critical ethnographic case analysis of the data. Ethnographic analysis "...aims to be contextual... [and] aims to represent the social world from the participants' perspective" (Silverman, 2004 p.183). The use of focus groups for this study resulted in three levels of data being generated: (1) data about individuals, (2) data about

the group discussion, and (3) data about group interaction (Onwuegbuzie et al. 2009). I also had my field notes (reflection diary) from observations at meetings, lectures and reflections post focus groups or interviews. Doody et al.(2013, p. 266) write that “the analysis of focus group interviews is often a complex process... where the researcher is involved in unraveling many strands and layers of meaning”. There is controversy about whether the unit of analysis should be the group or the individuals in the group (Kidd & Parshall, 2000). It has been suggested rather to use both as a “focus of analysis” and that the use of software to manage the data might be warranted (Doody et al., 2013; Kidd & Parshall, 2000).

After each focus group, I had the material transcribed, and then I thoroughly re-read it to “immerse” myself in the data, taking into consideration my reflections and field notes. In the analysis, I had to provide contextual, interpretive accounts of the students’ social world in UGME. I used a “funnel” approach as described by Hammersley and Atkinson (2007) where throughout the research, the research questions may be adjusted, ideas may evolve, and theories may be tested.

In the next section I describe my analysis of my documents- interview transcription data (focus groups, and individual interviews), my field notes (my reflections on interviews, classes and meetings observed) and analysis of medical institutions text (for example, RCPSC).

4.13 Document Analysis

I used the Atlas.ti8 qualitative software manager to manage my document analysis. Through immersion in the data, I analyzed the transcripts inductively, reading for emerging concepts, and trying to generate themes to understand what was going on. It

is cautioned in Emerson (2011) "...not to impose categories by asking exogenous questions rooted in an a priori research agenda or theoretical framework" (p.133). As I analyzed the data and looked for themes, I was conscious of ensuring that I was not inadvertently producing an analysis that might "ignore, marginalize and obscure... understandings" (Emerson, 2011, p. 134).

Reading the transcripts, I was able to formulate codes through identifying common concepts which the participants spoke about. For example, in Phase 1 (first-year) student focus group transcripts the most common code was *frustration*. I also used my background knowledge from published research to help identify codes in the transcripts. This has been defined as a being "perfectly legitimate" (Rubin & Rubin, 2005, p. 210).

Themes were identified through grouping together similar codes. This helped me to understand "what is going on here?" and "why is this happening?" (Creswell, 2015a). For example, the codes *frustration*, *acceptance*, and *stress* were grouped together to the theme of *wellness*. The theme of *wellness* was then used in formulating my recommendations in the final chapter.

Themes reflected the main findings of my study. I also made memos alongside my themes to add contextual information and data from other sources (like the RCPSC). I used memos as well to highlight any relevant quotes that I planned to use to support my findings.

Through rereading the transcription data and fieldnotes (my reflection diary including my summaries of focus groups, interviews and meetings attended) and building concepts, I documented a coherent story related to the medical students' development of the professional identity of "the good doctor" in UGME.

The analysis of text gained from medical institutions like the Faculty of Medicine website and the RCPSC was used to complement the findings of my field notes. From the authoritative medical institutions, including the medical school, I was able to identify the ideology of “the good doctor” and use this to frame my research findings from the study participants (for a list of documents reviewed see Appendix G).

I used my findings from analysis of all documents to show how they answered my research questions and used them to make my recommendations.

4.14 Rigour of data

In case design research, construct, internal and external validity and reliability are important (Yin, 2017, p. 42). The construct validity of my research was addressed through using multiple sources of data that supported my research objectives (Yin, 2017, p. 43). Lincoln and Guba (1985) suggested that credibility should replace internal validity, dependability should replace reliability, and transferability should replace external validity. The credibility of my data were strengthened by the frequent meetings I had with the research participants and the fact that I was able to develop a relationship with the participants. This helped me to have a better understanding of the UGME environment and their lived experiences. Participant validation of the data were achieved by providing summaries of the focus groups and interviews for the participants to check to ensure the information was correct.

The transferability or external validity is the ability to apply my findings to a different context “in such a way that others reading the results can understand and draw their own interpretations” (Patton, 2002, p. 375). Thus, I have provided here a description of my field site, methodology used, and analysis undertaken. The question of the validity

of qualitative data can be problematic, as the collected data will be my interpretations of participant experiences. However, it has been argued that ethnographic data can be valid because the researcher has had lengthy interactions with the participants, is familiar with their culture, and has to some extent participated in their world (Stahler & Cohen, 2000). It may be argued that my insider status as an ethnographer enhances the validity of my findings.

Ensuring the dependability or reliability of my study involved establishing that the “process of the research has been logical, traceable and documented” (Patton, 2002, p. 294). This was addressed through accurate note-taking and transcription of audiotapes and discussing the coding with my experienced supervisor (Green & Thorogood, 2014). To reinforce the reliability of my research, I fully took into consideration my insider status when collecting and analysing the data. It has been suggested that the trustworthiness of my research be enhanced through keeping a reflection diary which I did throughout the research process (Morse, 2015). Using my reflexive diary was useful in bringing attention to my own involvement in the research. At times, I did feel frustrated with the focus groups. An example of this was when students in the focus groups did not recognise that their IPE session was about team working and collaboration rather than being a message about the failure of the doctor. I noted my frustration and disappointment in the students’ inability to reflect on their IPE learning.

4.14.i Self-reflexivity

Following the recommendations of Allan (2006), I kept a reflective diary (my personal field notes) to help me document my emotions and document what the research participants said and felt. Researcher reflexivity has been described as “the active self-

reflection of an investigator on the research process” (Hays& Singh, 2012, p.137). I engaged in reflexive practice by keeping a journal on my personal computer to detail my experiences, through my fieldnotes. I practiced reflexivity as data were “produced” rather than collected (Green & Thorogood, 2014). Reflexivity has been described as “a process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject location(s), personal beliefs and emotions enter into their research” (Hsiung, 2008, p. 212). Reflexivity allowed for my role as a researcher in the analysis and generation of data to be accounted for as I brought my own experiences and opinions into the research process (Green& Thorogood, 2014, p.24). I needed to make myself accountable for the production of my written text. Being critically reflexive of one’s work can be challenging, and having to admit vulnerabilities and imperfections can be difficult (Hsiung, 2008).

Self-reflexivity should be considered across the pre-research, data collection, and data analysis stages of research (Rae & Green, 2016). This required me to constantly keep a journal to document my experiences. My reflective journaling prompted me to question my thoughts, biases, and judgments. I questioned myself as to whether I was having reactions to my research that I was not identifying or not wanting to accept or acknowledge. This helped me confront my emic perspectives of what I was experiencing in the field. The ability to triangulate data helped me to “see” the data in ways that are either aligned or not aligned with what was going on in the UGME field.

4.14.ii Limitations with Methodology

My main data collection method using focus groups can be subject to limitations. I used group interactions to gain the participants’ views; this meant that the time and

ability each participant had to voice their opinion in the group setting was reduced (Silverman, 2004). Also, doing individual interviews may encourage participants to speak more, leaving less interviewer interference (Agar & MacDonald, 1995). There are concerns with validity of focus groups results, because individual participant interviews may produce different results (Silverman, 2004). However, in my ethnographic research, my interest was in the collective experiences of the students in their lived context, so using focus groups was appropriate. The benefits of using focus groups exceeded any limitations.

This study took place at one of the smaller medical schools in Canada, which might make it difficult to generalize to other sites. I recruited 31 out of a class of 80 students (38.75%). I believe some of the students volunteered for the focus groups because of the free pizza lunch and coffee cards. However, some students brought their lunches to the focus groups, and some students said they recycled the coffee cards as gifts.

There was the attrition of volunteers, as at the end of data collection (June 2019) I only had 25 students volunteering (31.25%). There is the possibility that the opinions expressed and documented did not truly reflect all students in the class. The problem of over-generalization of the students' experiences had to be considered as I had less than half of the class as volunteers. I overcame this issue by making sure that the issues I reported were reflected by at least two of the individual focus groups in a set²¹. Also, since I used purposive sampling, the students who participated should be representative of

²¹ Reminder: A set of focus groups includes all the individual focus groups which happened that month. For example, in March I had a set of focus groups, consisting of 5 individual focus groups.

the class, as I aimed to understand their collective experiences, rather than trying to understand individual different experiences (Neale, 2016).

4.15 Ethical Considerations

In 2014, the Government of Canada issued the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans, 2nd edition (TCPS 2, 2014). That edition of the Tri-Council Policy Statement (TCPS 2) was used to ethically guide this research project (TCPS 2, 2014).

4.15.i Consent

The TCPS 2 requires consent to be given voluntarily, meaning “The voluntariness of consent is important because it respects human dignity and means that individuals have chosen to participate in research according to their own values, preferences and wishes” (TCPS 2, 2014). In this study, students were approached to volunteer for the research. Information regarding the research was provided, along with the plans for dissemination of the findings, related to advancing scholarship in medical education and professionalism. The students were told of any potential benefits and harms in taking part in the research. The potential benefits of the research would be an opportunity to reflect on their experiences in medical school and the chance to learn about their colleagues. The potential harm may be psychological, as students could become upset when reflecting on their experiences. In these scenarios, the student could leave the session if they desired or stay, and I would follow up with the student to offer a debriefing moment. If there continued to be “wellness” issues the participant would be advised to seek help from the Student Affairs Wellness Coordinator. I had two episodes where students became upset while reflecting on their experiences. However, the students received support from their

peers in the focus group and were happy to continue with the session. The participants were always advised that they were free to withdraw at any time.

According to TCPS 2 Article 3.7a, alterations to consent might be acceptable as “the nature of the research may justify some alteration(s) to consent requirements if the potential benefits outweigh the foreseeable risks” (TCPS 2, 2014). Participants were notified that I had an ethical responsibility to breach confidentiality if I believed there was evidence of potential self-harm, in which case an immediate referral to the Student Wellness Coordinator in the Faculty of Medicine would be made. Also, they were informed that if there was any admission of untoward behaviour including illegal activities that put public safety at risk, the appropriate authorities would be informed. These scenarios did not occur.

For participation observation, consent, and permission to attend the meetings for observation was only gained from the chair (authorized third party) of that meeting. This is consistent with TCPS 2 Article 3.5, which states that “Research shall begin only after the participants, or their authorized third parties, have provided their consent” (TCPS 2, 2014). Meeting participants were informed of my presence and that that I would not identify them in any knowledge translation activities. This is in keeping with TCSP 2 Chapter 10, which states that for participant observation in qualitative research “Where no personal information is collected, consent is not required”.

4.15.ii Anonymity, Privacy and Confidentiality

The identity, privacy and confidentiality of research participants were protected as much as possible. According to TCPS 2, “privacy risks in research relate to the identifiability of participants, and the potential harms they, or groups to which they

belong, may experience from the collection, use, and disclosure of personal information”. In this research, it was not possible for the data to be anonymous, as participants were in focus groups and meetings, or they may have been identifiable from their administrative role in UGME. In these scenarios, TCPS 2 recommends that a “next best” alternative is to use “de-identified data” (TCPS2, 2014). Thus, in this research, the participants were deidentified using a key code only accessible to me and my supervisor. The TCPS 2 also allows for the confidentiality of information to be breached if in “compelling circumstances, researchers may be subject to obligations to report information to authorities to protect the health, life or safety of a participant or a third party”. The situations that may call for a breach of data have been detailed above.

According to Tolich (2004), “Confidentiality is like an iceberg; only the tip is known, but what lurks unseen, below the surface, is also a source of potential harm” (p.101). It was stated on the consent form that deductive disclosure might occur (Kaiser, 2009). Deductive disclosure occurs when the traits of individuals or groups make them identifiable in research reports (Tolich, 2004). This might happen due to the specific nature of the faculty teaching sessions or the specific role an administrative staff member has in the medical school. Faculty and staff were assured those personal identifiers would not be used and that the data would be anonymized and kept confidential.

The data were stored on an encrypted USB and consent forms were stored in a locked filing cabinet at Memorial University. The data will be retained for five years as required by Memorial University's policy on Integrity in Scholarly Research.

4.16 Conflicts of Interest

The TCPS 2 states that a conflict of interest arises “when activities or situations place an individual or institution in a real, potential or perceived conflict between the duties or responsibilities related to research, and personal, institutional or other interests” (p. 93). A potential conflict of interest could occur if my research at the university had competing interests in the future. A perceived conflict of interest might occur if I am viewed as having competing interests in the university that are likely to interfere with or undermine my responsibility as a researcher.

I have previously worked in an administrative position at UGME. At the start of my research, I was no longer employed at Memorial University. Thus, there was no real, potential, or perceived conflict of interest, as there was no conflict between my research activities and work, institutional or personal interests.

As a graduate student of the Faculty of Medicine where my degree is conferred, there is still no real, potential, or perceived conflict of interest. My study was approved by the University ethics board and my findings do not compromise the integrity of the University. I continue in the following chapters presenting the results of my research. My approach to the data analysis was one where the literature and the raw data inform, and are informed by, each other. In this way my research findings are mixed with supporting data.

Chapter 5 Performing The Good Doctor

Style is thus foregrounded, and the most typically bourgeois deportment can be recognized by a certain breadth of gesture, posture and gait, which manifests by the amount of physical space that is occupied, the place occupied in social space; and above all are strained, measured, self-assured tempo. (Bourdieu, 1984, p. 218)

Students enter medical school intending to learn to be a well-rounded doctor.

However, at times, the hidden curriculum will promote a counter-orthodoxy by supporting an image of “the good doctor” that focuses solely on the clinically competent doctor. The clinically competent student adopts a “cloak of competence” (Haas & Shaffir, 1987) to gain symbolic capital, pass assignments and exams, and help secure future employment. Having a cloak of competence is endorsed by the Canadian Residency Matching Service (CaRMS) orthodoxy. The CaRMS website states, “Leaving the best impression you can with your preferred program is the only piece of advice we can provide to maximize your chances of matching to that program” (Canadian Residency Matching Service, 2020).

In this chapter I review the rites of passage students experience in the transition to becoming a professional “good doctor”. I show how the students navigate between doxa (the common-sense ideas of “the good doctor” taught through the hidden curriculum) and orthodoxy (the stated rules or official orthodoxy about what a “good doctor” is).

In all subfields of UGME – in the formal and informal curricula, the medical school’s governance structure, the national CaRMS process, in popular culture, and in all other places where medical professionalism as an identity is described and conveyed –

students are negotiating the doxa or hegemonic discourse of the UGME field. I emphasise how students *perform* the roles of “the good doctor” while trying to maintain a cloak of competence. I review the white coat ceremony, a key ritual for medical students at my field site and elsewhere that confirms their membership as a physician in training. Then I show how students use cultural artifacts, including the white coat, medical instruments, medical language, and patient charts, to socialize into the medical field. The wearing of the white coat, and the use of medical instruments, and other tools that are markers of the culture of medicine, all help medical students create a cloak of competence.

5.1 Rites of Passage

The transition to medical school is an introduction to what is involved in being “the good doctor”. The students begin to learn that their old values and attitudes are considered “inferior”, while the new medical ways of seeing, speaking, and being are more desirable and superior (Hafferty, 2000, pp. 241–242). The socialization of students is an integral part of medical school as they assimilate into their new professional identity (Norander et al., 2011). Part of that socialization is experiencing certain rites of passage, for example, dissecting a cadaver for the first time or participating in the white coat ceremony (Gillon, 2000; Goodwin et al., 2016).

The concept of the “rite of passage” was coined by van Gennep (1960, p. 10) to refer to the transition that “accompanies every change of place, state, social position, and age” of an individual. The concept was applied early on to medical education, with Becker describing the entire medical school process from admission to graduation as a rite of passage (Becker et al., 2007). Rites of passage are a way in which the ideology of “the good doctor” begins to be promoted. The transition of learners from a lay

environment to the medical environment is the first step in a rite of passage the learner takes to become part of the profession. The space between points of stability (such as between being a pre-medical student and being a medical student, or between being a medical student and being a doctor) is the transition. Transitions from one status to another can involve letting go of previous social supports, the loss of personal reference points (people or objects), the integration of new knowledge and behaviours, and an ultimate change in the way one views themselves (Bridges, 2004). Personal factors such as individual expectations, one's level of knowledge and skills, environmental barriers, and supports can affect transitions into new environments (Schumacher & Meleis, 1994).

5.1.i Transition into Medical School

Westerman and Teunissen (2016, p.372) define the various transitions experienced by medical students as "...a period of change in which medical students or medical doctors experience some form of discontinuity in their professional life space to cope with the new situation." A transition is a dynamic process in which an individual progresses from one set of circumstances to another (Teunissen & Westerman, 2011). It can be a threat or a time of opportunity in which the individual unconsciously questions who and what they are (Westerman & Teunissen, 2016). Becker et al. (1961) identified medical students' perspectives as they face "choice points" or times of transition. If these choice points occur frequently, the perspective becomes established as a way of responding (Becker et al., 2007). This way of responding in social fields represents the development of the student's disposition in that field. This results in the medical student developing a medical habitus, which then reinforces and continues to support medical practices and culture in the field (Luke, 2003, p. 22).

There is a paucity of research on the layperson's transition into medical school. Most of the research on transitions in medical education focuses on transitions to clerkship (Atherley et al., 2019; Nelson et al., 2014; Small et al., 2008; van Gessel et al., 2003), residency (Burford, 2012; Franzen et al., 2015; H. Morgan et al., 2017; Prince et al., 2005; Scicluna et al., 2014), and independent practice (Cleland et al., 2016; Westerman, 2014).

The limited research done on transition with pre-clerkship medical students included a Norwegian study on first-year medical students doing home visits with terminally ill patients (Schei et al., 2019). The researchers found that during the transition, the students struggled with maintaining their emotions, professionalism and they struggled with trying to maintain the accepted detached behaviour of the medical culture (Schei et al., 2019).

Transitions provide the opportunity for medical schools to offer responsive support and help students learn coping skills, which are essential for future training (Liu et al., 2016). The students have to “deconstruct elements of their previous identities and fill a new role for which their previous life experiences may not have fully prepared them” (Cruess et al., 2019, p. 722). Students' dispositions and ways of being are challenged as they assimilate into their new identity. The experience of the transition into the UGME field represents the students' rite of passage into medical school.

Rites of passage in medical school represent a change from one identity into another, with the new identity being a more advanced state (van Gennep, 1960). Rites of passage allow social order to be maintained in society; for example, the white coat ceremony as a rite of passage recognizes that the previous status, being a member of the

lay public, changes with admission to medical school with the student now becoming part of the medical profession as a learner (Vinson, 2018). This rite of passage ensures that medical learners will share similar experiences, such as learning events and challenges, as they assume their professional identity as a physician (Veazey Brooks & Bosk, 2012).

In the health care field, rites of passage have been described as experiences with “firsts”. Medical students experience rites of passage during their first day as a physician (Lefroy et al., 2017), initial experience with death (Wald et al., 2010), and early surgical training (Veazey Brooks & Bosk, 2012). In the following section, I review the rite of passage students experience with the white coat ceremony as they are officially welcomed into the medical education field.

5.2 The White Coat Ceremony: Wearing Power and Status

The white coat ceremony is regarded as a formal rite of passage to the medical profession (Monrouxe, 2010). The ceremony has been described as representing the “ideal, and to an extent, abstract representation of the core values and philosophy of medical practice” (Ellaway et al., 2014, p. 3). The ceremony was established to “help create an environment which fosters establishing a psychological contract for professionalism and empathy in medicine” for new students (Gillon, 2000, p. 84). This rite of passage is a symbolic indication that the students have left their old identity behind and are about to become a professional (Veatch, 2002).

The physician white coat ceremony was established by the North American Gold Foundation in 1993 to elevate the values of humanism and professionalism in medicine and to symbolically show the responsibilities and expectations of being a physician

(Goldberg, 2008). Blumhagen (1979) traces the history of doctors wearing white coats and the symbols associated with them, such as cleanliness, science, knowledge, religion, and power. While there were other symbols associated with physicians, such as stethoscopes, head mirrors, and black bags, the white coat had the most power, as it came to represent scientific knowledge (working in the lab), purity, modernity, morality, and authoritative knowledge (Blumhagen, 1979).

The cohort of students I was following in my research took part in the white coat ceremony during their first month of medical school. I received permission to attend and observe this ceremony. Many of the students and their family members were smiling, and I could see guests wiping tears from their eyes as the students received their short white coats. Representatives from the leadership team in the Faculty of Medicine, the Newfoundland and Labrador Medical Association, and the College of Physicians and Surgeons of Newfoundland and Labrador, as well as some senior medical residents, all attended the ceremony. The ceremony, as the Dean of Medicine emphasized, was meant to stress the importance of humanism and professionalism in the practice of medicine (Communications, 2017).

The white coat ceremony conveyed explicit and implicit messages about what it means to be “the good doctor”. In my reflection notes, I noted that one of the things that struck me was the explicit messaging that privilege and power are central to the emerging new identity of a medical student, a future physician. I observed how power and privilege were conveyed both implicitly and explicitly through the hidden curriculum as it functions within the formal and informal curricula. This messaging about the privilege and power of physicians was strongly conveyed in various ways through the hidden

curriculum and will be returned to throughout the chapters of this thesis. A second important point I noted, one that has also been suggested by others (Goldberg, 2008), was that the white coat ceremony conflated the concepts of humanism and professionalism. As Goldberg (2008) notes, humanism is about actions for the service of humanity and the welfare of individuals, whereas professionalism mainly involves maintaining the status of a profession. This theme, too, recurs throughout this thesis, as I observed multiple examples of how students encountered blurred lines between the goals of humanism and being a professional.

5.3 The Privilege and Hierarchy of Medicine

In these sections, I show how the students become attuned to their privilege and the hierarchy of medicine during their white coat ceremony.

5.3.i Medical Hierarchy, Privilege, and the White Coat Ceremony

In the 20th century, medical education was restructured around laboratory science. Physicians began wearing white coats to protect against contagious diseases in the lab. This resulted in an increased public perception of physicians having power and authority (Blumhagen, 1979). Related to the image of power and privilege was the notion of being set apart from the rest of society. At their white coat ceremony, the Dean of Medicine told the students that the white coat differentiated them from general society and that patients would see them as having the “power” to heal. Veatch analyzed this type of intentional differentiation of medical students/physicians from the public, and described it as:

A symbolic “setting apart” of the student from the lay population with a concomitant “bonding” with the members of the professional group. In the language of religious metaphor, this ceremony is the first step in the

“conversion” of the layperson into new priestly status set apart from the laity (2002, p. 6).

Similarly, a Newfoundland and Labrador Medical Association representative told the students that they were “fortunate” to be able to serve the people of Newfoundland and Labrador. A medical resident told the students that they were privileged and should be grateful, as many people would give anything to be in their place. One student noted:

Mila (Phase 1, first-year): It was pretty, *empowering*. Like, I don’t know, just having like all your classmates in one room and just being told what a *privilege* you have to study medicine, and practice medicine in the future and stuff like that so, so that was like, I don’t know, I think some people went into it thinking it was just going to be an hour service, like nothing special. But it was pretty, to me, it was *empowering*. [Italics are mine].

Mila commented on how she was being told that she was privileged to take part in the white coat ceremony and described developing a sense of empowerment. This fundamental ideology of physician power and privilege was reinforced and reproduced through the white coat ceremony. Later, I will show how quickly this sense of being powerful becomes part of the identity of students, who become upset when this assumption of power is challenged by others in the context of interprofessional education learning sessions.

My research participants described to me that those who attended the white coat ceremony were required to write a reflection assignment on the proceedings. The students generally appreciated having to do the assignment. I quote students from a focus group done in Phase 1 (first-year):

Iris: Well, I enjoyed, um, knowing that everyone was going to be reflecting on the ceremony. I know that with reflection, the white coat ceremony kind of is a balance of the responsibility, and the “Hurray, you got here, now get to work!”

Maeve: That reflection gave a tiny little glimpse into what that could mean [to work] and I think that that was valuable for me to do, and I think it’s valuable for them to require it.

The written reflection required the students to reflect on the ceremony to get them to think about things like power and privilege. However, for students, it conveyed a meaning that the white coat ceremony as a rite of passage meant now it is now time to focus on their work at medical school. Beyond the ceremony conveying symbols of power, the act of having to reflect on the ceremony had the equally important effect of conveying ideologies of professionalism by promoting ideas about hard work.

Wear (1998) proposed that the white coat ceremony does nothing more than symbolize the social and economic privilege of physicians and medicine’s established practices. The white coat ceremony focused on conveying the orthodoxy, the official message about the expectation that students must behave professionally. However, the white coat is also a symbol of power, legitimate knowledge, and authority that can operate equally through both the informal and hidden curriculum (Wear, 1998). The wearing of the white coat is a powerful act of non-verbal communication that facilitates the recognition of coveted knowledge (Luke, 2003). Therefore, while the white coat ceremony did convey the official message about professionalism, it also conveyed implicit messages about what it means to be a professional, most importantly, ideas about

privilege and power. In the white coat ceremony, part of the formal curriculum, the students were explicitly told they were privileged and had the power to heal.

5.3.ii The Medical Hierarchy of the White Coat

In this section, I describe the hierarchical nature of the white coat ceremony and the power and hierarchy of the white coat itself.

5.3.ii.a Status and the White Coat Ceremony. Wear (1998) pointed out that who is invited to the white coat ceremony (and who is not invited to attend) conveys ideas about who is worthy and less worthy in the hierarchy of medicine. The white coat ceremony at my field site similarly conveyed ideas about the hierarchy that divides clinical and non-clinical faculty in the medical school. In my research, interviews with faculty members showed how the social hierarchy of physicians exists in the medical school, as one faculty member (Fac03) from a non-clinical specialty hesitatingly critiqued:

So, in my [X] years that's I think, you know, I, you know, even small things, like you know, and this is going to be really petty, but you know, we've introduced the white coat thing at the beginning of the [term]... no PhDs get invited to that.

Me: No?

No, [The name of senior faculty and position] never got invited to that [to speak].

And this, you know, it's everywhere. Like I say, it's changed, and but there's still that clinical divide.

Thus, a hidden curriculum of who is recognized as being important for the medical students' introduction to the profession was being enacted. The status of being

from a non-clinical background did not meet the requirements needed to speak at the white coat ceremony, even though the non-clinical faculty member held a senior position in the medical school.

5.3.ii.b Medical Students and the High-Low Status of the White Coat. The students in my focus groups were aware of the responsibility that comes with the white coat; however, at that stage in pre-clerkship, they did not have sufficient knowledge to deal with medical cases. The wearing of the short white coat, as a semiotic practice, categorizes students as learners in the health care field who have low educational and symbolic capital. The short white coat reinforces the low status that is associated with being inexperienced in the hospital setting. This was evidenced when I questioned students in their Phase 3 (second-year) about wearing their white coats:

Me: You don't like to wear your white coats?

Iris: No.

Abigail: No.

Me: No? Why not?

Gabriel: No, it's too pretentious.

Abigail: I feel, yeah, in first year it was cool, but in second year it's a reminder of how much you don't know. That's what I feel.

Iris: Well, I don't like walking around in my white coat.

Me: No? Why not?

Lucy: It reminds me of, um, I guess, well there was all the, I don't know if you guys remember the talk at the white coat ceremony and we're kind of getting inflated a bit but it reminds me, if you see people doing the motorcycle licensing

course and they've got the big reflective vests on, and "Oh, they don't know how to ride motorcycles yet", and it's sort of that kind of thing. Like, you're wearing this symbol of being a doctor, and it's "Oh they don't know anything yet."

Me: I see you walking with your stethoscope. I'm seeing a lot of you with your white coats on and the stethoscope on. What is that like for you walking around all the corridors? Anybody call you "doctor" yet, like if you go to the cafeteria?

Iris: No.

Gabriel: It feels really fake to me. Yeah, like, it doesn't feel, I mean we're kind of advised to wear our stethoscope just as, like, they know that you're part of the medical program. I don't actually use it, so I don't know.

Me: Was that in clinical skills, right?

Gabriel: Yeah, and then like it was mentioned, when you're shadowing. You don't have to, but it's not a bad idea to bring it because maybe the doctor might ask you to do a blood pressure or something like that, and it kind of just shows the patients that you're actually a medical student.

It was apparent that there are two conflicting statuses of being a medical student.

The wearing of the white coat gives students a high level of status relative to patients and other general members of society, marking the status of being knowledgeable; however, they are at the bottom of the medical hierarchy, as they have little medical knowledge. To clinicians, the students will be seen as those who "*don't know anything yet*"; but in other contexts, and fields, the public would see the "*symbol of a being a doctor*" and someone capable of taking blood pressure because "*you are actually a medical student*". This

acknowledgment of being somehow separate from the public helps reproduce the status and power of physicians, an identity that is formed early in medical training.

Vinson (2019) examined medical students' perceptions of the white coat. She illustrated how "A white coat is not simply a piece of clothing—it is heavily invested with meaning" (p. 408). Vinson described how students are aware of the responsibility that comes with wearing the white coat, which results in peer policing (Vinson, 2018). Peer policing was apparent with my cohort of students in their second year when they commented on first-year students' habit of wearing their white coats to the hospital cafeteria:

Me: Guys, what about your white coats? I'm not seeing anybody with their white coats. I used to see you guys with your white coats on last year.

Maeve: White coats are for skills.

Ophelia: Yeah, I think we only wear them when we have to, although I've noticed that some of the first-years wear them around, like to the cafeteria.

Isabella: But we never did that.

Ophelia: No, it's not right.

Lorelei: I feel so awkward; I just take it off. I'm like, "This feels wrong". Like, I don't know what it's like?

Clara: I just feel like it just labels you. I just don't wear it.

This is in keeping with Vinson's findings. Vinson (2018) wrote about how students' policing of wearing the white coat was a form of "performative regulation" as termed by S. Scott, (2011). This performative regulation controlled the "pace and basis of identity change" (Vinson, 2019, p.408).

5.3.ii.c Transition and the White Coat. The Becoming. Wear (1998) points out, “A medical student, upon donning the occupational clothing of her profession, quickly recognizes that it establishes her ‘right’ to a given status without her need to prove herself” (p.736). This was illustrated in my research through an interview with a faculty member who believed that once the students were admitted to medical school, they were on their way to becoming a doctor, “Because we make the assumption if they’re in that program for the white coat ceremony, they are good to go” (Administration Fac04).

The short white coat symbolizes the medical student at the beginning of their training (Jenkins, 2014). The short white coat distinguishes the student from the physician, who wears a long white coat (Vinson, 2018). A Bourdieusian analysis of clothes worn in a hospital setting shows how clothes perpetuate hierarchy by bestowing the wearers with capital (symbolic, cultural, educational) (Jenkins, 2014). Thus, medical students are recognized as members of the group, and the hierarchy of the medical school culture is reinforced. This signifies the medical students becoming part of the profession as they wear their short white coats. The medical school social hierarchy categorizes and subjectifies the individual into their expected place. In this case, medical students are placed at the bottom of the hierarchy (Foucault et al., 2007).

In the following sections, I show how the students use cultural artifacts to socialise into the UGME field. Being able to use these cultural artifacts was important for the students’ “cloak of competence” in the UGME field.

5.4 Cultural Artifacts Used to Become a Physician

Material elements of medical practice such as patient charts and instruments are intimately associated with learning (McMurtry et al., 2016). The use of artifacts within

social relationships contributes to a sense of identity (Bleakley, 2011a). People can make connections and make sense of the world through artifacts, which also help to create a sense of identity (Latour, 2005). As Bleakley (2011) argues, identity is a continual process of people and artifacts coming together to enact change. Thus, medical students should be viewed as “becoming” rather than being in a fixed state (Bleakley, 2011a). Bleakley (2012), following Latour (2005), explains how identity creation is a process of “becoming” as the learners engage with different people and artifacts. It is a dynamic process in which the institution will act upon the learner to create change (Bleakley, 2012; Latour, 2005).

5.4.i Experiences on Clinical Wards: Developing a Cloak of Competence

Goffman (1959) spoke about the importance of being in the clinical setting for “role-playing” to aid in socialization and identity formation. The act of being able “to do”, that is, to act as a “good medical student/physician”, is important, and one must perform "a pattern of appropriate conduct, coherent, embellished, and well-articulated" (Goffman, 1959, p. 75). The artifacts of medicine help medical students portray an image of competency, and the use of key artifacts also gradually changes students’ perceptions of themselves and their professional identity (Beagan, 2001a, p. 284; Haas & Shaffir, 1987, pp. 70–78).

The increasing use of technology, tools, instruments, and other artifacts has shifted the “medical gaze”²² (Foucault, 1973) into new dimensions, as the physician can see the patient through different artifacts. Sheehan et al. (2017) conducted an ethnography

²² Medical gaze refers to doctors selecting parts of a patient’s history and examination to fit a biomedical model while ignoring the rest.

of a medical ward workplace learning site. The study found that artifacts such as patient notes and computers create tensions in the clinical team, as access to artifacts is limited due to a lack of space (Sheehan et al., 2017). The junior members of the team are often pushed to the periphery and excluded from learning. The authors concluded that the artifacts on the ward were beneficial for team engagement and helped to promote collaborative management of the patient. In this section of my ethnography, I consider key cultural artifacts that are symbols of and convey meaning about being a doctor. These include medical instruments, medical language, and patient charts as purveyors of cultural ideologies about professionalism.

The students in my research underwent early clinical experiences as part of their Community Engagement courses, and they also voluntarily attended wards as part of shadowing experiences. I asked students when they were in Phase 1 (first-year) about their experiences on wards and in Clinical Skills sessions using medical instruments, medical terminology, and patient charts.

5.4.ii Using Medical Instruments

The students spoke about learning how to use medical instruments:

Ivy: I was kind of nervous to ask them which way to put my stethoscope because I have never worn a stethoscope before, so I didn't even know, which way the thing was in your ears, so even asking that I was, I feel like I should know this, but we haven't, we just haven't gone over any of that, you know.

Nora: One of the stations there was a blood pressure cuff and I, yeah, I was so turned around in there I didn't realize that. Like, I thought they were portal cuffs. I didn't realize we had to attach them to the wall. I brought the patient to the other

side of the room so, you know, it was something simple. Does the student know that the blood pressure cuff needs to be attached to the wall? Do they know how to do that?

Eleanor: Yeah because we've never been taught that.

Nora: We've never had to attach it ourselves, too.

Owen: And to, the actual skill of taking a blood pressure, what they should have is the dual-head stethoscope, because the real challenge of the blood pressure is, can you actually hear the first and the fifth sounds?

Nora: Or you just fake it!

Owen: Or you fake it, right (laughing).

Nora: Because you can. Not that I do, but you can, right (laughing).

In this focus group, the students' unfamiliarity with taking blood pressure led to a confession to maintaining a "cloak of competence" (Haas & Shaffir, 1987), and the students considered faking the physical examination. The orthodoxy stresses physician competence, and so the students' resistance, the counter-orthodoxy, led to the possibility of faking results about the physical examination to maintain a cloak of competence.

Impression management is an important part of students' socialization into the medical culture (Conrad, 1988). The students' appearance of competence legitimizes their presence in the clinical field (Haas & Shaffir, 1987). In social actions, Goffman (2003) speaks about "face-work". Face-work involves the maintenance of the positive face or self-image of ourselves to others to win approval. Negative face involves the avoidance of being imposed on (Goffman, 2003), such as being asked to manage patients without having sufficient knowledge to do so.

Haas and Shaffir (1987) wrote about how students are socialized into this new culture in which they are expected to learn specific skills and techniques of the occupation as they assume their new identity (pp.54-55). The professionalization the students underwent involved the manipulation of symbols and symbolic behaviour, such as taking blood pressure to create an image of competence. Professional socialization to create a cloak of competence is anxiety-provoking (“*I was kind of nervous*” and “*I was so turned around in there*”), which gives the impression that there is hard work involved in gaining the skill of taking blood pressure.

The students in my focus groups were aware of the importance of being able to take patients’ blood pressure in the UGME field. Using medical instruments signified the “correct” way to be “the good doctor” and being able to perform the act helped to generate a cloak of competence. This performance ensures that the students’ bodily dispositions are mapped onto the expectation of the correct way to be “the good doctor”.

Faking results, or even considering doing so, goes against the concept of being professional. The capital gained through appearing to be competent by taking patients’ blood pressure was based on organizational structures that reward the appearance of competence. Students in this focus group admitted that “*you just fake*”, “*because you can*”, and this confession affects the students’ understanding of and embodiment of being “the good doctor”.

These acts of confession (Foucault, 1978, pp. 56–60) require the students to overcome resistance within themselves, the effect of which gives them the experience of being unburdened. Simultaneously, the confession helps the students realize the “right” professional they should be in the UGME field. They internalize the rules and regulations

of how to be a professional, and they monitor and reinforce the boundaries between being professional and unprofessional.

The students took an active role in their self-surveillance to become a professional who can take a blood pressure. The idea of being seen as unable to take a blood pressure renders the student as deviant and having a failed identity as a medical professional.

Foucault (1979) writes about “dividing practices” and how the “the disciplinary apparatuses hierarchized the ‘good’ and ‘bad’ subjects in relation to one another” (p.181). Self-surveillance causes the students to judge themselves along with the “dividing practices” in the cultural context they operate in as they judge themselves as being competent or not (Foucault, 1978, 1979).

5.4.iii The Language of Medicine to Appear Competent

Bourdieu (1996) writes about “mechanical solidarity” (pp.386-8), in which an elite body of knowledge is shared between teacher and learner, including ways to speak and move. This is transmitted as part of the developing habitus of the learner as the culture of medicine is reinforced and reproduced in the field. Good (1993) explained that:

Entry to the world of medicine is accomplished not only by learning the language and knowledge base of medicine but by learning quite fundamental practices through which medical practitioners engage and formulate reality in a specifically ‘medical’ way. These include specialized ways of ‘seeing,’ ‘writing,’ and ‘speaking’ (p.71).

Bourdieu regarded language as “an instrument of power and action” (Bourdieu & Eagleton, 1992). Wong et al. (2020) write that having the cultural capital of being able to

easily “talk the talk” promotes inequity in medical education. Medical students who have cultural capital through work experience, prior scientific education, or even family background may be able to effortlessly assimilate into the new medical language (Rivera, 2012; B. O. Wong et al., 2020). The interpretation, understanding, and appropriate use of medical language thus forms part of the hidden curriculum of medical education (B.O. Wong et al., 2020). This is part of the socialization of students into the medical culture as they move from outsider to insider status (S. Smith et al., 2017; Stern, 1998).

In their clinical skills sessions, Phase 2 (first-year) students quickly came across a new language in the form of unfamiliar medical terms they found difficult to pronounce:

Mila: I can’t pronounce the words. I literally have to, like, I can spell them, but I can’t pronounce them.

Me: What words?

Mila: Yeah, I can’t, I don’t know how to pronounce half of that. I literally have to be it’s spelled like this, and I can spell it, but I can’t pronounce it.

Audrey: We were, like, looking up the other day how to pronounce hematochezia, and we were all, like, we were all convinced that it was pronounced hemato*chezia*, but it is not.

Mila: If it was hemato*chezia*, I would be very, very sick.

Gabriel: That’s bright red blood in your stool, yeah.

Me: Okay. Why not just say blood in your stool?

Lucy: We need fancy words.

Gabriel: We need jargon apparently.

Me: You need jargon? So how are you guys coping with the medical jargon then?

Mila: I've looked up, oh my god, I look up the same words over and over and over again. They're going to stick. Some point in time they're going to stick. Like, I wouldn't be able to tell you how many times I've looked up orthop? Now, I'd say it's got to be like 45 times now! I don't know what it is now.

Audrey: That's, ah, when you need to put a lot of pillows under head because you get breathless.

Lucy: What about sore throat?

Audrey: That's a dystasia or, no, that's odynophagia.

The students alluded to the point that medical jargon was expected and acceptable in medical practice, stating, "*We need jargon*", and "*We need fancy words*".

Learning the medical language has been reported to be "critical" for students' symbolic participation and identification with the profession (Haas & Shaffir, 1987, p. 45). Students in my focus groups found the language difficult to pronounce and spell, creating feelings of anxiety: "*Oh my god, I look up the same words over and over and over again*". The students took action to relieve their anxiety by memorizing the spelling and practicing the words with their peers. These acts provide collective support for students in their mastering of the new language (Becker et al., 2007). In working to master this new language, they wear a "cloak of competence" (Haas & Shaffir, 1987) in the UGME field.

The language of medicine is seen as a symbol that identifies learners as members of the medical community (Roth, 1957). As is the case with the white coat ceremony, the use of medical language distinguishes and separates the medical student from the lay community and can make them appear surrounded by mystery, almost "priest-like"

(Branson, 1973). The students learn to communicate in a new “symbolic system” (Haas & Shaffir, 1987.p.71) that separates them from the lay person. As the students said in the focus group, “*We need fancy words*” and “*We need jargon*”. The students allude to the necessary new language, the jargon they need to learn as members of the medical community.

The symbolic importance of jargon has been studied in detail by Ansari in the context of treating a patient at Yale Medical School (Ansari, 2020). Ansari relays his experience as a medical resident reflecting on his use of medical jargon at work when speaking to the wife of a patient who had experienced a cardiac arrest. He commented on the use of his “code-switching” (where the speaker puts together two languages, tones, or dialects, in this case, medical jargon and lay English). He realized that medical jargon had become so much a part of his identity that he did not communicate the seriousness of the patient’s condition (Ansari, 2020). Code-switching can be a powerful tool for the benefit of patients’ understanding as well as their exclusion (Wood, 2019). Code-switching is more than using non-medical terms, as it also includes language, tone, and lexicon (Wood, 2019). The tone and lexicon used in the consultation are also important, especially in paediatrics when communicating with parents and children (Wood, 2019).

The ability to use the new language is part of the students’ developing habitus; the dispositions of learning to correctly use the jargon may help them acquire symbolic capital by allowing them to appear competent (Haas & Shaffir, 1987). The language of medicine is rooted in its ideology and assumptions and is sustained by physicians’ practice (Lock & Gordon, 1988). Lock and Gordon (1988) showed how medical knowledge functions as a “technical status which is not contestable” (p.3). Keeping

medical language elite helps ensure that medicine's power and knowledge are privileged. In other words, the use of medical language is subject to how the "self-interest of the medical profession influences ...the generation of medical knowledge and its practice" (Lock & Gordon, 1988, p.3).

Students in Phase 3 (second-year) become adept at using an "alphabet soup" (Pitt & Hendrickson, 2019) of clinical language to create an aura of efficiency and professionalism:

Ophelia: They had their FWPE and their SWPE on the same as within a day of the exam.

Me: The what, sorry?

Maeve: FWPE and SWPE.

Me: What?

Ophelia: It's like the ... our physical, our witnessed physical.

Me: What's it called?

Maeve: Like a head to toe. I don't —

Ophelia: Formative Witness Physical Exam and Summative Witness Physical Exam.

Me: A FWPE and a SWPE?

The students were immersed in a new world and a new language that required new ways of expressing signs and symptoms. The examination of the human body was reduced to being referred to as a "*head to toe*". This reductionism reflects the biomedical gaze of viewing the body (Foucault, 1973; B. Good, 1993; T. M. Johnson, 1985) in terms of its discrete parts. The reductionism of the body to parts becomes the normal and

natural thing to do, as it is the “...only reasonable way to think” (Good & Good, 1993, p. 90). The reduction of the patient to a “head to toe” also reflects the dehumanization of the patient in the form of mechanization²³ (Haque & Waytz, 2012). Dehumanization involves the lack of recognition of the experiences and agency of the person. In this case, the mechanization of the patient to a “head to toe” examination results in the objectification of the patient incapable of emotional responses (Haque & Waytz, 2012). The students were learning to embody their new identity as they began speaking as a medical professional. Good (1993) referred to this ability to use the new language as “speech acts”, which were “powerful way[s] of acting” (p. 81) that eventually led to further actions such as using patient charts.

5.4.iv Patient Charts, the Cloak of Competence and Hierarchy

The patient chart is a tool that health professionals use to communicate, problem-solve, and share information for patient care (Sheehan et al., 2017). Early in their training, medical students are introduced to new cultural artifacts in the form of patient charts, which they are required to use to document and analyze patients’ conditions. My research revealed how the patient chart becomes a learning tool, a shared symbol that forms part of the cultural context that the learner internalizes as part of their emerging professional identity.

5.4.iv.a Making an impression. Students described how they try to make a “good impression” with their knowledge about how to use patients’ charts to create a cloak of competence.

²³ Mechanization refers to treating the patient as though part of an operating system- the body as a machine.

Students in Phase 3 (second-year) described how their uncertainty about using the charts and their inexperience with patient management made them feel incompetent:

Clara: Most people use their electives [during their Phase 4, clinical learning phase] to try and make a good impression, and so you haven't even done any clerkship. [That is, students were voluntarily going onto the wards to gain clinical experience; they had not started the clinical phase of learning yet]. You don't know how to fill out a chart. You don't know how to read a chart. You don't know how to say hello to a patient. So, you're not going to make an *impression*.

Abigail: I honestly notice, though, and I don't think its extra pressure, but I don't know, shadowing, like, the last couple times I've shadowed, he's [physician] just like ... read the patient's chart and then [he] just got me to go in and sit with the patient and take a history and figure out what's up and stuff [the physician asked the students to manage the patient by reading the presenting complaint on the patient's chart, then take a history followed by an examination].

Nora: He [physician] showed me where all the charts were, showed me where everything was and blah, blah, whatever, and he was, "Oh yeah, go see this patient", like blah, blah, blah. So, my physician came back, and then [I] waited for him to talk to him [the patient], and he was like, he came back 20 minutes later, he said, "Did you see any other patients?" and I was, "No" and he was, like, "Aren't you a resident?" I was, "I'm a first-year student". He was, "I thought you were a resident". I was, like, "No". He thought I was just going to like just to pick it up and go, because I guess they don't have many people there. I was, like, "No!" I shut that down really quickly because I was, I cannot do this, but they just like

take the chart and go and, I was just in the rooms taking all the histories, checking on this guy, yeah.

Me: Did you feel like a real doctor?

Nora: I felt very stupid.

The students were actively attempting to appear more competent than they were, and their supervising physicians were expecting them to act outside of their competency.

The students were active in improving their low-status position in the field by trying to appear competent and in effect learning about patient management. These interactions appear to be an example of Foucault's "capillary power" (Foucault, 1979, p. 198), which views power as being embedded in everyday actions (enacted and resisted). The students continued seeing patients, as this was expected as part of their shadowing experiences, a norm of everyday social practice for shadowing medical students. Capillary power is not top-down/sovereign power but the infiltration of the dominant discourse through and within the institution, which in this scenario is the need to be competent. Capillary power within the hidden curriculum may be responsible for the normalization of certain identities and experiences (Bleakley, 2011a; Sharma, 2018). The actions and behaviours of supervising physicians, who are both educators and role models, contribute to the development of professional identity in the students.

Research has been done on the power relations between physicians and learners, both residents and students. For example, the power relations present in bedside teaching were examined in video observation done in a family practice clinic with third-year medical students, physicians, and patients (Rees et al., 2013). The study found that

physicians, students, and patients all enacted their relative position of power and powerlessness through verbal and nonverbal cues and the language they used.

Vanstone and Grierson (2019) used a grounded theory approach to examine clinical students' use of their resources to negotiate hierarchy in the clinical environment. The students went through an iterative cycle of assessing their resources and enacting their strategies (such as yielding to hierarchy) to be part of the team. The students were seen to be using “upward power” to achieve their personal goals (Vanstone & Grierson, 2019). These findings reflected the experiences of students in my focus groups, as they used “upward power” (agreeing to attend to patients) to create good impressions and gain symbolic capital.

5.4.v The White Coat, Stethoscope, and a Cloak of Competence

The wearing of the white coat and stethoscope creates and legitimizes students' competence to see patients. The white coat is seen as supporting the creation of the medical habitus in the future physician (Luke, 2003; Witman, 2014). Students in my focus groups saw the white coat and stethoscopes as powerful symbols in medicine, which gives them access to patients' bodies. They consciously recognized the power of the coat and when to use it. As Lucy said in second-year (Phase 3), students “*only wear them when you have to*” (that is, in clinical skills and clinical wards to access patients), and “*it labels you*”, pointing to how the white coat gives students the authority as a medical professional to access patients. The short white coat categorizes students at the bottom of the social hierarchy; however, at the same time, students recognize and value what the coat symbolizes in health care settings. The white coat symbolizes the legitimate

power they now have because of their access to patients, health care settings, and other UGME learning fields, such as the anatomy lab.

The symbolic capital gained by wearing the stethoscope and white coat legitimizes the student's presence in the physician's office to see patients; as Gabriel, (second-year, Phase 3) said, "[it] *shows the patients that you're actually a medical student*". The stethoscope gives legitimacy and cultural meaning to the wearer, as this item signifies professional membership. Wearing these symbols forms part of the medical identity, thus helping to create the medical habitus, a point previously raised by Rice (2010). Further, having the educational capital to measure blood pressure is recognized as possessing legitimate competence and thus authority, as Vinson (2019) has also observed. This legitimate competence and authority work through doxa (Bourdieu & Eagleton, 1992) and is taken for granted in health care settings because of "socially constituted collective expectations and beliefs" (Bourdieu, 1998, p. 102). The patient will thus automatically assume the medical student is competent in measuring blood pressure.

Similarly, the wearing of the white coat in the health care field supported pre-clerkship students' creation of a habitus of competence, which could later be transferred to other settings in their clinical training. It was also clear that the students knew when they should wear the white coat, and they used it to their advantage to carry out procedures on patients.

5.5 Summary Comments

In this chapter, I showed how the discourse of power in the form of symbols is used in UGME. The symbolic capital of wearing the white coat, using medical language,

and using medical instruments gives students legitimate authority in health care environments. However, at the same time students struggle with uncertainty and low status in the hierarchical medical field. The need to appear competent and create a good impression is prominent at this stage of training.

In the next chapter, I show how the medical habitus is developed as students learn to adopt a “medical gaze”. I look specifically at the formal curriculum and its subfields of Clinical Skills sessions with standardised patients, Integrated Learning Sessions, written assignments, lecture capture, and Anatomy lab sessions. I illustrate how the hidden curriculum perpetuates an ideology of “the good doctor” that emphasises science and clinical medicine and de-emphasises humanistic aspects and the non-medical role of physicians.

Chapter 6 The Medical Gaze: Clinical Competence

If you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal and being sick are in fact very different but have been reduced to the same thing. (Foucault, 1975, p. 95)

The CanMEDS roles are powerful statements signifying the attributes and characteristics students must possess to practice medicine in Canada (The Royal College of Physicians and Surgeons of Canada, 2014). The roles are divided into the medical expert and non-medical expert roles. The RCPSC (2015) defines the medical expert as someone who can “collect and interpret information, make clinical decisions, and carry out diagnostic and therapeutic interventions” (The Royal College of Physicians and Surgeons of Canada, n.d.b). This focus on metrics in health profession education establishes a binary of “hard” skills that deal with facts and “soft” skills based on feelings or intuition (Goldman & Wong, 2020; G. P. Martin et al., 2015). The so-called “soft” skills of physicians, such as health advocacy, communication, and collaboration, fall under the non-medical expert roles in the CanMEDS framework (The Royal College of Physicians and Surgeons of Canada, 2014). Teaching in medical school revolves around the CanMEDS roles. Some of the CanMEDS roles, for example, health advocate, leader, communicator, and collaborator, are considered roles that can be learned only by participating in the workplace (Renting et al., 2017).

In this chapter, I focus on the humanistic side of the medical doctor. I firstly describe the students’ experiences with physicians who acted as exemplar role models, by treating patients with empathy and compassion. I discuss the students’ experiences with

reductionism, humanism, reflection, and collaboration in their medical education. By reductionism I mean the separation of the person's body into discrete parts for study. Humanism, meanwhile, refers to treating patients and colleagues with respect. The term reflection refers to self-reflective narrative writing, while the term collaboration refers to interprofessional collaboration. I have chosen to group together these concepts as they are linked with the ideology of being a professional "good doctor". I show how the medical expert, meaning a clinically competent doctor, is considered the most important, while the humanist and non-medical expert roles tend to be ignored. As part of this de-emphasis of the humanistic aspects, students are taught, via the hidden curriculum, to develop a "medical gaze" (Foucault, 1973). Lingard et al. (2003, p. 614) describe the medical gaze as being rooted in a "pervasive biomedical worldview" in which "the patient is the object of medicine, her account is unreliable and must be rendered into a 'true' history, [and] her experience can be broken down and 'solved' as a biomedical puzzle". I show how the hidden curriculum contained in various subfields in UGME, such as the anatomy lab and teaching sessions in clinical skills, conveys a counter-orthodoxy of "the good doctor". That counter-orthodoxy rejects the well-rounded and humanistic multi-role physician represented in the CanMEDS daisy (the orthodoxy that is supposed to be taught to students) and restricts the image of "the good doctor" to one who is skilled in manipulating the physical body and its components.

6.1 Learning from Role Models

Students have faculty and peers, including medical residents, as role models. Here, I demonstrate how role modeling, done as part of both the formal and informal curricula, can be a means of teaching and reinforcing the official orthodoxy that "the

good doctor” is a compassionate communicator. (Unfortunately, the students also observed unprofessional behaviour that promoted counter-orthodoxies about being “the good doctor.” This will be discussed later in the thesis).

Research shows that role modeling in the clinical environment has a powerful impact on learners’ professionalism and ultimately their professional identity (Goldie, 2012; Park et al., 2010; White et al., 2011). The actions of role models have been known to impact students' specialty choice (Yang et al., 2019), learning of clinical skills (Jochemsen-van der Leeuw et al., 2015), and professional behaviours (Marisette et al., 2020). In my research, the students learned about being “the good doctor” by observing faculty behaviour with patients.

Role modeling can be effectively used to teach “soft” clinical skills such as verbal and nonverbal communication, humanism, professionalism, and teamwork (Potisek et al., 2019). Students are often tasked with the responsibility to learn about the humanistic side of medicine through informal learning with role models (Craig et al., 2018).

The students had positive learning experiences in observing faculty, as shown here (Phase 2, first-year):

Clara: I was doing [medical speciality] this month as well. Ah, I felt like it was a lot of the same thing. It was so great, we’d have a lecture that morning, and then I’d go shadow, and it would be all the same concepts that we just went over, which was really good.

Isla: And it’s interesting, too, to see how patients react to bad news. The way they react is so different. There was this one lady who was because I was shadowing [medical specialty], and when she came back with [worse disease] she was

literally just shutting down, and saying that “well it seems like I’m just being the guinea pig to the medical profession, so I’m not taking anything that you are suggesting”, and that was how she first started out during the appointment. I was scared. I was sitting there, and my face was just like I felt like maybe my blood was drained from my face, because my preceptor after that is just, “Okay, sit. We can sit there and just debrief for a bit about that case”. So, some of it it’s nice to actually see it because for our SPs [standardised patients], they are trained to react a certain way, so we’ve only been exposed to the nicest people possible when we are practicing. Yeah so, this experience really helps widen the horizon a little bit.

The clinical faculty member in the scenario described above engaged in an important act of creating educational space to offer support and allow the student to reflect on the consultation. This act allowed the student to retain and reflect on the experience and decide what future actions they would take if faced with a similar situation. This was part of creating the student’s habitus and developing their professional identity of who they can become. The scenario continued with the student reflecting on the physician’s behaviour and confirming that she learned about patient communication:

Me: How do you think your preceptor spoke to the lady. I mean, is there anything that stood out to you?

Isla: I’m such a fan of her.

Me: Which clinic was it?

Isla: She’s [medical specialty] yeah. She’s just very calm. She doesn’t take things personally, and she stands her ground without being aggressive. She worked her magic in the end, so.

Me: So, you think you learned from her then, you know, to approach like, I won't say a problem patient, but sort of challenging.

Isla: Yeah. You could say that, yeah.

The student realised the symbolic capital the physician possessed as “*she worked her magic in the end*”. Bourdieu would phrase this symbolic capital as “acts of performative magic” (Bourdieu, 2000, p. 243). He writes about how performative acts can make things real, and in this case observing a physician, an expert in her social field, empathically treating a patient was an important learning moment for the students.

In the narrative below, the student reflected on their learning about patient communication when faced with patients with complex problems:

Mila (Phase 2, first year): It was on, it was [medical speciality] but, you know people, were on Suboxone, Methadone clinics stuff like that right, and just seeing how the doctor talked to the patient, and, like navigated these super-complex people, who have super-complex problems, and just how he supported them, and then eventually got them around to a place where he's, like, “How about we start doing this again”, or “You were really enjoying that”. It was super cool to see how they [patients] interacted with him.

This quote illustrates that students had the opportunity to view positive role models in patient interactions. This learning can be seen as a form of acquiring cultural capital, an embodiment of predispositions of body language and ways of speaking to patients (Bourdieu, 2006; Moore, 2012). This embodiment of capital in education helps create the habitus of the learner to mirror the dominant group, in this case, a physician respectfully treating patients (Moore, 2012). The students used the informal curriculum

(shadowing) and hidden curriculum (considerately speaking to patients) to develop the dispositions of their emerging identity of “the good doctor”. Role modeling thus is an educational space/field where the official orthodoxy that doctors are empathetic and humanistic is learnt. This learning is contradictory to the dominant counter-ideology being conveyed through the hidden curriculum, which supports the “lesser value” of non-medical-expert teaching in the UGME curriculum (discussed later).

6.2 The Ideology of Humanism in Medicine

Students are taught, via the hidden curriculum, that there are two separate and conflicting aspects of being a physician: one is biomedical, and the other is humanistic. They are faced with conflicting discourses on what they should prioritize in learning: Should they focus on passing their biomedically-oriented exams and assignments, or on developing the skills associated with humanism and empathy in patient care? The message being communicated to them is that teaching relevant to the humanistic aspect of medicine is “soft”, and that the teaching strategies (for example, the use of narrative reflections) are not as rigorous as biomedical teaching methods (for example, MCQs). Other researchers have similarly discussed this attention given in undergraduate medical education to the biomedical aspects of medicine at the expense of the humanistic aspects, for example, MacNeill (2011), Shapiro et al. (2009) and Wear (2009).

Medical students’ professional identities are formed through the competing discourses of caring (humanism) and competence (clinical aspects) (MacLeod, 2011). Competence can be thought of as a “god term” (Burke, 1955, as cited in Lingard, 2009), an education ideal, and an “expression to which all other expressions are ranked as

subordinate” (Lingard, 2009, p. 265). The discourse of competence refers to being technically competent or having the required knowledge and skills (Lingard, 2009). The curriculum related to the discourse of caring, in contrast, tends to focus on the social aspects of medicine such as relationships, attitudes, and emotions, that is, the non-technical aspects of medicine (Good & Good, 1993).

In a qualitative study examining the development of professional identities amongst medical students who are caught between the discourses of competence and caring, the students displayed “professional identities consistent with discourses of caring” (MacLeod, 2011). The study employed the observation of small group teaching sessions and in-depth interviews with students and educators. During the interviews, the researcher found that the students showed tendencies to wear a “cloak of competence” and a “cloak of caring”. The researcher found that the students were able to negotiate the discourses of caring and competence, though there was a clear focus on attempting “to pass the exam”. The research found that, for students, scientific information was most important to their educational goals. This was similar to my research findings.

This counter-orthodoxy discourse on the medical expert has also been observed by others examining medical education. As Whitehead et al. (2011) says, in “...the parlance of educators, the non-medical expert roles are frequently discussed as add-ons to the centrality of medical expert teaching” (p.691). This was apparent in my research, as the students (Phase 3, second-year) were aware of the “add on” nature of the non-medical expert role in their curriculum.

Owen: Like, medical expert is the center of the curriculum, and it's the center of the daffodil²⁴ of the CanMEDS roles, but it's, every other part of the curriculum is an afterthought, it's sort of like, um, we'll do 16 lectures on healthy person this week and we'll squeeze in three lectures that are two hours long each on this thing, chock full of additional readings and then put an exam on it and a reflection paper, and so it just seems disproportionate for the amount of exposure.

Adeline: The big difference to is that we don't have those filler lectures. It's every day, it's full acute and episodic, so it's a lot. Like, you go to —

Caleb: Remember when we used to complain about those?

Me: What do you mean by filler lectures?

Adeline: Physician competencies.

Caleb: Not-testable materials.

The students spoke about the non-medical expert role teaching as an “*afterthought*”, and the teaching was regarded as “*filler lectures*”. The students unknowingly point out the “institutional privileging” (MacLeod, 2011) of the scheduling hierarchy that occurs with priority being given to the medical expert classes, an observation that has also been made by Hafferty and Castellani (2009). The non-medical expert teaching sessions were allotted only “*two hours long each on this thing, chock full of additional readings*” for which they then had an assignment and an exam. This contrasts with “*we'll do 16 lectures on healthy person this week*”, meaning they had 16 hours of medical expert teaching, which they were then tested on with MCQ exams.

²⁴ Owen made an error; the flower is a daisy, not a daffodil.

Humanities teaching often requires students to reflect on their values, vulnerabilities, and uncertainties (Shapiro et al., 2009), which my research revealed can be challenging for some students (Phase 3, second-year):

Luna: I absolutely hate how medical school is trying to make me creative or artistic because I'm not, and I don't think it's fair to have that expectation on me in a curriculum.

Me: What does that mean, creative or artistic? Do you all have a dance class in the curriculum?

Isabella: You write poetry. You have to, like, we did watch the video about somebody dealing with chronic kidney disease, but it was written as it was a poem, and I was, I can't understand this.

Colin: Yeah, it was too artistic for me.

Luna: There's, like, metaphors. There's poems, I don't know what it is. I got more out of her just talking to us, and I'm, like, okay!

Me: Was that a lecture on chronic kidney disease?

Isla: Suicide patients.

Luna: That was something for us to reflect on as well.

Isabella: It was on managing chronic illness or something.

Colin: Yeah. [The] patient perception of chronic illness or something along those lines. Yeah.

Luna: I get that they're scared people and that helps with resiliency or whatever, and that's great for them, but not everyone is the same, so it's not fair to people who because the community engagement people, and they're always talking about

arts and how arts is great for us. I'm like, maybe for some, but not for me, and I don't like that I'm graded on how well I can't do something.

Students enter medical school based on competitive scores on Medical College Admissions Test (MCAT) exams, in which the *Critical Analysis and Reasoning Skills* sections (Humanities and Social Sciences) have a lower number of questions than the *Biological and Biochemical Foundations of Living Systems* section and the *Chemical and Physical Foundations of Biological Systems* section (Association of American Colleges, 2015). Popular culture, including television shows, portrays the image of a doctor as someone who has factual scientific, clinical knowledge and technical skills (Tapper, 2010). Thus, the students in my focus groups had grievances with being taught poetry in class. In various fields and subfields, then, medical students are being taught (via the hidden curriculum) that of the two competing aspects of being a doctor, the humanistic side is not important, while the biomedical side is important.

6.3 Learning about Humanism: Integrated Learning Sessions

The medical school at my field site uses Integrated Learning Sessions (ILS) in the first two years of the program to integrate the use of the CanMEDS roles. The function of ILS is described in the student handbook:

Students attend Integrated Learning Sessions (ILS) to integrate content from the preceding teaching block prior to the respective block exam. Students work in small groups for ILS and use parts of the *fictional stories* (stems)²⁵ for their

²⁵ Stems are scenarios based on the patient's history and examination. The students discuss the stems in small groups then each group presents one stem to the entire class.

discussion. ILS enhances integration of CanMEDS roles into learning (Faculty of Medicine, Memorial University, 2019c).

The fictional stories given to the students not only present the reality of patients experiences but also construct it. Stories are a way of organizing and interpreting experience, creating an idealized experience and a standard way of interacting with situations (B. Good, 1993). These stories present the patient as an object of medical practice, as a medical project. The patients in these fictional stories become sites of disease rather than actual patients in need of care (B. Good, 1993).

The ILS teaching seeks to juxtapose medical (clinical) and non-medical (humanistic, non-clinical) roles, which the students spoke about in Phase 3 (second-year):

Maeve: I still feel the, like as much as I completely support the CanMED roles whatever, if you're the non-medical expert, you sit there, and you're like, "Okay, cool", and everybody just messes around for a full hour or forty-five minutes or whatever, because there's no point. You're going to get there, and it's the same things despite every phase.

Genevieve: Like communicate, collaborate. If somebody doesn't say social worker eight times, you didn't have ILS.

The students quoted above appear to be mocking the teaching strategy of the non-medical expert roles in their teaching session. This act was part of the students' resistance to the "non-medical expert" discourse of medical education.

In ILS teaching, the CanMEDS roles are used to reinforce the hierarchy of clinical and non-clinical work. The students' main concern was the teaching involved in clinical learning:

Scarlett (Phase 2, first-year): I think ILS, I understand they want to do like the non-medical expert and medical expert thing, but I think, first year, the non-medical expert is just repetition ...I think getting in a group and discussing a case is super beneficial from, a medical standpoint because we're just learning, treatments, diagnosis, what do we do here; but I found that especially for the assignments and stuff, you're just racking your brain trying to come up with some useless thing to say about collaboration or communication that you've already said eight hundred times before.

Lucy (Phase 3, second-year): It's mostly just communicator and collaborator I would say, and then it's like very easy to say I would collaborate with the social worker, but then when you're actually in the clinic, like, how do you do that? Do you call 1-800 social workers?

The students above continue to mock the non-medical expert roles as “*some useless thing to say about collaboration or communication*”. The students did, however, value the group discussions that dealt with the medical expert role: “*discussing a case is super beneficial from a medical standpoint because we're just learning, like, treatments, diagnosis*”. Learning about the treatment and diagnosis of diseases was seen as important. However, the humanistic part of patient care, such as knowing when and how to collaborate interprofessionally with social workers, appeared to be bothersome. This mocking discourse of the non-medical expert roles reflects the overall medical culture, as the students reinforce biomedical dominance through their resistance to the teaching of non-medical expert roles. Students are being socialized to prioritize the medical expert role through the hidden curriculum that is part of the formal ILS curriculum.

A second UGME sub-field where the hidden curriculum operates to teach students to dismiss the humanistic side of medicine is in the anatomy lab. As with the ILS curriculum, anatomy instruction functions to convey a counter-orthodoxy of “the good doctor” that contrasts with the official orthodoxy promoted through the CanMEDS roles.

6.4 The Anatomy Lab

The anatomy lab has been described as a liminal place where students are transformed from the status of the lay person to a provisional member of the medical community (Vinson, 2019). Liminal places allow the learner to leave their old identity behind and become a member of the community (Turner, 1967). The liminal phase represents the actual transition of the learner to their new identity (McDermid et al., 2018).

At my research field site, pre-clerkship students begin learning anatomy early in their curriculum. The lab relies on plastinated human specimens. The move away from the traditional use of cadavers has become more common among medical schools (Goodwin et al., 2016). Increasingly, anatomy pedagogy uses virtual simulation, mannequins, the 3D printing of organs, and radiological approaches. Teaching simulators in medical education are meant to help standardise teaching and learning experiences; however, the uniqueness of the human body and its variants could be lost (Prentice, 2013). The shift toward simulated human specimens has been associated with the objectification of patients and a loss of humanism in learners (Krieger, 1994; Scheper-Hughes & Lock, 1987; Sugand et al., 2010; Young, 1982).

In the section below, I show how experiences in the anatomy lab led students to distance bodies from personhood.

6.4.i The Language of Anatomy

The language of anatomy serves to dissociate medical students from patients and to dissociate patients' body parts from personhood. The set of technical terms used to position the cadaver and to describe body parts “begins the acculturation of medical students...initiating them into the culture of biomedical practice” (Prentice, 2013, p. 42). In one focus group, students in Phase 2 (first-year) described struggling with using positioning language for body parts:

Mila: And there was no, introductory, session that was, “Here’s the terminology used for nerves, here’s the terminology used”.

Adeline: For cardiovascular or, histology or whatever, but it was just like talking about, interior?

Me: Yeah, interior?

Isla: posterior, and superior and inferior, yeah, we didn’t do that stuff, but just not other terminology, I guess?

The students were learning to use the “medical gaze” (Foucault, 1973; B. Good, 1993) by thinking anatomically. This means focusing on discrete body parts rather than the whole person and minimizing or ignoring the recognition that body parts are part of a human being.

6.4.ii Developing the Medical Gaze

Foucault's (1973) notion of a "medical gaze" refers to the reductionism of the patient into symptoms and problems to be solved rather than considering the person. The patient no longer exists; rather, the disease is the object for consideration, and the doctor has the power of knowledge to classify and organise interventions (Foucault, 1973). Students acquiring this way of seeing learn to view the plastinated body in terms of its discrete parts that can be affected by disease or produce symptoms rather than seeing a whole person who experiences disease or symptoms.

Good (1993, pp. 65–87) writes about how the dismemberment of the body allows for regulation and surveillance. This enables students to separate what looks normal from the abnormal. The students use the "unchallenged socially constructed categories" (Brosnan & Turner, 2009, p. 163) to determine what is considered normal and abnormal when looking at the human body. This was evident in a focus group with Phase 1 (first-year) students who attended Obstetrics and Gynaecology surgery. I had asked them whether observing the surgery had been helpful to them in terms of supporting their anatomy learning (Phase 1 first-year):

Lucy: Yeah, it did because it looked so different from an actual person. When we're seeing you know, female pelvic anatomy, the cervix, the fundus, all that stuff, it looks so clear on the model, and then when you see it coming out of a person, because she had a hysterectomy [removal of the uterus], it looks completely different. The uterus was all bumpy because of fibroids [muscular growths on the uterine wall]. Yeah, so I think it's good to have these experiences

because I wouldn't know what they're doing. They're cutting stuff that all looks like it's continuous, you know, like it's so different when it's the actual body.

In the focus group above, the students acknowledge that their anatomy models showed the “normal” organ, while in reality a patient's diseased uterus was “bumpy” because of fibroids.

In my research, the students were astonished by how the portrayal of the simulated plastinated body in anatomy was different from reality in surgical operating rooms:

Isabella (Phase 3, second-year): Like, I was shadowing a surgery, and they were pointing to a red thing, and they're like, “What is this?” Honestly, I was, “I don't know. On our specimens, the nerves are yellow, the veins are blue, and the arteries are red; everything here is pink. I don't know.”

The sterilized plastinated anatomy parts were different from an actual body in practice, contributing to and reinforcing a dehumanizing experience. The use of the plastinated specimens contributes to a body-personhood split in anatomy teaching by emphasizing the body as an object—an object without the characteristics that make the body human (Lindenbaum & Lock, 1993). Lindenbaum and Lock (1993) argue that students will need “cultural work” to recreate the human body as a person, and that this act of reconstruction is “essential to a student becoming a competent physician” (p.97).

The act of a person donating their body for plastination is seen as one of pure generosity and admirable character (Kassam et al., 2020). This act of generosity is not always acknowledged in UGME anatomy teaching, resulting in a lost opportunity to recognize aspects of the human, such as generosity, that are invisible to the medical gaze. Anatomy teaching has evolved from a holistic paradigm in the early 18th century to the

current post-modern concept of the “body as a machine” in biomedicine (Regan de Bere & Petersen, 2009). The reductionism of the body into specimens of parts contributes to this dehumanization.

The separation of the body instinctively perpetuates the “mechanistic conception of the body and its functions, and a failure to conceptualize ‘mindful’ causation of somatic states” (Scheper-Hughes & Lock, 1987, p. 9). The culture of the medical school reinforces the reductionist view of the “body as a machine” (Krieger, 1994; Macneill, 2011; Regan de Bere & Petersen, 2009, pp. 156–167). This reductionism was noted by Phase 1 students (first-year):

Gabriel: Right, but I think that, as you know, you guys [referring to UGME] are alluding to us as people who are supposed to use humanism and compassion as a guiding compass for how we do things in our career. Um, there should be an amount of built-in respect for who you are working with because we are trying to get out of that, the doctor being the detached academic scientific, you know, drone, and more into us being, you know, custodians or counselors of health that are supposed to be working with people.

Owen: But, yeah, I noticed there’s, um, the making the connections, uh, seems to kind of be up to us. Like the same thing I brought up about metabolism question earlier, um, we are not being given the connection between, “Hey, this is how you got to treat people in clinical skills,” to, “Hey, these were people in the cadaver lab.” They’re, it’s almost, it is sort of up to us to put the pieces together.

Me: Yeah?

Gabriel: um, I don't know. I think busy-ness is often an excuse. I think, too, using even an acronym that you might refer to a patient as instead of saying their name you'd be like "Yeah, buddy up there, PKU [Phenylketonuria Disease]" or whatever, you reduce somebody to acronyms or to a status, and you reduce specimens to just that when you are too busy to acknowledge that there's a person there.

Olivia: Yeah, I got floored handling some of the specimens and thinking, holy crap, this could be my leg in 50 years.

The students correctly identified the medical gaze that turns persons into patients, patients into symptoms and symptoms into locations (Bleakley, 2011a, p. 173). The loss of empathy and humanism, referred to as emotional neutralization, as medical students progress through training has been well documented. For example, Hojat et al. (2009) annually surveyed the empathy ratings of a group of medical students using the Jefferson Scale of Physician Empathy (JSPE). The researchers showed a sequential decrease in scores as the students progressed through medical school (Hojat et al., 2009). The researchers did note that their findings might be limited to small samples because of low class participation (27%), and the survey was only conducted in one school. Spatoula et al.'s (2019) meta-analysis found declining empathy during undergraduate medical education. However, qualitative research studies were excluded, and the studies used included only one measuring tool: the JSPE (Spatoula et al., 2019).

Emotional neutralization is a by-product of a hidden curriculum in the institution (Lempp & Seale, 2004). As shown above, the students in my study, acknowledged the

body is being sectioned into discrete parts as objects of study, and that, as a result, the students' need to be humanistic and compassionate could be diminished.

6.4.iii The Process of Becoming “Removist”

A few students had previously done anatomy courses in their undergraduate or postgraduate degrees before starting medical school. One student, Gabriel, described anatomy in UGME as “removist”. His description of a “removist” approach in anatomy reflects what Gordon (1988) has described as the tendency of biomedicine to treat the body as a thing that belongs to no social field. These Phase 1 students (first-year) were taken aback by the lack of awareness that the specimens were once human beings:

Owen: We dealt with human remains a lot for different courses, one of which I did was like a [name of class in undergraduate degree], and we spent an entire, like, 50-minute lecture before we ever handled any specimens talking about sensitivity and acknowledgement that this used to be an individual. Um, and what I found interesting is that when we moved into, like, using the models in the, in the anatomy labs, there wasn't any discussion or disclaimer that these people used to be individuals. Uh, it was almost like a disconnect. It was, it was, these are learning tools and use them as such as opposed to, I don't know, if it would have to be sensitivity training, but I just, I found that there was a, there was a big disconnect there between um, I mean like there's almost like an aspect of medicine, a culture of medicine that just kind of says, like, you know, use things for what they are, like a very utilitarian approach to organs or even a patient that you might be treating, you know.

Me: So, do you think that there was just no respect for these, specimens?

Owen: I don't, I don't think that there was disrespect or that there was like no respect or that there was even like what you call, I guess like "arespect" in the sense.

Me: So, like, acknowledge this used to be part of someone?

Owen: I just don't think it was a part of the agenda.

Me: Yeah?

Olivia: There should be some reverence involved for the fact that people who died gave their bodies to give us an educational resource.

Gabriel: I wonder though if it is because we don't have any wet models or wet specimen, like what we are working with is like plastinated so it doesn't even, there's like been a process to kind of removist.

Gabriel's recognition of the use of "*removist*" plastinated specimens to teach in anatomy shows his resistance to the counter-orthodoxy of the non-humanistic physician. Gabriel was trying to support the orthodoxy of a doctor with both medical expert and humanistic qualities. The students' developing dispositions were being molded into a "*removist*" position that was at odds with the expectation of becoming a compassionate physician. This observation that students are being trained away from values such as compassion and empathy has also been made among other researchers (MacLeod et al., 2021; Mehta, 2011; Shelton, 2013). Kassam et al. (2020) takes an even more critical stance, arguing that students transition to a new unemotional episteme of knowledge that applies an analytical, scientific gaze to the body. A.C. Smith and Kleinman (1989) argue, in fact, that medical training is an "emotion management strategy". As I continue to show

below and throughout this dissertation, this rendering of the human being as a collection of plastinated parts or objects happens via the hidden curriculum in various subfields of the medical school.

The dehumanization of the body was also apparent in the students' clinical skills training with standardised patients (SPs).

6.5 Learning with Standardised Patients

Along with the ILS curriculum and the anatomy lab, the use of SPs in the Clinical Learning and Simulation Centre (CLSC) is a third UGME subfield where the hidden curriculum purveys the counter-orthodoxy of the non-humanist, clinically-focused professional physician.

SPs do not necessarily act as authentic patients but rather perform as “professional” patients (Nestel & Kneebone, 2010). Johnston et al. (2013) explain that SPs occupy a “third space” as expert patients. The “third space” refers to the SP being part of the triad in the OSCE clinical encounter. The expert patient refers to an empowered patient who is knowledgeable because of their experience and training in the clinical encounter (Johnston et al., 2013).

Previous research has shown that SPs are “dehumanized”²⁶ by students (Gormley et al., 2016; Johnston et al., 2013). In my study, SPs were dehumanized by being referred to as just a “warm body” for physical examination. As one administrator put it, “They’re here as just a warm body” (FGAdmin04). This comment by a student in a focus group is even more telling:

²⁶ Dehumanization refers to the lack of awareness of the persons experiences and their agency, their ability to make informed decisions.

Caleb: The patient is, like, there's a body to do a physical on right, with no real signs.

Me: Is that like a mannequin you do?

Caleb: No. Like an SP.

Me: Oh, an SP comes. You just said a body comes, and I just thought you meant a mannequin.

The “body” the student refers to was like a “sophisticated prop” (Gormley et al., 2020) used in the students’ performance of the simulated clinical examination. The deindividuation²⁷ of the SP as just a body has the effect of rendering the patient as just part of a “less[er] human herd” (Dawson, 2021, p. 224), rather than as a person. The language used with the SPs has the effect of depersonalizing the patient.

In three subfields of the UGME curriculum, the ILS curriculum, the anatomy lab, and clinical skills, the teaching was mutually reinforcing. A “dehumanizing experience” (Lindenbaum & Lock, 1993, p. 97) of patients as SPs and plastinated body parts can have a cumulative effect. From a Bourdieusian perspective, the normative assumptions of the depersonalization of the body were replicated across subfields of the medical school, which contributes to the formation of the students' medical habitus. This depersonalization and dehumanization of the body are all effects of the hidden curriculum of medicine (Martimianakis & Hafferty, 2016).

²⁷ Deindividuation refers to the person becoming absorbed into a group or anonymized (Kelman, 1976 and Zimbardo, P.G., 1969 as cited in Haque & Waytz, 2012)

6.6 Written Assignments

Assessments are yet another way in which the ideology of “the good doctor” as one with medical skills, rather than humanistic skills, is conveyed in a hidden curriculum. At the medical school that was my research field site, as with many medical schools, students are required to produce written reflections on their experiences. Self-reflection has been shown to promote professional identity formation in students (Monrouxe, 2016; A. Wong & Trollope-Kumar, 2014). Self-reflection can help students determine what their experiences mean to them and how the experiences will contribute to their future practice (Holden et al., 2016).

Reflective writing has been shown to promote reflective practice (Wald et al., 2012). Reflection on learning and practice is important to help identify learning needs and integrate new knowledge (Uygur et al., 2019; Westberg & Jason, 2001). It is a tool to aid in development and for learning coping strategies to deal with difficult situations (Boland et al., 2016).

Reflection on personal beliefs and actions can also help develop professionalism (Epstein, 2008). An important part of being a professional is self-regulation and assessment, which is promoted through reflection during and after actions (Westberg & Jason, 2001). There are four essential elements of reflection (Wear et al., 2012). These elements are the elaboration or detailed expression of the experience followed by what issues arose, then acknowledging the possibility that there may not be easy or straightforward solutions and then a transformative aspect on what action will be/should be taken. The action taken could be physical such as using different speech/language or

doing something different next time, or it could involve adopting a new attitude or way of thinking (Wear et al., 2012).

Learning through self-reflection assignments, like other mechanisms of learning, depends on assessment of the learning. Students rely on receiving feedback about their self-reflection assignments in order to facilitate their learning and correct their mistakes (Westberg & Jason, 2001). The students in my research (Phase 3, second-year) did not find the feedback they received on some assignments helpful:

Iris: And, like, they are not hard assignments.

Amelia: I just don't feel they're useful.

Mila: Yeah.

Iris: We've just been reflecting a lot and not getting a lot of feedback.

Luna: They gave us feedback, but it wasn't I found at all useful like—I don't know.

Colin: Yeah. No, I'll agree with that.

Luna: It was critiquing what we said instead of telling us what we should've [done differently]. ...because I don't know [where] the confusion was where/what we wanted to say. Like, what was our answer?

Colin: Yeah. So, they were, this isn't—

Luna: This isn't what I want but they didn't tell us what they wanted, so we're, it's not this, so maybe I'll try this, and so we still don't know if we passed.

The students expected that their reflections would be assessed as “right or wrong” answers to determine whether they passed the assignment. Reflection is a personal

subjective experience with no wrong or right answer (Lovy et al., 2010; Song & Stewart, 2012).

The dominant culture of medicine tends to reward busyness and productivity (Westberg & Jason, 2001, p. 26) and not taking time to pause and reflect. It would be seen as heterodoxic (or, counter-orthodoxy in my conception) to use the time for reflecting on action and giving feedback, thus making change difficult (M. J. Gordon, 1999).

A systematic review that examined methods to support reflection amongst medical students found that students are often asked to reflect without being taught how to do so (Uygur et al., 2019). My research cohort had a session on reflection with detailed objectives; however, there is a possibility that this class was poorly attended. Students skipping non-medical expert lectures is another example of the marginalization of the humanistic aspects of education; this is addressed elsewhere in this dissertation.

Hodges (2006) warns about creating hidden incompetence through too many reflection assignments, as students may be able to produce the assignments but unable to identify their learning needs or skills. Further, Hodges (2015) cautions that reflection has become “a kind of generic salve to heal all wounds: reflection is taken up to address burnout, professionalism lapses, empathy, cultural competence, wellbeing, diagnostic decision making, medical error, interprofessionalism, lifelong learning, tolerance of ambiguity and on and on” (p.263).

It has been suggested that reflection should not become a competency to be assessed; rather, it should be taught and learned as a way of seeing and being (Ng et al., 2015). Students should be taught not only to reflect on their individual experiences but

also to critically reflect on why social and systemic forces shape understandings and assumptions and how these forces will always affect individual actions and decisions (Ng et al., 2015).

The RCPSC identifies reflection on learning and practices as just as important as being a scholar in the CanMEDS roles framework (The Royal College of Physicians and Surgeons of Canada, n.d.d). The students in my focus groups did not appreciate the importance of reflection exercises for their future careers as “good doctors”. As I continue to show, the importance of reflection was lost, as the students wrote their assignments only to “pass the assignment”. This is illustrated in the following conversation amongst Phase 3 (second-year) students:

Lucy: I could write about pink elephants, and as long as I’m in the rubric I’m good to go.

Scarlett: I’m not the biggest fan. I find that I don’t actually get anything out of them. I just do them really quick just to get them done and check it off the list because we have so much other stuff to do. I think we’re meant to, reflect on our experiences or, like, our peer assessment²⁸ or community engagement²⁹, but because, I don’t know if it’s the timing or just the format of the reflections, I find that they’re very micromanaged and it’s not even allowing me to reflect, I’m too busy.

Me: When you say micromanage is that—

²⁸ The student was referring to their written assignment on doing peer assessment.

²⁹ The student was referring to the reflection assignments the students do on their rural visits.

Scarlett: They give us a rubric, and it's like, include this, include this, include this, so I find I'm just putting sentences in to get the points on the rubric. Like, I'm not reflecting.

Olivia: That's a true reflection. My issue with the reflection assignments is they are not my reflections because they just give us the rubric, and they're, like, "Alright, here's what we want". Like, when reality, my own reflection, like what I want to talk about is probably not what the rubric wants to talk about.

Iris: Yeah, you just follow the rubric, and I did, and they passed me, even though everything I wrote was garbage.

Isla: That's the theme of these essays. You follow the rubric, you write garbage, and you pass it.

The students were explicitly challenging the official orthodoxy that reflection is a useful way to teach medicine. Thus, the use of reflection assignments as a tool for critical thinking is reversed, and it instead becomes a tool for control and counter-orthodoxy, a point also made by Bradbury et al. (2009, p. 3). The students reported that they pretend to support the assessment method, while they are in fact outright rejecting it: "*Like, I'm not reflecting*"; "*You follow the rubric, you write garbage, and you pass it*".

The students' stance is heterodoxic in part because they disagree with the method, which is not compatible with what they understand to be a good approach to teaching and learning – they prefer the approach used in teaching the medical roles, which is based on clear "right or wrong" answers. But importantly, their stance is also heterodoxic because they see the reflections as a waste of time because they have been taught, repeatedly, across various UGME subfields, that it is a waste of time to focus on the humanistic

aspect of being a physician. This message that the humanistic aspect of being a physician should be de-emphasised is also reinforced by “lecture capture”.

6.7 Lecture Capture

Lecture capture involves using technology such as microphones to digitally record a live lecture (Krautscheid et al., 2019). In the lecture theatres at my field site, lecture capture is restricted positionally, unlike untethered lecture capture in which the lecturer can move freely (Krautscheid et al., 2019). The recordings are converted into a media file and uploaded to course management learning platforms. Research has shown that lecture capture reduces note-taking stress during class, improves focus during lectures, and gives students a sense of control over their learning (Dommett & Gardner, 2019; Groen et al., 2016; Mayer, 2008).

The students in my research cohort generally welcomed the availability of the lecture capture service despite technical difficulties (Phase 3, second-year):

Caleb: I find the best way for me to actually learn is to be in the lecture, but sometimes they're just talking so fast, or you can't keep up when you want to be able to go back and look things up. And then, of course, you have other stuff on the go, like conference or shadowing, so you can't be at the lecture, so. I do really like it. I think it should be available.

Clare: Basically, every lecture that we have is captured. Yeah, except for that one hour. Which is really good because I don't go to class anymore really; I only go to a couple, but I just stay or just watch at home. I put it on my laptop, my notes on my tablet.

As these students indicated, one reason for using lecture capture is to accommodate shadowing experiences, which is an important way to increase symbolic and educational capital. The medical school, by providing the facilities for lecture capture, unwittingly endorses clinical experience over attending lectures. Students who rely on lecture capture and miss classes are also reproducing the counter-orthodoxy of valuing clinical learning over classes, especially non-medical classes.

A clinical faculty member (Fac09) voiced their concerns about the students demanding that lectures be recorded:

One of the faculty in our faculty meeting was annoyed by what happened when she was asked to record the lecture. She said, no, she didn't want to record it, and she really felt like she was being harassed and pressured into it. And so, what we in the faculty group said, "Okay, tell them. Tell the students if the faculty says no, it's no." [...] and when I said "no" in the afternoon to the students [that is, Fac 09 said no to having the upcoming class recorded], and I said, "No. I don't want this recorded". Then, he [student] went on and on about how important it was so for students reviewing and all this and I said "no", but he wasn't like, he wasn't taking no. He was just continuing on and on...

Me: Is that almost like bullying?

It is, it is to a certain extent because he's trying to make you feel guilty.

The students demanding that teaching sessions be recorded goes against the Faculty of Medicine's Statement of Professional Attributes (Faculty of Medicine, Memorial University, 2013) and the University's Code of Conduct (Faculty of Medicine, Memorial University, 2017c). The student was resisting the power of the faculty

member's decision not to use lecture capture. The faculty member tried to support the official orthodoxy of students being in class to learn; however, the students supported the counter-orthodoxy of using lecture capture to facilitate clinical learning.

The introductory page of the student handbook states, “You will have opportunities to interact with our faculty who come from many different areas of medicine. In addition to clinical disciplines, you will learn so much from our medical scientists” (Faculty of Medicine, Memorial University, 2019c). The wording of this statement is ambiguous and appears to omit the humanities, yet on the Faculty of Medicine webpage, three divisions/disciplines are identified: Clinical, Biomedical Sciences, and Community Health and Humanities (Faculty of Medicine, Memorial University, 2020b). The Community Health and Humanities division traditionally hosts most of the non-medical expert objectives in the curriculum, while the Clinical and Biomedical Sciences disciplines focus on the medical expert objectives (Faculty of Medicine, Memorial University, 2020a). The RCPSC agreed that the phrase “non-medical expert” was “adopted by educators and clinicians”, and there ideally should be “the inter-linkage of all of the Intrinsic Roles via the integrative Medical Expert Role [to] symbolize the competent practice of medicine” (Sherbino et al., 2011, p. 696).

The lack of attendance to the non-medical expert teaching classes was raised at a phase governance meeting (Undergraduate Medical Education, Faculty of Medicine, Memorial University, 2018c), so I asked the students about this in the focus groups (Phase 2 first-year):

Lorelei: But they do always put community engagement³⁰ [classes] or physician competencies³¹ [classes] in slots they know that people won't be around for.

Me: So, it's intent. You say UGME is doing it intentionally?

Clara: I think students do it intentionally and UGME knows, so they just do it as well. It's just, I guess hard for the lecturers, especially when there's a class afterwards that everyone wants to attend, and they're all waiting outside.

Audrey: Yeah, they tend to schedule stuff like that when they know no one is going. Like the day before an exam, it will be like an ethics lecture and no one will go, even though ethics is obviously very important. Like, we went to one ethics class, there was like five people there, and it was the day before an exam.

This scheduling reflects the “way things are” (or the doxa) in the UGME environment. The “*students do it intentionally*”, and “*UGME knows so they just do it as well*”, which shows how the counter-ideology of the non-medical expert roles having lesser or no value in UGME gets reinforced and reproduced over time, in various ways, and by various stakeholders. The official orthodoxy of UGME (in keeping with the RCPSC) is that students are supposed to be taught to treat both aspects of being “the good doctor” equally; however, through the hidden curriculum, the non-medical expert roles are taught to be less valued.

³⁰ The students refers to community engagement classes, which focuses on the determinants of health (Faculty of Medicine, Memorial University, 2020a).

³¹ Physician competencies classes focuses on the non-medical expert roles teaching (Faculty of Medicine, Memorial University, 2020a).

6.8 Summary Comments

I began this chapter by showing how physicians as role models demonstrated to students how to embrace the humanistic side of medicine. However, much of this chapter highlights the dominant counter-orthodoxy of the superiority of medical expert learning and the resistance to the official orthodoxy (of the well-rounded physician) by some of the students. For patient care, physicians need to be humanistic and empathetic, which can be achieved through collaboration with colleagues and reflective practice. Humanism, collaboration, and reflection were resisted through practices via the hidden curriculum. Anatomy instruction facilitated a “removist” position in the students, and SPs were considered as a “body” for examination.

Reflection assignments were too prescriptive, and they did not allow the students the freedom to truly reflect on what their experiences meant to them. Medical students in my study rejected the idea that they are a useful tool for developing the skills of humanism – which then supported the overarching message of the hidden curriculum (the counter-orthodoxy), that developing humanistic skills is a waste of time. The non-medical expert role teachings were relegated as subordinate through practices in the subfields of UGME scheduling and ILS. The continued reinforcement and reproduction of the counter-orthodoxy of clinical dominance in the various subfields in the field of UGME will have a cumulative effect on the students’ developing habitus.

In the next chapter, I continue to show how the students perform being a clinically competent “good doctor”. I look at different subfields, like the curriculum, the students’ use of self-directed learning, the research course, tutorials, the clinical skills exam, and their effects on the students’ developing habitus.

Chapter 7 Resistance and The Good Doctor

Where there is power, there is resistance. (Foucault, 1978, p. 95)

Medical education exists to train students to be of service to the patient, as “Learning with, from and about patients is the heart of the matter of medical education and is the foundation for medical education for the future” (Bleakley, 2011a, p. 269). The Medical Council of Canada and the Royal College of Physicians and Surgeons of Canada (RCPSC) state in their vision and mission statements that they strive to provide “...the highest level of medical care for Canadians” (Medical Council of Canada, n.d.b) and aim to “serve patients, (and) diverse populations” (The Royal College of Physicians and Surgeons of Canada, 2018). Medical communities need individuals who are committed to upholding the highest standard of care (Cruess et al., 2019).

This section explains the curriculum structure in my field site and the way students and staff respond to the official ideologies of how to be “the good doctor” curriculum through acts of resistance. I examine how the hidden curriculum operates within the formal framework of instruction embedded within the formal curriculum, the way that teaching occurs, and how interactions with peers, faculty and other health professionals happen. I will particularly emphasize the hidden curriculum as it evolves in the students’ protected time for self-directed learning, their research methods course and peer assessment. I show how students react through acts of resistance to the official discourse as they balance and negotiate their own beliefs and actions in relation to official ideologies of the medical school and the counter-ideologies of the hidden curriculum on how to be a “good” medical student and ultimately “the good doctor”.

7.1 The Spiral Curriculum

The medical degree program at my field site is a four-year program divided into pre-clerkship and clerkship phases. The medical school further divides the pre-clerkship phase into four courses: the Patient course, Physician Competencies, Clinical Skills, and Community Health. The objectives of the courses are based on the CanMEDS roles framework (Royal College of Physicians & Surgeons Canada, 2014). The overall curriculum was, at the time of my research, a spiral design³². The curriculum reflects the expected learning outcomes for graduation from the Doctor of Medicine (MD) program at Memorial University.

7.1.i Curriculum Integration and the Spiral Curriculum

A spiral curriculum involves repeatedly revisiting topics at different levels of difficulty. Thus, students can relate new learning with previous learning, and the competence of students increases with each visit to a topic (Harden, 1999). The use of a spiral curriculum is supposed to help reinforce learning and aid in integration through both the horizontal and vertical integration of teaching objectives (Harden, 1999; Prideaux et al., 2013). Horizontal integration refers to the simultaneous teaching of topics across different subject areas in a specified time, while vertical integration refers to the teaching of basic sciences together with clinical practice to reduce the basic science/clinical divide (De Cates et al., 2018).

³² The spiral curriculum was introduced in the academic year 2013/14. In 2018, a review of the MD curriculum was carried out and a decision was made to change the curriculum design (Faculty of Medicine, Memorial University, 2019a).

The integration of the curricula involves the incorporation of biopsychosocial learning to help students make connections between disease and underlying biological, psychological, and sociological mechanisms (Bandiera et al., 2018; Prideaux et al., 2013). The term “integration” has been recognized as a popular “buzzword” or “odd job” word and is loosely defined in medical education (Brauer & Ferguson, 2015; B. Good, 1993). Integration refers to the development of teaching and learning in which knowledge from different areas, such as the basic sciences and clinical learning, connect and are related to each other (Norman et al., 2000; Woods et al., 2005). These connections should nurture the learner’s understanding and performance of the expected professional activities of medicine (Woods et al., 2005). Integration should be understood as a cognitive function or operation that occurs within learners as they link clinical concepts with basic sciences. Once this understanding is adopted, the focus should shift to examining how the learning context, particularly workplace environments, aid or hinder cognitive integration (Brauer & Ferguson, 2015). The use of different learning models in medical education has been debated and explored, and, as of yet, no one model is considered superior (Brauer & Ferguson, 2015). Curriculum integration has been referred to as the “paradox of change without difference” (Woodbury & Gess-Newsome, 2002, as cited in R. Hopkins et al., 2015, p. 150), showing the complexity of trying to accomplish this feat.

7.1.i.a Students and the Spiral Curriculum. The students in my cohort were the fifth class using the spiral curriculum; therefore, it was still considered a novel approach to teaching and learning in UGME. In my research, the students were initially receptive to the spiral curriculum. As Amelia (Phase 1, first-year) said: “The spiral curriculum, I think, it is a pretty neat idea, um, and I have noticed too, the way things are proceeding is

we're allowing to kind of learn some of the basics and then integrate it". This comment illustrates that the ideology of the spiral curriculum was functioning as expected for students early in their training. The spiral curriculum did initially help the students integrate their knowledge. However, the situation changed as time passed.

The issue of a lack of integration was the main concern for students (Phase 3, second-year):

Caleb: ...the thing with the spiral curriculum, right, like, it's a blessing and a curse. Where it's nice because you don't learn it once and then that's the only time you're going to see, and you're responsible for knowing everything like that one time because you're always going to see things coming back, but the same time, it was so random.

Mila: Yeah, spiraling my life out of control, that's what it is.

Hazel: I feel like you almost need to do the blocks like that first year and then second year do the spiral because we do first year we're spiraling around, and we're like, "Is this the kidney? Is this the liver?" I don't really know.

Olivia: I think the spiral curriculum is just a conspiracy. It's easy to schedule lectures randomly than all in one block so they could schedule a lecture many times and be like, "Hey, it's a spiral", so...

The students explain that the spiral curriculum was not useful in helping them integrate their knowledge. It was useful as a teaching method to help them learn information they may have missed the first time. Iris (Phase 3, second- year) said, "I think, like, I don't know – it gives you a second chance to understand something if you

didn't the first time." Isabella (Phase 3, second-year) said, "Yeah, it's kind of like a reminder of things that you've forgotten".

7.1.i.b Faculty and the Spiral Curriculum. Teaching faculty were also not impressed with the spiral curriculum as topics that were being taught were unrelated:

Non-Clinical Fac06: It's supposed to be a spiral program and it's not anymore, at least not for our material. The issue with that is that it's supposed to be an integrated curriculum, and it's not. If I look at the things that are being taught [around the same time] when I'm teaching, they're not related to what I teach.

Non-Clinical Fac17: That's the thing, too, it's never technically a spiral, right, because a spiral means that you revisit the topics. I don't think that ever happens.

Another faculty member said it this way:

Non-Clinical Fac20: The new curriculum was supposed to be the spiral curriculum, but when you look at the schedule you definitely still see blocks. So, most of [subject] is still taught in a block. Most of [subject] is taught by block, which I thought it wasn't supposed to be like.

Faculty resistance to the spiral curriculum was shown in my interview with an administration faculty member (Fac 04) who was part of organizing the spiral curriculum: "There were umpteen, in some ways the MELT [Medical Education Leadership Team] team gets unfairly criticized. They, they gave faculty many opportunities for consultation and participation on certain things, and faculty ignored those left, right, and center."

Tensions and resistance to the spiral curriculum arose in which both students and faculty were not supportive of the curriculum. The medical school governance supported the official orthodoxy of the spiral curriculum as a set of fundamental beliefs that could

not be questioned. The medical school administration believed that in the spiral curriculum, “topics related to the learning objectives will be revisited over time and through continued repetition.” Documents confirmed this: “Students will build their knowledge and understanding in a structured fashion” (Undergraduate Medical Education, Faculty of Medicine, Memorial University, 2013). However, teaching faculty and students did not adhere to that official orthodoxy; they not only resisted the spiral curriculum as a teaching framework but rejected the assumption that a spiral curriculum was even in use. This led to counter-orthodoxy in students and faculty, leading to acts of resistance. Faculty pointed out that subjects were still being taught in “blocks” rather than the true integration of teaching material. The students also found the utility of the spiral curriculum to be ineffective, “...*spiraling my life out of control, that’s what it is*” and “...*the spiral curriculum, right, like, it’s a blessing and a curse.*”

Bourdieu believed that educational institutions espouse the ideologies of particular world views that are “legitimate” (Grenfell, 1998). In the case of the spiral curriculum, the official orthodoxy (which in this case is described in policy guidance documents) was that a spiral curriculum supports integrated learning. This was not, in turn, manifested in the taken-for-granted normative assumption about how things are, either by students or faculty. Both groups resisted the orthodoxy in the form of the counter-orthodoxy (or the “heterodoxy”, in Bourdieu’s formulation).

7.2 Self-Directed Learning

There was time dedicated in the curriculum every week for self-directed learning (SDL). The students were allowed three hours of SDL per week. SDL can be free time, with no associated module, or students could access a learning module in that time slot.

SDL was defined by Knowles (1975) as:

A process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing, and implementing appropriate learning strategies, and evaluating learning outcomes. (p. 18)

The first step of SDL is recognizing one's limitations and deficiencies in knowledge (R. Hays, 2009; Knowles, 1975). SDL is incorporated into medical school curricula to provide students with the skills necessary to become lifelong learners (Simon & Aschenbrener, 2005). It is recommended that learners be taught SDL skills to help them succeed in their future careers and engage in lifelong learning (McGrath et al., 2015).

The students in my research took part in a two-hour session on SDL and peer assessment. The session involved instructing the students on the importance of lifelong learning in medicine (Faculty of Medicine, Memorial University, 2017b). I questioned the students about the use of their SDL time and asked them whether they found the SDL sessions useful (Phase 1, first-year):

Me: Do you find that useful? Would you prefer to have lectures in that time?

Olivia: No

Nora: No

Me: No?

Gabriel: No, because I feel like sometimes for the self-directed learning there's an actual assignment or module that you are supposed to do, and I feel like 9 times out of 10 most people that I talk to, they don't do the module at the specified time; they use that time to like...

Owen: Catch up.

Ivy: Catch up on sleep or study.

Owen: I found the time useful but not the activity.

Clara: Yeah. You can go home, you watch Netflix.

Maeve: Go get groceries.

7.2.i Acts of Resistance to SDL

The students' acts of resistance to using SDL time for academic work was part of their response to the disciplinary control of the UGME curriculum. This counter-orthodoxy was reflected in their resistance, such as not engaging with the intended learning (Frank & Jones, 2003).

It is hoped that by the students engaging in SDL it will be developed as part of the dispositions and abilities of their habitus as "the good doctor" (Bourdieu, 1984). The students' resistance to SDL may eventually impact their professional identity development. As a professional, the good medical student and eventual physician should engage in self-directed lifelong learning (The Royal College of Physicians and Surgeons of Canada, n.d.c). The experiences within the subfield of SDL in UGME resulted in counter-orthodoxy behaviours in the students, "*You can go home, you watch Netflix. Go*

get groceries”, which may reduce their desire to continue with their professional development.

7.2.ii The Consequences and Resistance to Independent Learning Modules

The students in the focus group above spoke about being assigned learning modules. The students explained that the faculty member was not available to teach a topic, so instead the faculty member provided a PowerPoint presentation with no explanation of the slides. I questioned the students about their independent learning modules (Phase 3, second-year):

Luna: One interesting thing we talk about, Jinelle, is there’s been a lot of e-modules for this block so far, I find largely useless, and that a lot of our classmates feel the same way... they cram more than the hour’s worth of material into an online thing ... but they’re just the slides that they would have used to give a PowerPoint, to give a talk and...

Me: You don’t have writing under [the PowerPoint slides]?

Iris: So, we weren’t supposed to have any [specialty area notes] except that one lecture we had. So, I guess this is their solution, is, give the slides that they would teach, call it an e-module.

Emmett: That’s what are e-modules. All the self-directive is just slides.

Faculty members as role models can exert a powerful influence on students’ professional identity development (Kenny et al., 2003; Noble et al., 2014). The messages help inform the students’ medical habitus, as they learn about the counter-orthodoxy of being a scholar. In this case, the students were given only PowerPoint slides instead of

full notes with guidance to support their SDL. In the above narratives, the students described being provided no direction for their learning. The learning modules were supposed to help the students' SDL. However, the lack of guidance by faculty can send mixed messages about the orthodoxy importance of being a scholar.

I continue in the next section to show how the counter-orthodoxy of being a scholar in the research curriculum is enacted by students, faculty, and administration in UGME.

7.3 The Research Curriculum

The research curriculum is taught and assessed in all phases of the curriculum, pre-clerkship, and clerkship, with the final product being a scholarly work. There are concerns internationally about the lack of engagement of medical students in research and the subsequent difficulties in recruiting academic faculty (Alamri, 2018; J. P. Collins et al., 2010; Funston & Young, 2012). Reasons for the lack of participation in research have been reported to include a lack of time, financial constraints if students delayed graduation to do an intercalated degree, and not being able to participate in their preferred research topic (Alamri, 2018; Pearson et al., 2017).

The RCPSC identifies being a scholar as an integral part of being a professional who can evaluate research, their practice, and contribute to health care scholarship (The Royal College of Physicians and Surgeons of Canada, n.d.d). In keeping with this belief that “the good doctor” is a professional scholar; the formal curriculum includes training in research. The medical school has research integrated into the curriculum, with sessions taught on research skills, and time being allotted to research activities.

7.3.i Cultural Privileging and the Research Curriculum

The research curriculum is shaped by the dominant discourse of science and positivism. And medical school admissions have, historically, favoured students with science backgrounds over those with a non-science background (Milne et al., 2015). As Bourdieu (1974) stated, “by its own logic, the educational system can help to perpetuate cultural privileges without those who are privileged having to use it” (p. 42). The medical school is complicit in its cultural privileging of the assumed “good” medical student who has a science research background (Wright, 2015), and this cultural privileging is played out in the research curriculum. The lack of instruction and support for non-science-based students aligns with the cultural values of the institution, which support science-based students. Evidence of this was shown in the students’ difficulty in doing research presentations and lack of guidance on these skills (Phase 1, first-year):

Mila: For me, with so little background, ...they didn’t give me enough to prepare adequately.

Iris: Um, yeah, we don’t really get a whole lot of formal instruction. We got some tips on how to, ah, how to do literature review, and things and you know, some informal plugs of, “Hey you can go here if you want some help getting tips with these kinds of things”. Like go to the library, but, ah, kind of bridging on what Mila is saying, is that we’re all kind of held to the same standard, but not everybody has got the same level of research experience.

Cultural privileging has been recognized as occurring in medical education, especially in the admission of non-traditional students. Non-traditional students are people who are under-represented in medical schools and include people from low socio-

economic backgrounds, people from particular cultural and ethnic groups, the mature aged, those from rural areas, and people with a disability (Brosnan et al., 2016; Wright, 2015). These groups are identified as being “deficient” or non-traditional compared to the socially accepted medical student (Burke & McManus, 2011). In my research, my findings suggest that students from a non-science background also fit into the category of being non-traditional.

7.3.ii “Learned Hopelessness” and the Research Curriculum

Students without a science research background are placed at a disadvantage, resulting in feelings of incompetence and despair (Phase 2, first-year):

Mila: I just didn’t like the research day because, number one, I guess coming from the [non-science subject area] background research is different ...and I don’t feel they gave us enough. Like, when I went in, I noticed it’s just the small things, and maybe it don’t matter.

Me: But that was okay if you had to use your notes?

Mila: It was okay to use it, but I felt like it made me look less prepared because everybody else got up and gave a freehand-like presentation, whereas, I mean I wasn’t really reading off them, but I was definitely referring to them.

Me: But was that required that you not have notes?

Mila: It wasn’t, but it’s, if you know that you’re being graded compared to the other nine people that [are] present, and I felt like mine looked significantly less professional and the presentation was just different; it stood out compared to everybody else’s, and I just didn’t know.

Scarlett: I would like to meet the person who managed to do a research project in specific time frames and stay on track so much. So, it's just, I don't know, it's so unfortunate. I feel like medical school is just learned hopelessness.

In the above narrative of Mila's feelings, "*I guess coming from the [non-science subject area] background research is different ... I noticed it's just the small things, and maybe it don't matter*" implies a diminishment of her non-science background (Southgate et al., 2017). This sense of diminishment has been called a "deficit perspective" (Gorski, 2011). Scarlett's feeling of "learned hopelessness" implied a diminishment of her non-science background. In medical education, the struggles for "fit" of non-science students can be viewed as a mismatch of habitus (Bourdieu, 1977). The students highlighted the importance of having the cultural capital of knowing about scientific presentations and the symbolic violence felt by those whose cultural capital did not live up to expectations (Bourdieu, 1986a; Lehmann, 2013). The greater similarity between the students' dispositional skills and the medical schools "institutionalized standards of evaluation" (Lareau & Weininger, 2003, p. 569) would enable the students to successfully manage the research curriculum and effect favourable academic outcomes (Edgerton & Roberts, 2014)

Students are expected to be able to complete their research projects based on the instruction provided in the curriculum. The students may have lacked the skills required to perform research; however, they were measured and evaluated by the required standards and even compared to their peers in the teaching session. This led to feelings of incompetence by the students: "*It made me look less prepared*", "*I felt like mine looked significantly less professional*", and "*Medical school is just learned hopelessness*". The

students in fact supported the official orthodoxy (“physician as scholar”) by wanting proper instruction in research skills. But they were subjected to a hidden curriculum that conveyed a counter-orthodoxy – the idea that medical students are, by way of being in medical school, knowledgeable in science and do not need a great deal of training; and by extension, research skills are not worth developing at this stage of training.

7.3.iii The Checkbox and the Research Curriculum

Early exposure to research and scholarly activity may promote students’ interest in research and future decisions on an academic career (Amgad et al., 2015). This was not apparent in my research, as their educational experiences led students to perform research to “*check a box*”. The pedagogic action experienced by the students turned the invisible power into legitimate authority, making the research process symbolically violent. This authority resulted in the students succumbing to the process, as they simply aimed to “*check a box*”.

I asked the students in their second year about their research projects. Many of the students had been matched to simulation-based research projects, for example research involving the 3D printing of body parts to use in practice scenarios. In these Phase 3 focus groups (second-year) students explained:

Iris: Yeah, and that’s part of the simulation [research activity], too. I think that UGME and the simulation [research activity] guys just kind of work together to try to push people into simulation because it’s an easy project to get done.

Ophelia: And you don't need ethics [i.e., research ethics approval], so it's an easy thing to do. Um, but also, I think that it's a cop-out for research. It didn't teach me any research skills, like.

Iris: I don't think it's really meant to. I think it's kind of meant to check a box to say we did research ...but it feels like it's just to check a box.

The message being conveyed to students was that research is postpositivist and quantitative and that this is the most valued type of research. Students were being encouraged to “simulate”³³ learning to be a scholar, by completing a simple research project thereby “checking a box” to signifying their accomplishment as a scholar and medical expert. The students did so, solidifying their learning — via the hidden curriculum — that the orthodoxy of “physician as scholar” can be and should be ignored.

In my interviews with faculty, they were also not impressed with the UGME research curriculum, “It's a bit artificial and difficult because they're doing it over such a long period of time but with so little resources available to them” (Clinical Fac11); and “we should encourage students not to take on such big projects that would require ethics, moving forward, we're going to be encouraging, right from phase one and in phase two, to try to limit projects to non-ethics, smaller” (Administrative Fac13). There are limited time and resources to help support the students in their research projects and having to take on smaller “non-ethics” projects was seen as a “cop-out” for research.

³³ Pun intended (students are being matched to research using simulations and are therefore, ironically, then themselves simulating learning how to be a researcher).

7.3.iv Using the Research Curriculum

Students quickly learned about the unspoken, taken-for-granted assumptions (“doxa”) surrounding the role of research in medical education, learning early on to use the research project to accrue symbolic capital for their CaRMS residency application. Luna (Phase 2, first-year) said, “... you want to do research that you can use in your CaRMS application because you want to be a [medical specialist], and you did like research in [medical specialty], and they’re going to be like ‘Wow, you’re so interested in it!’”

A systematic review of medical students' research activities indicated that students explicitly use research projects to aid in securing residency positions through developing relationships with faculty members (Amgad et al., 2015). This showed how the students were socialized to “play the game” to secure symbolic capital for their residency applications. These actions were becoming embodied as part of their developing habitus in the UGME field.

7.4 Unprofessional Behaviour: Tutorials and OSCEs

The students had tutorial sessions on various topics in both their first and second years. There was evidence of resistance to this format of teaching. This resistance to tutorials served to reify the counter-orthodoxy of the hidden curriculum in which it is “normal” to miss tutorials.

It was noted at phase governance meetings that there were issues regarding students' attendance at tutorials (Phase 3 Management Team, 2018). I asked the students about this in focus groups (second-year):

Me: I thought tutorials were mandatory?

Iris: No, I go to the tutorial. I just go to a different [assigned room], but they're not mandatory but, um...

Lorelei: Anything that even says mandatory, they don't really take attendance.

Me: Oh, they don't [take attendance]. Yeah, um, but is that fair, though, you going into somebody else's group? Because then, you're going to end up with like a huge group?

Iris: It doesn't end up happening that way.

Me: No?

Caleb: It used to be, but now nobody comes so, and I wouldn't do it, and usually they have too many people than room capacity, so people are sitting on the floor, but now people don't go to tutorials, so you could really go anywhere, and it wouldn't make a difference.

Abigail: And I sometimes do intentionally go to the resident³⁴ one [tutorial room], though because sometimes they just like read off the sheet and tell you what you need to know for the exam rather than talking around the subject for an extra hour.

The students were receiving mixed messages from the medical school administration regarding labelling teaching sessions as *mandatory*. As Lorelei points out sessions are assigned as mandatory, but attendance was not taken. The medical school faculty and administrative staff regarded sessions with skills development and assessments as mandatory (Faculty of Medicine, Memorial University, 2018). Lamb et

³⁴ A resident is a postgraduate learner. They have completed medical school and are doing their speciality training.

al., (2020) found that identifying teaching as mandatory has the effect of creating “infantilized” medical students. The infantilization of medical students results in “... inducing puerility in adults and preserving what is childish in children trying to grow up...” (Barber, 2007, pp. 81–82).

Labelling some teaching as mandatory may have the effect of creating a paternalistic hierarchical atmosphere in the medical school (Lamb et al., 2020). This belief was highlighted in an Administrative faculty Fac (05) interview, “they are new to medical school, and I think that a lot of us have been around longer might know a little bit more about what’s better for them.”

There is the risk that mandatory teaching sessions indicate that some topics are more important than others. This is heterodoxic to the understanding that all teaching sessions in the curriculum are based on the RCPSC orthodoxy of “the good doctor” and are thus equal.

The students in the focus group above admit going to rooms they were not assigned to and intentionally going to the room with the resident to quickly obtain the information required for the exam. Success at examinations helped the students appear competent. The students were reinforcing and reproducing the doxa of the medical school that prioritized passing the exam over the process of learning.

The students were supposed to be learning to be medical experts and being professional is an integral part of this. Students revealed to me that there was collusion between them in the OSCEs (Phase 3, second-year):

Isla: And there’s people that went in the morning who were telling people what was on the exam in the afternoon.

Me: Has that happened again? I remember that happened in the first year as well.

Maeve: One hundred percent it happened. I don't think it happened as much as it did last year, but it definitely one hundred percent happened. So, then, the people in the morning are competing with the people in the evening who got all the exam questions from the morning.

The students do the OSCEs in both their first and second years, and in both instances, students shared the questions with their colleagues. This is regarded as unethical behaviour, and it puts the integrity of the medical school into question. The RCPSC CanMEDS description of the role of a Professional states, "The Professional Role reflects contemporary society's expectations of physicians, which include ... values such as integrity, [and] honesty...." (The Royal College of Physicians and Surgeons of Canada, n.d.c). The students were thus behaving in an unprofessional manner by sharing the questions.

The counter-orthodoxy of the OSCE subfield supported the need to pass the exam and avoid remediation. The students in my focus group were more concerned about their grades rather than the unprofessional behaviour of their colleagues. I am unaware of whether students reported this behaviour, but it was not addressed in governance meetings. This could reflect a culture of silence or acceptance of this counter-orthodoxic behaviour in the OSCE field.

7.5 Peer Assessment in Clinical Settings

The RCPSC identifies the professional as being committed to the profession of medicine, which includes peer assessment (The Royal College of Physicians and

Surgeons of Canada, n.d.c). The students did their peer assessment of professional behaviours during their clinical skills sessions. An advantage of peer assessment is that it provides an opportunity for students to become the assessor, encouraging active learning as they become the expert (Adachi et al., 2018). A systematic review looking at peer assessment in collaborative settings like problem based learning or team learning indicates that, overall, it is possible to assess professionalism behaviours in medical students; however, some studies reported negative findings (Lerchenfeldt et al., 2019). A scoping review of peer assessment by Stenberg et al. (2021) reported that peer assessment can be used as a predictor of students' future unprofessional behaviour, allowing early remediation. Haas and Shaffir (1987), whose research involved medical students at McMaster University, write about a "gentleman's agreement" (p. 43) in which students tacitly agreed to be collectively "nice" in peer evaluations to give the impression that everything was okay, creating a "pluralistic ignorance". In this focus group (Phase 1, first-year), some students also found it difficult to give feedback, as they themselves did not feel they were competent to do this:

Isla: It's like of useful because obviously you don't want to say like anything negative about anybody because everyone's trying their best.

Adeline: You could probably put any negative feedback there but that's because we don't know anything we don't know what we're doing.

Owen: I also like question like I didn't feel qualified, to like make any comments.

My findings were similar to those of Rees et al. (2002). Their survey of medical students indicates that pre-clinical students do not feel that peer assessment is useful as

colleagues are too polite and do not have the knowledge to provide feedback. An Australian qualitative study examines the use of peer assessment in PBL (Papinczak et al., 2007). In this research, some students were not comfortable with grading their peers and chose to withdraw as a study volunteer. In my research, evidence of being unprofessional amongst the students was apparent, as personal negative feedback was given (Phase 1, first-year):

Ivy: Yeah, it's hard to separate sometimes though, because and especially if you already have opinions of people, it's maybe a good exercise for people to learn how to give [feedback].

Me: Constructive?

Abigail: Well in the group a bunch of people in the group had a lot of negative commentary so it seems like maybe it's just an environment, maybe?

Ivy: But I think some people did give other people harsh feedback.

Me: What did, what does it mean like harsh feedback?

Nora: This person is a know it all.

Me: Did somebody write that?

Audrey: But I do think there is a big difference between like saying something constructive, [and] saying something like hurtful like about their character or something.

Ivy: Yeah, I heard, I heard someone say that they um, someone in their group said like you're uncompassionate and thoughtless and like really like hurled insults.

The use of anonymous peer feedback facilitated the delivery of unhelpful, hostile feedback. This behaviour was not addressed at Phase Governance meetings, allowing the culture of unprofessional behaviour to be reinforced and reproduced in the UGME field.

The use of peer evaluation of professionalism with respect to student attire was particularly illustrative of how counter-orthodoxies of being professional are developed and promoted. The clothes worn in healthcare environments indicates cultural and economic capital (Jenkins, 2014). There are no set standard guidelines for what medical students should wear; however, they learn over time about an “unofficial uniform” (Luke, 2003). Medical attire has been described as a “theatrical costume” (Luke, 2003, p. 82). A British survey reports that physicians wearing casual clothing, like blue jeans, t-shirts, and trainers, commanded less respect and trust compared to those who dressed more formally (Brase & Richmond, 2004). These findings were similar to those of an American study that surveyed over 400 patients (Rehman et al., 2005). The preferred clothing for doctors surveyed in that study was business attire under their white coats, rather than scrubs or casual clothes. Patients appear to have more trust and confidence in physicians who wear business attire, and they are also more likely to discuss social, sexual, and psychological problems with these physicians.

At my field site, medical students were bound by a Statement of Professional Attributes (Faculty of Medicine, Memorial University, 2013). This directed the students to be “conscious of appropriate dress and hygiene”, which is especially important in clinical settings. In my focus groups, the students were aware of the importance of wearing their white coats as well as wearing professional clothing in clinical settings, even in clinical skills training sessions. In the quote below, second-year students talk

about a challenge they faced in being appropriately dressed for a clinical skills session they had not known about in advance:

Ophelia: Yeah, if we don't have clin skills I usually wear sweatpants.

Maeve: And, like, I can't go home and change, and though I'll show[sic] up in like jeans.... you can't really be held accountable for not being prepared and, like, professionally dressed if you only found out when you were already here.

The students were taught their clinical skills by faculty physicians and were exposed to the accepted standards and rules about their clothing for clinical work. The formal curriculum explicitly directed the students to dress appropriately for health care standards (Faculty of Medicine, Memorial University, 2019c). They were assessed on their appearance in peer review.

Peer review assessment was part of the formal curriculum where they are asked to judge their colleagues' appearance on a Likert scale of 1 to 5. This resulted in some students receiving low scores on personal appearance. Phase 2 (first- year) students explain:

Nora: I haven't seen one person that looks unprofessional in clinical skills. Like, you wear dress pants and a top and everybody, I would never give anybody [a low score] unless they showed up in, socks and sandals.

Me: Is that what you have to comment on people's appearance?

Eleanor: ... I know of somebody like that [who received a low score]. A similar thing had happened, but then they're stuck, and they're, like, I don't get it because, like, what is wrong with my appearance?

Me: Were their nails dirty or something?

Owen: Well, that happened to me. I had like all good scores, and then I had this one outlying value that was like a 3.2 out of 5, which was my appearance, and there was no comment. Yeah so, I had, above 4 or about 4.5 for all of them, and then I had this one.

Me: But appearance, why? You didn't shave or something?

Owen: So, I don't feel comfortable to ask my group and I don't know if, like, maybe I'm overdressing, maybe I'm under dressing maybe. Like, yeah, maybe I went two days without shaving. I had like, I had as much scruff as I have now, like, I don't know how to interpret it.

The students in the focus group quoted above were unsure of what was expected in terms of their clothing, given that students were assigned low scores by their peers. The medical students' clothing (including the white coat) helps to demarcate them from members of the public. It perpetuates the idea of the power of physicians compared to the public.

The students did have ideas about what was inappropriate, like wearing socks and sandals. The students learned to dress from associating with clinical faculty in clinical teaching skills and through their early clinical experiences. The fields of the teaching hospital and clinical skills created a habitus that led the students to accept the clothing norms as natural (Jenkins, 2014).

Thus, dress style was becoming part of the students' developing dispositions and part of their becoming an emerging professional physician. The medical school does not have a strict dress code; rather, the students learn by viewing physicians in clinical settings. Although there was a lack of formal guidelines on how to dress in UGME,

people dress like their colleagues and clinical faculty. This was not necessarily a conscious decision to imitate, as it would be natural to dress similarly (Jenkins, 2014). The medical school, thus, produced a collective habitus in which it was self-evident and legitimate to dress in a certain way.

Luke's (2003) ethnography of newly graduated junior doctors transitioning into medical practice includes an analysis of medical students' clothing. The students experience "emotional labor" (Hochschild, 2012) in order to conform to the understandings of the appropriate conservative clothing for the clinical ward (Luke, 2003). In my research, students experienced "emotional labor" while trying to dress to an undetermined, invisible standard. The male student in the focus group above was attempting to be "himself" and growing a beard. This resulted in possible low scores in his assessment, as he did not conform to the expected conservative dress style. Also, it should be noted that there was no discussion with the students about clothes as a marker of wealth or religion. These topics did not come up for discussion.

The counter-orthodoxy of being professional towards colleagues was shown above as students were judged against an undefined standard of appearance. The colleagues of this male student may have been socialised to the "order of things", which they see as natural, self-evident, and legitimate (Emirbayer & Johnson, 2008, p. 31). The medical school produces a habitus in the students that makes them active in their own domination. Habitus reproduces social conditions because it imprints in individuals the requirements or doxa of the field—be it the field of the medical school or hospital (Luke, 2003). The male student in my focus group was being heterodoxic, choosing to move

away from the accepted norm of appearances, resulting in receiving low scores from his peers.

7.6 Summary Comments

The students reproduced the counter-orthodoxies that were taught to them via the hidden curriculum and reinforced through the various subfields of the UGME curriculum. The pedagogical intent of the spiral curriculum, SDL, the research curriculum, tutorials OSCEs and peer assessment was to promote the orthodoxy of the qualities of being a medical expert, particularly the scholar and professional roles. However, through the teachings in the hidden curriculum, unprofessional behaviour towards colleagues and a counter-orthodoxy to “check the box”, “pass the exam” and “play the game” was predominant.

In the next chapter, I continue to examine the orthodoxy and counter-orthodoxies at work in UGME. I focus on power and privilege in medicine and the hierarchy that exists.

Chapter 8 Power and Privilege. The Hierarchy of Medicine

Power exists only when it is put into action. (Foucault, 1982b, p. 788)

In medicine, hierarchy exists to enable more senior physicians to supervise their junior learners (Salehi et al., 2020). Functional hierarchy takes place when junior learners benefit from positive reinforcement, role modelling, and having a safety net when providing patient care (Salehi et al., 2020). In a functional hierarchy, the learners are treated as respected members of the group and they can confidently share information (Anicich et al., 2015). Conversely, dysfunctional hierarchy results in legitimizing trainees' mistreatment resulting in moral distress³⁵, increased stress, fatigue and decreases the trainees learning (Salehi et al., 2020). Patient safety is also at risk as trainees may feel unable to challenge senior physicians on their clinical decisions (Friedman et al., 2015). Dysfunctional hierarchy takes form in the counter-orthodoxic interactions between learners and faculty members in the field.

The orthodoxy (CanMEDS roles, communicated via the formal and informal curriculum) and counter-orthodoxy (that challenges or ignores the CanMEDS roles, communicated via a hidden curriculum within the formal and informal curriculum) are inextricably related to power and privilege in medicine. In this section, I show how the students both enact and resist orthodoxies about power and privilege. I look specifically at sub-fields in both the informal curriculum (physician shadowing experiences and speciality interest groups) and formal curriculum (interprofessional education).

³⁵ Moral distress refers to feeling powerless when a trainee knows the correct actions to be taken but are unable to do so.

8.1 Counter-Orthodoxy in the Informal Curriculum

The orthodoxy of how to be “the good doctor” is based on the overarching regulations of the RCPSC. Orthodoxy legitimises the “universe of things that can be stated” (Bourdieu, 1977, p. 169). It shows what is taken for granted and what is “right” or the right way of doing things as a physician (Maritz & Prinsloo, 2019). The counter-orthodoxy is the emergence of competing and alternative opinions (Thomson, 2012, p. 118). The counter-orthodoxy is supported by those with symbolic capital to maintain the doxa or status quo (Thomson, 2012, p. 119). The hidden curriculum, through which the counter-orthodoxy is conveyed, happens in the context of the formal curriculum (for example, interprofessional education, OSCEs,) but it also operates in the context of the informal curriculum (for example, speciality interest groups). I will show in this section how the hidden curriculum operates through the informal learning opportunities that are an integral part of UGME and has a powerful influence on students’ priorities and planning for their future careers. For UGME students, there is a drive to gain symbolic capital in the forms of faculty recognition and clinical experiences.

Educational capital is acquired through informal learning, and the students in my research actively sought to acquire capital through prioritizing and participating in shadowing experiences and specialty interest groups. The Office of Student Affairs endorsed this practice, legitimizing it through support for shadowing programs and speciality interest groups (Office of Student Affairs, Faculty of Medicine, Memorial University, 2018a, 2018b). The students in my research competed to secure capital to open doors for their future residency positions, which is similar to previous research findings (Balmer et al., 2015; Becker et al., 2007; Sinclair, 1997b).

In the following sections, I demonstrate the importance of this informal learning as a place where the hidden curriculum works to convey ideas about power and medicine. The counter-orthodoxy that doctors are superior to others is a reaction to the (relatively new) orthodoxy that doctors are *not* superior to others, an orthodoxy of professional equality that is explicitly taught in the formal curriculum of IPE. The IPE curriculum is itself a counter-orthodoxy to the previous long-standing idea that doctors are superior to other professionals.

I show how students' actions are evidence of "hidden transcripts of resistance" (J. C. Scott, 1990) that appear to align with the counter-orthodoxy they are being taught through the hidden curriculum (i.e., that doctors are superior to other professionals), but in fact resist it: that is, students are in fact aligning with the new orthodoxy of physician non-superiority. I show how students are taught, in the informal curriculum – through extracurricular activities such as workshops, conferences, shadowing and specialty interest groups – that harassment, racism, and gendered environments are the norm (doxa) and that this is how "good doctors" (with all the power this entails) are formed.

8.2 Getting Involved

The informal curriculum plays an important role in student learning (Mi, 2017). The students in my research were involved in several informal learning opportunities, including governance meetings, shadowing, speciality interest groups, and peer interactions. For example, in my conversation with Owen (Phase 3, second-year):

Owen: I'm part of that strategic planning steering committee, and then I'm trying to get more involved with another interest group, and then there's a global health

certificate course that's being offered, so I'm going to take that. So, something else always takes the place of something else. Yeah, it's just kind of like a revolving door of stuff.

Me:[Lots] Going on, a lot of opportunities to get involved.

Owen: Like one thing, [student] and I did at the beginning of the semester as well as [student] in our class, we did this, like, ultrasound course, where we were participants. Like we were, study subjects in an ultrasound course, and then I did another pediatric emergency conference. All these kinds of mini conferences or workshops that are going on in the hospital as a whole, um, that I'd, I'd go in there, and just admit that I know nothing and people kind of take you under their wing, then and show you this is how this technology works or here are the procedures here. So, it's this, kind of, I would encourage anybody in the upcoming class, try to identify the workshops that are going on throughout the hospital, and if you can be a study subject, or if you can actually be involved in the conference, do that, because you're going to get a lot out of that exposure and meet people. I met my research mentor through that.

Students were fully aware that one of their goals in participating in these extracurricular activities was the accumulation of social as well as educational capital, particularly in terms of advancing their future careers. As Owen showed above, taking part in the informal curriculum allowed him to gain educational symbolic capital necessary to complete his research course, "...*get a lot of exposure and meet people. I met my research mentor through that*".

The students accepted that they would not challenge their seniors on unprofessional behaviours such as bullying or racism. The students were aware that they needed faculty physician reference letters to secure their residency in the future: “*you need them for CaRMS [Canadian Residency Matching Service]*”; “*that’s the person who’s going to be, like, writing reference letters*” (focus groups discussed below). This was similar to Lempp’s (2009) findings that students accept unprofessional behaviours from their seniors to progress in their careers. In Canada, the progression of careers into residency occurs through the Canadian Residency Matching Service (CaRMS) application.

The importance of doing well in CaRMS applications for residency was apparent and was framed by students as a way to “play the game” (Phase 2, first -year):

Nora: And then, like, those people that don’t match, they usually match the year after anyway; it’s just maybe you didn’t play the game right.

Me: When you say, Nora, when you say they didn’t play the game right, what, what do you mean by that?

Nora: With, like, the algorithm³⁶. I’ve just heard that, like, there’s better ways to, like, set yourself up to match. So, like, if at the last minute if you’ve done everything in gen surg [general surgery], and then you’re like, “No, I want to do peds [pediatrics]”, it’s, like, it’s harder, I guess so?

³⁶ CaRMS uses an algorithm to match students to residency positions. The algorithm is based on the number of available residency positions, the names of the applicants a program wants to train, in order of preference and the students preferred list of training sites (Canadian Residency Matching Service, 2020).

Ophelia: Or if you only apply to, like, ophthalmology and don't apply to anything else like...

The anxiety over residency led students to start to prepare for their CaRMS applications early in medical school:

Ophelia: Now you have to decide what you want on, like, day one of medical school and you're like, "Oh well, I'm gunning for ENT [Ear Nose and Throat surgery] day one," like for those competitive specialties.

Me: Is that with all these interest groups as well?

Nora: Yeah, I think that's what they're for, but then you don't know.

Audrey: There's lots of interest groups.

Nora: It shows you were interested from year one.

Audrey: I think for me and CaRMS is that, like, I'm not interested in doing family medicine in the least, and CaRMS just basically threatens you with family medicine. It's like if you're not good enough, you're in family.

The student referred to the presence of a hierarchy in the medical specialties, as the student was being "*threatened*" with family medicine and expressed that if you are "*not good enough you're in family*". There is a widespread assumption that the work of family physicians is not prestigious, as the treatment they provide is not immediate and does not require invasive procedures on vital organs (Album & Westin, 2008). Related to this hierarchy of prestige, family medicine is gendered, with more women being accepted to Family Medicine than other residency programs (Glauser, 2018).

One important source of informal learning (and a way to gain symbolic capital) is the shadowing program. Shadowing gives students opportunities to meet faculty and gain

educational capital (Balmer et al., 2015). Shadowing experiences have been shown to promote teamwork, communication, and interprofessional collaboration (Kusnoor & Stelljes, 2016). The students become a part of communities of clinical practice (Jaye & Egan, 2006). Taking part in shadowing experiences where the students became transiently involved in a community of clinical practice helps the development of the students' habitus as they learn to be "one of us" on the team. However, the shadowing program is one of the subfields in which the hidden curriculum promotes a counter-ideology of unprofessionalism in the form of establishing and enforcing gendered, racialized, and other hierarchical power relations, an unintended effect that leads to students' and physicians' unprofessional behaviours.

8.2.i Becoming Competitive and Unprofessional

The medical education field is typically a competitive environment (Buja, 2019; Frishman & Alpert, 2019). Students in my research cohort discussed how the competition for residency positions meant that early on in their training they had to seek out and prioritize shadowing opportunities (Phase 2, first-year):

Nora: Here's the issue, I just think that, like, it's a huge extra stressor for, students right now so, by extension students are now going to be more worried about their CaRMS applications more than ever, and so the environment is going to be more competitive because you're going to feel like you need to do more, to see more, have more hours shadowing, and stuff to get a more competitive CaRMS application and that's going to have a huge strain on, in terms of stress level and stuff for a lot of students, that's going to affect their performance and their mental health, too.

Hazel: And people trying to shadow the same person that someone else is already assigned to, like, under the table.

Olivia: It's hilarious.

Hazel: I'll tell you, yeah, it's weirdly competitive, trying to get spots.

The students in the above focus group speak about the unprofessional behaviour of colleagues who were shadowing physicians they were not assigned to. This behaviour reflected the competition amongst the students to get ahead and may ultimately influence their developing dispositions in medical practice. In one aspect, this heterodoxic unprofessional behaviour successfully allowed the students to accrue symbolic educational capital for future residency applications. However, this also could be framed as disrespectful behaviour towards their colleagues that may ultimately lead to poor collegiality and teamwork (Mak-van der Vossen et al., 2017). The behaviour supports the counter-orthodoxy, which goes against the ideology of being a professional and a collaborator.

Jaye and Egan (2010), in their research study with surgery medical students, commented that "problematic" behaviours such as competitiveness and aggression were accepted as the students became acculturated to the surgical field. Problematic behaviours were found in a unit assessment review that took place at the Faculty of Medicine, at my field site (LeFort, 2018). There was evidence of students' exposure to unprofessional behaviours on the clinical wards, such as harassment, bullying, and racism. The unprofessional behaviours symbolised the counter-orthodoxy which is communicated via the hidden curriculum.

8.3 Hierarchy, Harassment, and Bullying

Medical education is organized into a hierarchical system of knowledge and skills that explicitly gives senior staff coercive power over medical students. This sovereign power maintains and legitimizes the authoritative voice of physicians over trainees (Bleakley, 2011a).

The presence of a hierarchy in the clinical setting was apparent in this focus group (Phase 3, second-year), where students were shadowing on a ward:

Me: So, did you do the full exam? Did you get to do, the full exam?

Isla: Oh my gosh, no. I was just, like, don't even, and, I was, not allowed to breathe on the baby, and the dude in third year was in, he was the clerk,³⁷ you know. What I mean so, he's the one [who did the examination]. I was just happy to watch, yeah.

Iris: Their learning is prioritized in this instance over a shadowing student, however, if there is no shadowing student or if the clerk who has attended and or that physician doesn't have a clerk with them by all means.

Isla: Because, like, residents are there to practice, and then clerks are there to learn, and the students are there to watch.

Iris: Just soak it in...

The students point out that “*learning is prioritized*”, with residents, then clerks, then shadowing students having opportunities for patient care. The hierarchal structure in medicine is accepted by students through professional socialization, as the students do not

³⁷ A clerk is a medical student in the clinical phase of training.

question the norms of practice (Lempp & Seale, 2004). The embodiment of medical practice accepts the “social contextual cues and cultural systems of meaning”(Kirmayer, 2011, p. 115). This embodiment includes the enculturation of hierarchal institutional structures and accepting “culturally informed ways” (Kirmayer, 2011, p.135). In my study, the medical students accepted the hierarchies and relations of power as the way things are.

Further, the students encountered behaviours they felt they could not challenge. In the first-year (Phase 2), students witnessed a surgeon doing a body examination on an anaesthetized patient without gloves on. As Audrey said: “... but [physician] didn’t have gloves on. I just wonder how the actual, physician just doesn’t think that that’s clean. Just for myself, I don’t want to touch you without a glove”.

I noted two things in my field notes after this focus group. Firstly, the surgeon should have been challenged for not wearing gloves, as he was not demonstrating good hygienic surgical practices to the trainees. The surgeon’s behaviour reflected the counter-orthodoxy of expert patient care. The maintenance of sterility in the operating theatre is one of the first steps that become ritualized in a surgeon (Katz, 1999; Prentice, 2007; Tisdell & Cooper, 2020).

Secondly, the students in the above scenario were in their first year. A Canadian survey found that first-year medical students were more likely to remind seniors about proper handwashing than students in the later years (Sahai et al., 2015). That research found that the first-year students were more idealistic and not yet closely attuned to the medical hierarchy. At my field site, the student quoted above was aware of her position and chose not to challenge the senior doctor, thus reproducing the school’s culture of

silence and hierarchy (see also Lempp, 2009; Lempp & Seale, 2004). These findings were similar to an Irish qualitative study that examined specialist trainees' experiences during their training (Crowe et al., 2017). The trainees were "...not to challenge or question the judgments or actions of their seniors" (Crowe et al., 2017, p. 75).

This scenario reflects Foucault's formulation of power, where power is not only a difference between those who possess the power and those who do not, but, rather, the power can be enacted in interactions between both sets of individuals in which they both have the ability to act (Foucault, 1982b, p. 789). However, the subordinated may choose not to act out of a fear of repercussions (Shaw et al., 2018), and in my research, this included a fear of not obtaining important reference letters.

This hierarchy in medical education puts medical students in a low-status power position where they are susceptible to abuse (Vanstone & Grierson, 2019). One example of this type of abuse is the bullying teaching technique known as "pimping". Pimping is when an attending physician poses a series of very difficult questions, in rapid succession, to an intern or a student, such that it is nearly impossible to answer them (Brancati, 1989, p. 89). Pimping and other forms of aggressive and harsh teaching techniques were described by the students in my study. These Phase 3 (second-year) students explain:

Maeve: So, in my session the tutor literally gave someone a pencil or a pointer and was, "Okay get up and tell us what this is," and then the person is, like, "I don't know what it is."

Scarlett: The tutor told the person to pass the pencil on to one of his friends so, and then, buddy was like, "I don't want to pass it on to anybody, nobody knows what they're doing."

Maeve: I've had other ones where they're like, "You answer this question, and what did you get for this one, and then what did you get for this one," and I'm like, I don't like being put on the spot. It was incredibly intimidating.

Scarlett: It was quite intimidating. It was one of most intimidating tutorials I'd ever been in.

The above were examples of "malignant pimping", which is done to humiliate learners in front of their peers (Wear et al., 2005). This is contrary to what an ideal tutor should be, as they should engage in non-threatening and encouraging interaction (Rudland, 2013). Teaching through shaming and intimidation is recognized to occur in the perceived power differential between students and faculty (Kost & Chen, 2015; Stone et al., 2015). Shaming medical students impacts their identity formation, as it reveals the individual to be "defective" or not living up to the ideals and values recognized in the medical culture (Kaufman, 1974; Miles, 2020).

Lempp (2009) observed that it is in the faculty members' interest to maintain control over students by providing or withholding symbolic capital. Some faculty may feel justified in intimidating learners, having had their own medical habitus developed in just this way (Kost & Chen, 2015; McEvoy et al., 2019). These behaviours may be regarded as natural and expected as part of the socialization of becoming a physician (Musselman et al., 2005).

The students experienced unprofessional behaviours such as bullying, which was part of the counter-orthodoxy of the hidden curriculum (Phase 3, second-year):

Olivia: I've been shadowing, and, I think that's why I'm trying to thicken my skin is because I've been shadowing and no one expects anything of me because I'm a

med student, so I'm just, like, sitting in the back, but they're treating the clerks [clinical medical students - Years 3 and 4] so shittingly. They're being so...

Me: The clerks?

Olivia: Yeah. Even like Saturday night, I saw one physician was just so rude. No, but there was a bunch of different physicians coming in, and there was this one physician that was so rude to the clerk and so dismissive and, like, and I was so stressed out just witnessing it, like it caught, I was, having heart palpitations, anxiety, just by being in the presence of it, and I was, if that had been me, I would cry. I would 100% cry.

Me: Like what? What happened? What was so bad?

Olivia: Oh no, just really, they were like, okay, I really don't know what to do. They were, "Figure it out, obviously like dah, dah, dah," and then it was, "So what? Where's the exam, where is the exam, where is the test? Did they come back yet? Did they come back yet? Did they come back yet?", and he [the student] was, "I don't know", and I was just behind them, oh my god.

Me: Was that emergency or something going on?

Olivia: No, nothing, the waiting room was empty. There was like – it was—

Me: Was it a resident or a staff?

Olivia: It was the staff.

Me: They knew it was a student?

Olivia: Yeah, yeah, it was the clerk for the night shift, and it was terrible. I came out, and I called my boyfriend, and I cried only because I was stressing. There would have been like four hours of this, but I need to be able to, not that I think

that that's okay, but those people exist. People are not great people, you know. Not everyone that goes into medicine is going to be a good person, and they're going to treat other people below them terribly, and right now I cry when someone is mean to me, so I need to take like...

The student recognized the inevitable bullying and believed that shadowing allowed her to "*thicken*" her skin. Other researchers have similarly observed that the hidden curriculum teaches students by praising or recognizing them for having "thick skin" and suppressing their own needs and well-being (Martimianakis & Hafferty, 2016). The student's desire to "thicken her skin" towards bullying behaviour shows her unconscious learning on how to survive the UGME field as part of the hidden curriculum of medicine. This "thick skin" can translate to the expectation of being "invincible" later on in their careers (LaDonna et al., 2021).

A physician in the hospital is supposed to be the exemplar of the CanMEDS roles, a medical expert who is a communicator and collaborator. The physician's bullying behaviours in the above student narrative goes against this ideology, supporting the counter-orthodoxy. The student's acceptance of humiliation and rage can be seen as a form of social control (Boler, 1999). These emotions reproduce and reinforce power over the students, as bullying serves to "embody" and "act out" relations of power (Boler, 1999, p.3-4). Ideas about a hierarchy in medicine, where the students must develop "thick skin" and accept harassment and bullying, are part of a cluster of normative beliefs and behaviours that teach about the role of power in medicine. It contradicts the official orthodoxy of the physician as a professional and collaborator and instead supports the counter-orthodoxy that you need to be tough and powerful to succeed on clinical wards.

This learning then contributes to the development of the student's dispositions as they form their medical habitus.

Importantly, as further described by the student in the focus group, the physician in question always had bad reviews from students, yet the medical school did not act on the students' feedback, meaning that these counter-orthodoxies of relations of power are supported by the institution or are at least not contradicted. Students know this, and their knowledge of the institution's complicity in supporting the counter-orthodoxy then reinforces students' perceptions that this is the normal and accepted way to be a professional.

Olivia: But I know that this person that I saw do this, year over year gets bad reviews from clerks, and they're all anonymous, and he always bitches about it afterwards, but he doesn't know who gives it to them, so obviously someone up there is seeing this and they're probably along the lines of being hard on you, cutting you down for no reason, like so obviously someone is seeing that feedback, but I don't know they're not. What are they going to do? You speak to them, they are staff, they've been there a long time, they're very, they're part, of the system ...

The continuing abuse of clerks was accepted by the medical school as part of the culture of medicine. However as mentioned above, a formal review of bullying within the Faculty of Medicine with recommendations for changes to be made to increase professionalism (LeFort, 2018) was sanctioned by the Faculty of Medicine. In other words, the Faculty of Medicine was promoting the orthodoxy, while simultaneously not contradicting the counter-orthodoxy, of professionalism.

8.4 Experience of Racism

The students were exposed to racist behaviours by their mentors, with the understanding that such behaviour is part of the culture of medicine and would go unchallenged, and that they themselves could not challenge it because they would lose the symbolic capital that is so key to their future success (Phase 2, first-year):

Miles: I've had that experience with, like, an Indigenous patient, with a resident and the staff [physician], and they were, like, the way they were talking about him, and I was so upset by it, but I honestly, I didn't speak up, but I was just shadowing, and it was really upsetting. Um, but yeah, I don't know, I would have liked to have thought that I would have said something in the moment, but when you're actually in the scenario, it's like.

Me: In retrospect now, do you think maybe because, like you say, in the moment and because they're more senior than you are, do you think maybe you would go to student affairs at least or? Would student affairs do anything? I don't know what?

Iris: If you want them to, they might.

Isla: They would tell you what to do.

Miles: Yeah. I mean I don't know.

Me: But, shadowing you're not marked right, that's just?

Miles: Yeah, but it's like you're usually shadowing a physician that you want to then ask [for a reference].

Me: Okay, that's right.

Gabriel: That's somewhere you're thinking, like, you need them for CaRMS, and this who you're shadowing, well, that's the person who's going to be, like, writing reference letters and stuff for you.

Me: You guys are really, really getting into shadowing, reference letters.

Miles: I've been shadowing multiple times where, like, a doc said something that, like, wouldn't have offended me, but maybe it would have offended someone else. Like, it was borderline inappropriate, and they just turn to you, and they're like, "You're not going to report [me] for that are you?" And you're just, "No, like, I wasn't considering reporting you."

Once again, the students learning that happened through the hidden curriculum in the subfields of the clinical wards supported the counter-orthodoxy of being a professional. The students' habitus was being moulded to not challenge the hierarchy and to accept racist behaviour, "*I honestly, I didn't speak up*" and "*like, no, like, I wasn't considering reporting you*".

The informal learning the student experienced was a result of the informal and hidden curriculum, which supported a lack of cultural competence. Cultural competence formed part of the formal curriculum in a lecture in the Physician Competencies course (Undergraduate Medical Education, Faculty of Medicine, Memorial University, 2018b). However, where the dominant health care workforce in Newfoundland and Labrador is not consisted of visible minority groups, the dominant ideology has a significant impact on informal learning (Paul et al., 2014). Paul et al. (2014) suggested that much of the cultural competency teaching that medical students receive takes place throughout the

hidden curriculum rather than formal instruction. It has been suggested that institutional anti-racist approaches will be required to address racism in healthcare (Frye et al., 2020).

The hidden curriculum promotes the teaching of cultural competency about the “other” and difference rather than examining the culture of medicine. This is an example of the null curriculum at my field site. Since at least 1990, social scientists have argued that medical education in Canada and elsewhere should focus on critical cultural approaches, like cultural safety and cultural humility, rather than skills-based cultural competence alone (Brunger, 2016; Dharamsi, 2011; Gustafson & Reitmanova, 2010; Tervalon & Murray-García, 1998).

In my research, I do not have enough explicit data on these topics (institutional racism) to go into depth on this, but I wanted to raise this as a point of consideration. There is the possibility that because I am a woman of colour that the students may not have felt comfortable discussing race. Thus, my own ethnicity could have influenced the participants, as the presence of the race-of-interviewer effect exists where there is an “adjustment’ that people make to their opinions and attitudes when questioned by an interviewer from another racial or ethnic group” (Gunaratnam, 2003, p. 54). In all likelihood, institutional racism, and the marginalization of “othered” communities exists in the medical school. The medical school is characterized by a biomedical discourse of facts, MCQs, right or wrong answers, and a positivist orientation that does not accommodate different “shades of gray” or the “other” (Volpe et al., 2019).

The participation in the shadowing program at my field site exposed students to gendered behaviour, which supported the need for a female-orientated specialty interest group.

8.5 Gendered Experiences

As part of the shadowing program, students voluntarily attended clinical wards, health care clinics and operating theatres. In the shadowing program, students voluntarily accompany a physician in their daily activities, learning the work of the doctor. The students' shadowing experiences exposed them to gendered work environments, especially in the surgical settings:

Olivia (Phase 2, first-year): The surgeon's lounge, they were all shitting on her.

They were. It was all old men. Old men, 50 and 60s, and they were, they were, like, teasing her, but, like, in a way that I felt like she must have to put up with so much shit. I was the only other female in the room. There was a bunch of male residents, too and then, the old surgeons.

Well it's, I took the, I left right at lunchtime, and I stayed until six p.m. So anyways, they were oh, the phone is ringing, and buddy was there I'm not answering that, it's probably for missus over there, which is my physician, and it was for him, but he got her to answer it, and then, I don't know, I was just, very uncomfortable with the dynamic, but she seemed like...

Me: Is that something you think should be shared, that sort of attitude in this surgeon's lounge because that's sexist.

Olivia: That's not even academic, that was just at the hospital.

Gendered health care work environments, especially in surgery, have discouraged many females from seeking surgical specialty training (Alers et al., 2014; Hill et al., 2014; Peters & Ryan, 2014). There can be "gendered assumptions and expectations" (Beagan, 2001b), such as women being expected to answer the phone,

which can be uncomfortable for female students, “*I was just like very uncomfortable with the dynamic*”. As part of the shadowing program, students voluntarily attended clinical wards, health care clinics and operating theatres.

The culture of medicine typically views a surgeon as a “macho” man (Bartlett, 2018; Peters & Ryan, 2014). The student above pointed out a scenario that occurred at the local hospital and showed how discrimination can occur in the health care system. The experience of the student was part of the hidden curriculum. The attitudes of the male surgeons go against the expected professionalism of a “good” doctor.

The students at my field site, however, established a Women in Surgery Interest Group to help support women who are thinking about surgical careers:

Me: I knew there was a surgery interest group. I didn’t realize there were women in surgery interest group. Is that a good thing?

Lorelei (Phase 3, second-year): I’m honestly, I think it’s a good thing... I think the staff here at MUN [Memorial University], for the surgeons I think there’s 70% men and 30% women, so we’re just trying to spread the interest and, like, start a mentorship program just to, if people are interested in surgery, match them up with somebody that they can talk to, that sort of thing. But I mean, I feel like it’s just, like, any other interest group really, you know.

An important function of this group is that it helps to provide mentorship for women who are considering careers in surgery. Research with medical students indicates that having female surgical faculty is important, as it provided role models for women considering surgical careers (Faucett et al., 2017).

The students also took part in other informal curriculum activities like the student speciality interest groups (Office of Student Affairs, Faculty of Medicine, Memorial University, 2018b). I continue to show in the next section how the students competed in the subfields of speciality interest groups for capital.

8.6 Competition in Subfields of Speciality Interest Groups

Speciality interest groups are forums for mentorship and students' interactions with speciality-specific faculty (Naples et al., 2019; Reardon et al., 2013). The groups function to generate interest in that speciality with the outcome of increased applications to that area of medicine (Lang et al., 2020). The interest groups are subfields in UGME that offer the students' opportunities to gain symbolic capital in the forms of education and cultural capital through making social connections. The speciality interest groups themselves operate as cultural fields of networks of connections. The students gain social connections that can ultimately help with future references for residency positions. Membership in the speciality interest groups gave the students the opportunity to express, strengthen and transmit cultural capital in and through their interactions and integration within the field of cultural production (DeLuca & Andrews, 2016).

In my reflection notes, I wrote about the "competition" I faced in organising focus groups. There were "Family Fridays", which I learnt was the Family Medicine Interest Group Day. This group also met at lunchtime, with pizza and soda provided, as well as educational learning opportunities. I continue to show in the next section how the students competed in the subfields of speciality interest groups for capital.

Being part of speciality interest groups is a “highly controlled social exchange” (Bourdieu 1984, p. 217) and provides the students with an opportunity to augment their capital to reproduce their status and privilege. The students were advised on the need to be part of the speciality interest groups to be “competitive”:

Owen (Phase 1, first-year): I’m kind of confused by the interest groups in a way, so in a way, it sort of seems, one of the professors told us, get into a speciality of interest; it’s not good enough to just be on an interest group, you got to be an executive on an interest group. You got to be competitive, and other people have said, they don’t mean anything.

The students were aware of the clinical skills training the interest groups offered, resulting in competition for places to learn. The speciality interest groups are part of the informal curriculum, but they supported a hidden curriculum of being competitive. This competition to secure clinical experience as capital in UGME has been documented in previous research (Balmer et al., 2015). In Balmer et al. (2015), the pre-clinical students used their acquired dispositions of flexibility and initiative to secure clinical experience as capital to help them in their next phase of training.

As the students pointed out in the following focus group discussion, attending the specialty interest groups helped them learn the skills of a doctor, thereby indirectly influencing their professional identity (Phase 1, first-year):

Luna: Oh, we, they just have talks that we go to and sometimes they have skills nights, but the competition is really high, so it’s like drawing names out of a hat.

Me: Oh.

Luna: Yeah, I haven’t won yet, so...

Me: Oh, wow, how is it so oversubscribed?

Luna: They said tonight there was an emergency medicine suture skills practice, and I think they're taking 10 to 15 per class.

Colin: Ten per class, and I think, the whole class signed up just because they wanted to try out suturing or whatever the skills is, so yeah.

The competition for capital in the form of clinical experience was seen as a valuable resource for educational and cultural capital, as Luna failed to “win” the opportunity. Making the connections needed to secure surgery rotations was highly important as seen below:

Maeve (Phase 3, second-year): I heard if you're interested in gen surge [general surgery] it's kind of competitive. You should start making your connections in second year. So, I was, like, maybe I should shadow gen surge and just see because then if I know I like it, after that then in clerkship, I can start making it.

Me: Start making connections. It's so funny the way the competition starts now.

The competition for “*making your connections*” was seen as valuable symbolic capital that the students needed for their residency applications.

In the sections above, the students also spoke about the unprofessional behaviour of their peers. I showed how the counter-orthodoxy of being “the good doctor” was demonstrated by teaching physicians. The students may have felt moral distress experiencing their peers being unprofessional, gendered environments, bullying, harassment and feeling unable to act (Shaw et al., 2018). Moral distress has been described as a feeling of powerlessness when one knows the correct actions to be taken, but are unable to carry it out (Jameton, 1984; Ulrich et al., 2010). A survey of medical

students showed that the more times students experience these counter-orthodoxic behaviours, the more likely it will impact on the students professional identity formation (Monrouxe et al., 2015). Students become desensitised to professionalism lapses the more times they are exposed to it. In some cases, the students justify unprofessional behaviour, like examining a patient without consent, because it helps in their learning (Monrouxe et al., 2015).

The students at my field site experienced hierarchy, bullying, harassment and gender discrimination, which is counter-orthodoxic to the official discourse of how to be a “good” doctor. Foucault says, “Where there is power, there is resistance” (1978, p. 95). The physicians were senior and more qualified than the medical students. They possessed symbolic capital and were in a more powerful position. It would appear as though the students did not resist this power and stayed silent in the encounters.

I suggest, however, that the students did resist, most obviously through their participation in these focus groups and speaking out about the events. Subtle resistance may be “practiced to escape, rather than to change or stabilize, a relationship of power” (Ewick & Silbey, 2003, p. 1337). Acts of resistance may be subtle and discreet, like being verbal rather than physical (Shaw et al., 2018). Individuals with reduced power use subtle acts available to them to avoid negative consequences (Shaw et al., 2018). In her ethnography of Bedouin women in Egypt, Abu-Lughod (1990) showed how the women resisted the patriarchal environment through subtle acts of verbal resistance in song and stories.

The counter-orthodoxy of being “the good doctor” also extended to the subfield of the students’ interprofessional education (IPE) sessions. I continue to show how the

counter-orthodoxy of physicians being at the top of the medical hierarchy persists as well as the students' resistance and acceptance of this counter-orthodoxy.

8.7 The Collaborator Roles in Interprofessional Education

IPE is a necessity to enhance the skills needed for collaborative work in health care and has been shown to benefit the care of patients (Weinstein et al., 2013). The RCPSC identified the doctor as a collaborative participant in IPE, and internationally the World Health Organization cited the importance of collaboration in situations of limited resources (The Royal College of Physicians and Surgeons of Canada, n.d.a; World Health Organization, 2010).

In the IPE subfield, the students take part in group case discussions with community and health professional students from different disciplines, such as nursing, social work, physiotherapy, and occupational therapy. The Centre for Collaborative Health Professional Education (CCHPE) is responsible for the overall running of the program across the different disciplines. The CCPHE outlines that the role of IPE is to, “introduce health and social care students to principles and concepts of interprofessional teamwork and how to apply those concepts to collaborative patient-centred care” (Centre for Collaborative Health Professional Education, 2020). The orthodoxy of collaborative care was not successfully promoted through systems that were out of the control of UGME; however, the IPE subfield helped reinforce the ideology of physician superiority.

8.7.i Interprofessional Education: The Micropolitics

The health care environment is structured into teams in which identity may function collectively rather than individually. The functioning of teams can be seen as an

activity system. The activity system has elements, each of which has its own “rules” and “division of labor” steeped in their own cultural and historical backgrounds (Engeström, 2014). Activity theory explains how groups function using artifacts within regulations and protocols (Engeström, 2014). The physician must then learn collaborative practices, which are part of their identity formation.

There has been a move to establish education frameworks to support the socialization of a dual identity: one of a professional group and one of an interprofessional community (Divall et al., 2014; Khalili et al., 2013). It is expected that learners will incorporate interprofessional behaviours as part of their professional socialization process. As Khalili et al. (2013) writes, “adoption of a dual identity creates an expanded ‘in-group’ perspective beyond learners' own professional roles to that of a shared understanding of how all health profession roles combine for effective collaborative and complementary teamwork” (p. 449). Thus, the professional identity of the physician shifts to that of an ‘interprofessional’ rather than solely a professional. Bleakley (2014, p.191) suggests that the medical student takes on the identity of a “nomad” as they move between different teams and clinical placements.

8.7.ii Challenging the Physician Status - Belittling Doctors in IPE

The literature shows that IPE can be a barrier to professional identity formation (P. Hall, 2005). Each profession tries to define a “sphere of practice and role in patient care ... which [has allowed] the professions [to be] developed in ‘silos’” (P. Hall, 2005, p190). The research reported on IPE is mixed, with Kuper and Whitehead (2012) claiming that the discourse surrounding IPE is a form of “boundary-work”. The term

“boundary-work” was introduced by Gieryn (1983) and describes the struggles different groups experience as they try to hold onto their knowledge and ultimately power (Kuper & Whitehead, 2012; Mizrachi & Shuval, 2005). Bleakley (2014, p.191) drew on Deleuze to discuss the “deterritorialization” of what was once traditionally the unchallenged work of doctors. He defines micropolitics as the construction of identities within power constraints, such as roles and rules (Bleakley, 2014). Micropolitics becomes obvious when traditional hierarchies are challenged, such as in the disruption of team silos.

There was evidence of this tension and micropolitics created by the scenarios the students discussed while supervised by facilitators (Phase 3, second-year):

Ophelia: Every single case we do is a doctor messed up. Every single facilitator we’ve had, it’s always the doctor’s fault. It’s always the doctor messed up. Here here’s how the team can collaborate to make it better. I’ve had not one IPE group, well my group is awesome, they’re, like, deadly, but I’ve not had one session where it wasn’t like brought up by either the facilitator... they’re really great, but I mean, like, the nursing profs in particular I find and the group sessions, it’s here’s how the doctor messed up.

Nora:...after a while, it just gets repetitive of, situations where we all work through where the doctor messed up and how the nurse can take over everybody’s roles, and the rest of us are irrelevant, and it just kind of gets sickening after a while, and the nurses [students] in my group weren’t like that, but it just seemed like the scenario and the facilitators just kind of facilitated that mindset.

Me: Is that the doctors mess up?

Gabriel: Like that the doctors mess up and that the nurses basically talk like [they] can do all the rest of our roles, there's no need for a social worker on scene because the nurse knows about how to do community health stuff, knows how to do drug stuff, knows how to — what orders to be making and really they should. Like, it was just was even though my group was great, like, the environment that kind of surrounded us ...

The medical students, the future doctors, felt belittled by the nursing faculty, who showed that it “*is always the doctor's fault*”. The understood ideology has been that physicians have a higher professional status than nurses (Malik et al., 2019). The IPE session is meant to foster a collaborative environment to show that teamwork is better for patient care, as the nursing faculty did try to show improved patient care if there was collaboration (“*here's how the team can collaborate to make it better*”). The students seemed to have missed the point of the learning experience, and they instead reacted through their resistance by “deterritorialization” and “boundary work”, as “...*the nurses basically talk like [they] can do all the rest of our roles*”. The students tried to re-establish their physician superiority in the IPE subfield.

The IPE session discussed above focused on team collaboration in patient management. The IPE sessions are facilitated by faculty members. Students from various health professions discuss the presented cases. With this particular IPE session, I suggest that IPE challenged the medical students' thinking about their role in collaborative patient practice. It seemed as though the students took offense to the notion that the patient's care could have been better if the doctor had collaborated. This shows that the assumption that

the doctor is the ultimate authority on the clinical wards is embedded in the professional identity of students early in their training.

The purpose of IPE is to demonstrate that collaboration is important (supporting the official orthodoxy of the CanMEDS roles) and to introduce students to the roles of other professions. There is the possibility that through different exposures of other UGME subfields, like examining SPs in clinical skills and the white coat ceremony, the students are entering IPE already with enculturated beliefs or values of the superior role of the physician. They have already been taught the counter-orthodoxy of the superiority of the physician, via the hidden curriculum. That counter-orthodoxy of physician superiority is very compelling because it is so long-standing and deeply rooted in western biomedicine. However, the explicit challenge to that dominant counter-ideology (that is, the efforts of IPE to promote the official orthodoxy of the physician as equal to others) is actively resisted by the students, who seem to be unwilling to dismantle the counter-ideology of physician superiority.

8.7.iii Wrong timing of IPE

A qualitative phenomenological study of first-year medical students' IPE reflections indicates that medical students appreciated how to be interprofessional (Imafuku et al., 2018). Interprofessional identity is stimulated when different groups of health care students, including medicine, nursing, pharmacy, and occupational therapy students, participated in problem-based learning sessions. The analysis of students' reflective portfolios shows that the students sought to build collective learning and mutual engagement rather than having individualistic goals. In my research, the students found

that their IPE sessions were too early in the curriculum, and they were not sure how they should function in their new emerging professional identity:

Isla (Phase 1, first-year): We're with a bunch of students who are in their first-year of each respective program to know what their role is, but, like, you don't really know at that point not, like, not just the nursing students, they don't really know, what they do in the team at that point.

Ophelia (Phase 3, second-year): Like, a part of the problem is that you're getting a first or second year or second-year social work student teaching you what a social worker does, and, if we teach someone what a doctor does, you can't give a completely accurate pictures. It's like the blind is leading the blind.

IPE at my field site did not appear successful because of wrong timing, as the students were not established enough in their identity or role to be able to fully participate in the sessions, "*the blind is leading the blind.*" A British qualitative project with health service and academic staff, supports this finding saying collaborative practice comes with experience rather than being taught (Joynes, 2018).

A Canadian qualitative study using focus groups with health professional students, found that when the IPE groups were not well-organized there is a lack of interest in collaboration (Rosenfield et al., 2011). The same sentiments were echoed in my field site (Phase 3, second-year):

Nora: Like a very disservice to something that could be so good.

Maeve: I know. It's such a good idea and such poor implementation.

Gabriel: Like, I would love to know the scope of practice of other professions that [I] still don't think I know...

The IPE sessions appeared to occur too early in medical students' training, with "*the blind is leading the blind.*" This perpetuates the idea that collaboration across the disciplines is too difficult. There is a sociohistorical perception of the dominance of physicians in patient care given their longer training and the high financial cost of their education (Baker et al., 2011). Foucault (1979, p. 27) says, "power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations". This means that physicians are instinctively more powerful in healthcare environments given their longer educational training. My research findings suggest that power differentials were not addressed in IPE sessions. This is a similar finding as in Paradis and Whitehead's (2015) systematic review of IPE research published from 1954 to 2013. Only 6 out of 2191 articles reviewed referred to power, suggesting that, "ignoring power and conflict, the IPE literature obscures what exactly it is that IPE initiatives are theoretically aiming to correct" (Paradis & Whitehead, 2015, p. 405).

8.7.iv Unintended consequences of IPE

There were concerns with attendance at IPE sessions. The medical students complained that attendance was mandatory for them and that only medical students were graded on participation. This led to tensions in the groups (Phase 2, first-year):

Iris: Accountability, uniform mandatory things from everybody involved. Right now, it's like kinesiologists are there on a volunteer basis.

Scarlett: Different programs don't have to come, plus we have it mandatory. I had to put in leave to miss [a] session and stuff like that.

Clara: And one of our social workers never shows up because she's active in other things like indigenous rights and self-government.

Olivia: I found the same problem in my group. Like me, [student name] and [student name] did everything, and, not on purpose. It's just they wouldn't contribute. We made a Google doc after the meeting. I looked at it two weeks later, and nobody had touched it, and I was like, "Guys, this is a little bit ridiculous."

The above narrative reflects the medical school supporting an environment in which the medical students believe the other health care professionals were undependable, that they "*wouldn't contribute*" and were non-interested in interprofessional collaboration: "*one of our social workers never shows up*".

An unintentional consequence of the IPE sessions was the creation of a hierarchical system, as the medical students were older and had more educational experience (Phase 3, second-year):

Olivia: I feel like part of it too is the med students, most of us are older, we're on, our second, or third or fourth degree and just the added experience I would say sometimes some of the younger students in their first program probably also look to the med students to have more expertise, or maybe they have less confidence in speaking up.

Luna: Right, but yeah, it's definitely not an equal environment. I feel like where it's kind of easy for us to look and be out of the way no one is talking. But we're

also yeah, older being older I guess. Yeah, have that greater experience and maybe credentials.

This hierarchical situation was also reported in an American qualitative study with family medicine residents and nursing, pharmacy, and counseling psychology students (Gergerich et al., 2019). The research found that the physician was considered to be the leader of the team, as they had a wider range of knowledge of patient care, which led to the marginalization of other team members. The findings of my research echoed this, as the medical students were being more vocal and assuming leadership, “*not an equal environment*”.

This situation was never resolved over the two years and was never raised as an issue by the medical students at the phase governance meetings. That preferred status may influence their developing habitus about their power and status in collaborative health care teams. The IPE subfield thus reproduced the doxa of physician dominance in health care teams (Dellafiore et al., 2019; Hartley, 2002). At the same time, my findings also pointed to resistance to a counter-orthodoxy of superiority.

8.7.v Benefits of IPE

Some of the students in my research appreciated and valued the experience of working in an interprofessional team (Phase 3, second-year):

Eleanor: It was nice to, like, sit down and go through okay this is what physiotherapy does, this is what occupational therapy does; it gave me an understanding if you didn't have any idea, which is excellent.

Nora: I enjoy it, too, because I think it keeps everyone grounded as to, especially when in medicine, we are always talking about, make sure you don't have too big of an ego. Like don't, like don't take a power trip on, because you are higher on the power differential scale or whatever, but so I like that, because I've, I know some people when they get into medicine, they just think they are on top of the world, and they are not going to need help from other disciplines. But I think it gives you an appreciation of other disciplines and how much you actually rely on them.

The student above acknowledged that doctors maybe on a “*higher power differential scale*”, but IPE helped to show “*how much you actually rely on*” the other disciplines. This contrasts with the earlier focus group, in which the students were upset with the case discussion showing how the doctor could improve patient care through collaboration. This resistance to the counter-orthodoxy of physician superiority actually supported the official orthodoxy of collaborative care.

8.7.vi The Hidden Curriculum of IPE

The medical students' experiences in IPE reflect competing discourses and ideologies. The dominant ideology, one that is relatively new, is that other professionals are peers. Cochrane Systematic Reviews confirm the benefits of IPE for collaborative working environments, showing that it ultimately benefits patient care (Reeves et al., 2008). The competing ideology (which was, until recently, the dominant ideology) is that other professionals are lesser than, or inconsequential to, physicians, who are understood to be the authorities in patient care (Gergerich et al., 2019; Lingard et al., 2012).

Some studies report that resistance to interprofessional teamwork and collaboration continues to exist in healthcare (Reeves & Zwarenstein, 2017). Medical students at my field site, were aware of their assumed position of being powerful in the hierarchical scale of health care environments. They showed their resistance to the official ideology (and support of the competing dominant counter-ideology) in their comments about not appreciating having their role as a physician in patient care questioned. The way that IPE was managed and scheduled reinforced the idea that other professionals' roles were not reliable or of value (for example, medical students reported having mandatory attendance and being graded). A hierarchy was created that further reinforced the "power" of the physician, as medical students were older and had more education and life experiences. The systems of IPE within medical school supported the counter-orthodoxy of solo working. The medical students were exposed to competing ideologies of what "the good doctor" should be in the different subfields of UGME, which will become ingrained as the dispositions of their habitus, dictating their future actions as emerging physicians in the field.

8.8 Summary Comments

The power, privilege and hierarchy of physicians were reinforced and resisted in the subfields of UGME. The symbolic capital gained from physician shadowing and being a part of specialty interest groups came at the cost of reinforcing the counter-orthodoxy of what being a professional should be. The students encountered bullying, racism, and gendered environments in medical education fields, which are not acknowledged in their formal curriculum. The IPE program was counterintuitive, as the

medical students were still at the top of the hierarchy; however, some students did appreciate the value of interprofessional working.

In the concluding chapter, I summarise the power of the UGME curriculum in the development of the students' professional identity. I also suggest a pedagogical model that could be used at medical schools to address the hidden curriculum.

Chapter 9 Becoming The Good Doctor

I don't feel that it is necessary to know exactly what I am. The main interest in life and work is to become someone else that you were not in the beginning. (Foucault & Hutton, 1988, p. 9)

My research showed how the undergraduate medical education learning field shaped the development of a professional “good doctor” identity in pre-clerkship medical students. My research addressed the gap in the literature about the experiences of learners as they transitioned into medical school. I used the established theoretical frameworks of Bourdieu and Foucault to analyze the complex and multiple relations of power and influence in pre-clerkship education and the role they play as the identity of a medical professional is constructed. I explored UGME from the students’ perspectives, focusing on how the formal, informal, and hidden curricula shape their professional identity as students develop as emerging professionals in medicine. My research findings illustrated how medical students experience the effects of a powerful but hidden curriculum that influenced their professional identity development as “the good doctor”.

The official orthodoxy of the Royal College of Physicians and Surgeons of Canada and subsequently Canadian medical schools revolves around the CanMEDS roles. These roles are used to structure the formal curriculum of training in UGME. However, a counter-orthodoxy arose in UGME in the different subfields that promoted (and was in turn promoted by) a hidden curriculum. This hidden curriculum operated in a way that completely counteracted, and in many cases was the opposite of the orthodoxy of what was supposed to be taught. Medical students must navigate and negotiate between competing views of what it means to be “the good doctor”. I believe the students

participating in my research and talking about how they had to navigate these competing ideologies of being “the good doctor” was itself an expression of their negotiation of these competing orthodoxies. My findings suggest that having a recognized educational space within the formal curriculum can help the students develop their professional identity to the orthodoxy of “the good doctor”.

In this final chapter of my thesis, I review my key findings, and summarize how the hidden curriculum supported a counter-orthodoxy of being “the good doctor”. I conclude my thesis by making recommendations to support the development of professionalism in students and lessen the impact of the hidden curriculum at medical schools. I also identify the limitations of my research and suggest areas for further research.

9.1 The Medical Gaze

In the formal curriculum, students were exposed to a predominantly biomedical discourse that included a “removist” attitude and a perceived lack of respect for plastinated anatomy specimens. Standardised patients were conceptualized as a “body” for examination, demonstrating a lack of consideration for the humanity of the person. These dehumanizing actions helped to create the students' dispositions of the habitus which will shape their future actions in their careers. There were constant tensions between being scientific and humanistic, with the scientific biomedical discourse being very predominant in certain UGME subfields, such as the anatomy lab, clinical skills teaching, and Integrated Learning Sessions.

The students were concerned about passing exams and assignments, leading to a prioritization of clinical learning and medical expert teaching sessions, while the non-medical, non-science sessions were reportedly poorly attended. UGME faculty and administrators inadvertently accommodated this counter-orthodoxy of “the good doctor” (as *not* encompassing the humanistic CanMEDS roles). This was done by providing lecture capture, supporting students’ prioritizing of speciality interest groups and shadowing experiences over attending non-scientific-non-medical classes, scheduling non-medical expert sessions at unpopular times in the curriculum, and providing insufficient guidance to non-science-based medical students in the research curriculum.

For students, prioritizing specialty interest groups and shadowing was key to gaining the cultural, symbolic, and educational capital needed to advance as a successful medical professional. The importance of capital for future CaRMS applications was a prevailing theme. Students became immersed in the unregulated informal learning environment, where they chose to prioritize clinical learning over their formal curriculum. The students prioritised the medical expert teaching sessions, as these sessions had multiple choice questions (MCQs) on their exams and chose to miss classes whose content did not appear on their MCQ exams. The students learned to prioritise diagnosis and clinical management over empathy and teamwork. In effect, the students became enculturated into the doxa of medicine and learned that the scientific and clinical aspects of medicine are important, while the humanistic aspects of being a physician can be ignored.

9.2 Achieving a Cloak of Competence

Students learned how to “play the game” by appearing to support the orthodoxy of “the good doctor” but resisting some aspects to secure important clinical symbolic capital. The students learned a new “medical language” to describe the body, which symbolized their membership to the medical community and at the same time separated them from the lay public. The students used their white coats and stethoscopes as symbols that gave them the power to access patients for clinical examination. The appearance of being competent was valued, so much so, that the students considered lying about their physical examination.

9.3 Power and Hierarchy

Power works most effectively when it is masked and hidden in the routine actions of everyday life (Bourdieu, 1977; Foucault, 1979). In my thesis, the power of the hidden curriculum supported a counter-orthodoxy of what “the good doctor” should be.

Faculty acted as role models, with the students having both positive and negative experiences. The “pimping” and bullying of students functioned to maintain the hierarchal structure of the learning environment and of medicine. Students’ position in the learning field, being at the bottom of the hierarchy, was reinforced through their short white coats and the limited amount of clinical experience they could gain on the ward.

The students were engaged in interprofessional education, which did not help to establish the collaborative work environment that was intended. The sessions were structured so that medical students were placed with other health professional students who were also not yet sure of their position in the hierarchy of caring for patients.

Interprofessional education sessions did not fully support collaborative care and working; rather, these sessions reinforced a hierarchy that favoured medical students over students from the other disciplines. The hierarchal position of physicians was confirmed in the IPE health care team.

My research results show how medical students respond to the effects of an influential hidden curriculum that influenced their professional identity development as “the good doctor” (see Figure 3). In the next section, I make suggestions that medical schools may use to help lessen the negative effects of hidden curriculum and promote the official orthodoxy of “the good doctor”.

9.4 Recommendations

My research revealed the power and persuasiveness of the hidden curriculum in shaping professional identity at the pre-clerkship level of undergraduate medical education. The following sections itemise suggestions that medical schools can use to help address the influence of the hidden curriculum in professional identity formation in the pre-clerkship years. I begin my recommendations by identifying a pedagogical space model which can be used in the formal curriculum.

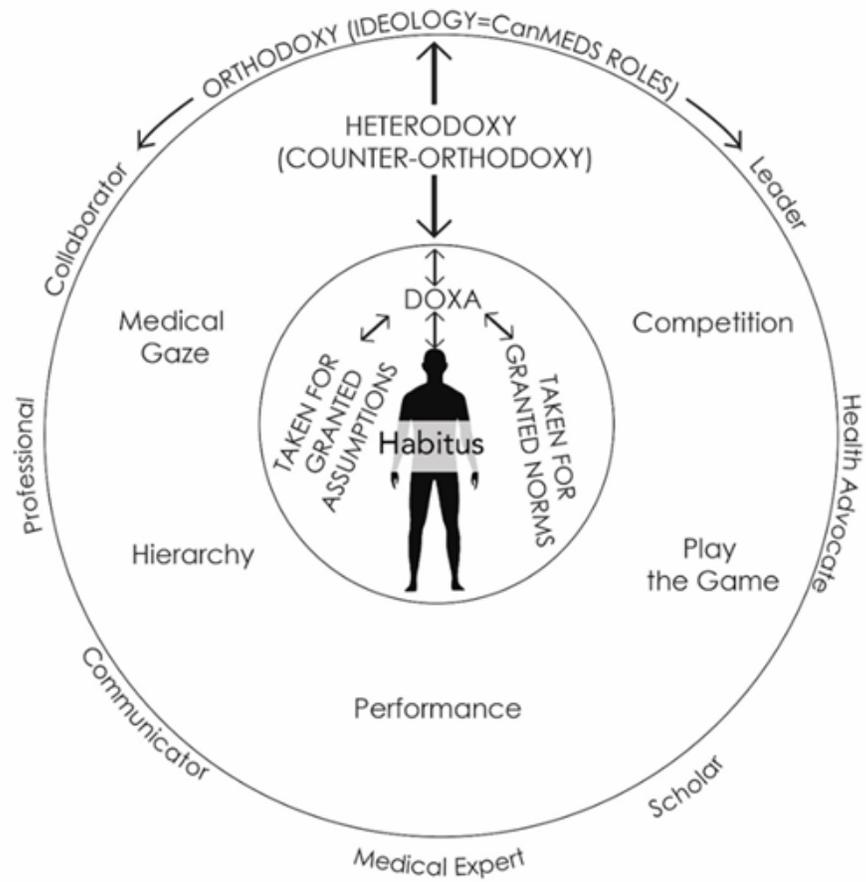


Figure 3

The Formation of the Habitus: The Good Doctor

9.4.i Critical Reflection and Communities of Practice

Students need space to critically reflect on their own embeddedness in a new culture, (that is medical education) and their own development as professionals as well as to understand how they accept or resist the official orthodoxy and counter-orthodoxies. The findings of my thesis point strongly to a need for students to be able to explicitly reflect on their experiences. One pedagogical strategy for how to operationalise professional identity development and allow students to reflect is the establishment of communities of practice. A community of practice is formed when a group of people, such as students and faculty, learn from each other (Hatem & Halpin, 2019). The groups function to provide a sense of belonging and membership which will eventually promote the learners' professional identity (Hatem & Halpin, 2019; Osterberg et al., 2016).

The learning environment consists of different communities of practice that are taught and reproduced mainly in the informal learning curriculum. Thus, formalizing communities of practice as part of the curriculum may help in revealing informal and hidden practices in the medical education field (Cruess et al., 2018; Ong et al., 2020). The community of practice is led by a faculty member or senior learner who performs a mentorship role. The mentor acts as the first point of contact for students and provides a structured space for reflection with mentors and classmates (S. D. Smith et al., 2016).

In communities of practice, the students should be able to reflect on their emergence as a professional, the culture of medicine, and the learning environment to which they are being encultured. They should be able to explicitly speak about and reveal the hidden assumptions that are part of the hidden curriculum. The forum should help the students deal with the tension between the official orthodoxy of the CanMEDS roles and

the dominant counter-orthodoxies being conveyed through informal learning. Formalising communities of practice in the curriculum can be a way to incorporate and acknowledge the informal learning that the students experience through the hidden curriculum.

Communities of practice have been found to help medical students learn in small groups and collectively reflect on complex issues (Cruess et al., 2018). Hafferty and Watson (2007) suggested that communities of practice might be an “antidote” to the hidden curriculum.

9.4.ii Challenges to implementing Communities of Practice

There would be inherent challenges to implementing communities of practice in the formal curriculum, particularly with respect to ensuring full participation by students and assessing the learning – features of non-medical expert learning that are resisted by students. I realise that the students resisted doing their reflection assignments, as they found the rubrics too prescriptive. However, by contrast, a community of practice can act as a forum for critical reflection, where students can recount their experiences, which is the first step of reflection (Uygur et al., 2019), and then spend time reflecting on those experiences, verbally, with their peers. There is value in critical reflection using small groups and being able to speak to other students without fear of judgement. In this model, students share their experiences with each other in a neutral confidential environment, which helps them express emotions without fear of judgment (Nicolson, 2003). This may help alleviate any moral distress that, as I argued (Chapter 8), students can experience as a result of observing unprofessional behaviour.

It has been recognized that in learning communities, conflict of interests can arise between faculty and students (Gliatto et al., 2019). Faculty in learning communities can be in the role of mentor, advisor, or counselor, which can create a conflict of interest if they must also assess students. Also, students may be hesitant to engage with faculty if they are aware that they are going to be assessed by them. Gliatto et al. (2019) surveyed faculty in learning communities, with the majority thinking it was acceptable to provide formative assessment and feedback to students but not to contribute to summative assessment. Having faculty in separate roles, such as advising and assessment, would lessen the stigma and anxiety students may experience when asking for help. Some medical schools have vertical communities of practice, having near peers or senior learners mentoring the junior medical students (Banos et al., 2019; Shochet et al., 2019). Also, in some schools, formal assessments is not required, rather a minimum of 80% attendance to sessions is required to succeed (Banos et al., 2019).

Medical schools have used communities of practice for mentoring, social activities, community service (Chen et al., 2014; Hunt et al., 2011; S. Smith et al., 2014), student-run free clinics (Buchanan & Witlen, 2006; Meah et al., 2009) and clinical skills training (Roussel et al., 2019).

I believe that students who participated in my research focus groups benefitted by sharing their experiences and critically reflecting on them. In particular, students reported to me that talking about their significant experiences in UGME in the focus groups helped them to adjust to their new learning environment. My focus groups served the purpose of longitudinal communities of practice where the students were able to make explicit the

hidden normative assumptions of how to be a professional and openly discuss the process of navigating between the competing orthodoxies.

Students shared their stories and acts of resistance with their peers within the safe environment of the focus groups. Naming and exposing poor physician and colleague behaviour led the students to discuss these acts. Acts of resistance were extended in the focus groups, as the students verbally supported their peers and criticized the offending students and physicians (Ewick & Silbey, 2003). The students' resistance in the focus groups shows how power can be productive, as their "complaining" (see below) can be framed as acts of reflecting and learning from their experiences (Foucault, 1984, p. 61). This was evident from my final focus groups, conducted in June 2019 (Phase 3, second-year):

Colin: I've been looking forward to this all week.

Me: Yeah, you keep on saying that.

Colin: This is like my favorite thing. I love it.

Luna: It's like you get rewards for complaining like it doesn't get any better than this.

Me: But you see, I don't see it as complaining.

Iris: Oh, it's like [I] get stuff off my chest

Owen: Now it makes us feel even better that you don't think this is complaining.

Me: I don't think it's complaining, to me, it's data.

Owen: But yeah, I think everybody loves coming to these.

Iris: Do you know what I find? I think you're the only person that listens to us, that's what it feels like sometimes....

Owen: I like being listened to.

Caleb: This has been very therapeutic.

Olivia: I feel like this has contributed to my wellness.

The focus groups were enabling students to participate in resistance through critical reflection, a process Shaw et al. (2018) explains as, “resistance through reflection, including reflecting on one’s situation, the decisions one makes, or those made by other[s], the reasons for making such decisions and what alternative decisions could have been made” (p.46). Norander et al. (2011) describe how identity is “...a communicative process and a site of struggle constantly negotiated through interaction with others and retroactive sensemaking about one’s self” (p. 60).

The focus groups I conducted acted as a forum for reflection for the students, as they were able to be part of “the process of constructing a sense of self-hood through talk” (Nicolson, 2003, p. 141), and thus they were able to help construct their new identity through discussion and reflection. The descriptions of the students’ lives portrayed in everyday conversation, however ordinary, can influence identity formation (Goldie, 2012).

I strongly suggest the use of communities of practice to help identify and remediate the negative effects of the hidden curriculum in both formal and informal learning fields. There is a lack of scholarship on how to best implement and evaluate communities of practice. Also, it is unclear if communities of practice or other methods are available to allow students to acknowledge and reflect on the hidden curriculum. This could be an area of future research.

9.4.ii Address the Curriculum Issues

Medical school faculty and administrative staff need to reflect on the ways in which the design of the formal curriculum may perpetuate the normative assumptions about professionalism that are purveyed via a hidden curriculum. They need to ensure that the formal curriculum does not inadvertently enable the hidden curriculum to convey the counter ideology of “the good doctor”. I recommend that faculty and administrative staff should review and reflect on their curriculum, including how all aspects of the CanMEDS roles are represented.

Furthermore, I recommend that faculty and administrative staff involved in the UGME curriculum, make a concerted effort to ensure that the humanistic aspects of patient care are emphasized. For example, it was clear from my research findings that having an introductory session in anatomy, “*The Body as a Human Being*” must highlight the personhood of the specific individual’s body that students have the privilege of learning from. This would be an ideal opportunity to marry both medical-scientific and non-medical humanistic aspects of being “the good doctor”³⁸.

Those responsible for scheduling teaching sessions must ensure that non-medical expert sessions are not scheduled at unpopular times in the curriculum, such as just before an exam. Attention to this issue may address my finding that content that does not appear on MCQ exams is considered “filler sessions” in the curriculum. This may also lessen the hidden curriculum surrounding the importance of non-medical expert sessions.

³⁸ An Australian study finds it is possible to combine ethics and anatomy teaching focusing on human donors and dissection of the body (Stephens et al., 2019).

Language use in medical schools is also important. Language is known to influence physicians and trainees attitudes and bias (Amen & Nolen, 2021; Goddu et al., 2019). Faculty and administrative staff involved in clinical skills teaching should be conscious of the language they use. Care should be taken to avoid expressions such as examining a “body” in clinical skills or doing a “head to toe” examination. Efforts should be made to re-individualize the patient in clinical skills. Personification³⁹ of the patient can be done just by stating that a person is here for a full body examination. As Leopald et. al (2014, p. 262) reported that they found, “pausing to speak or write an extra few syllables to be well worth the effort expended”.

The medical school administration should also consider which sessions are deemed mandatory in the curriculum. As I discussed (chapter 7), labelling teaching sessions as mandatory has the effect of creating “infantilized” medical students, and can create a paternalistic atmosphere in medical schools (Lamb et al., 2020). Instead, phrases such as “expected attendance” or “attendance recommended” to all classes should be part of medical school policy.

My findings support the recommendation that faculty involved in IPE conduct a review of IPE sessions to address hierarchy and power in health care teams. This would entail reviewing the timing of the sessions in the different student groups' training schedules to avoid unknowledgeable, inexperienced students trying to explain their professional roles.

³⁹ Personification refers to highlighting personal characteristics which differentiates from an object.

I also recommend robust faculty development to ensure the IPE experiences are beneficial. Medical schools cannot assume that bringing together faculty from different backgrounds will result in beneficial experiences. Faculty facilitating IPE sessions may have never received instruction in IPE and often witness poor team working (L. W. Hall & Zierler, 2015). Existing studies suggest that IPE should be focused on a shared purpose for patient care (Gergerich et al., 2019). Students having a shared purpose for patients may help lessen the need to differentiate their roles and instead focus on learning from each other (Sims et al., 2015).

9.4.iii Reflect on the Null Curriculum

It is impossible to teach everything in medical education; many subject areas must be intentionally excluded from the formal curriculum. For example, I have shown in my findings that the personhood associated with the body was neglected in different subfields of the UGME curriculum (particularly in anatomy lab and clinical skills). The exclusion of certain topics shapes identity formation because of the very absence of attention to those topics. UGME administrators and the RCPSC must reflect critically on what they are *not* teaching and what they may be inadvertently – or intentionally – marginalizing. This reflects Foucault’s ideas about the subjugated knowledge that is confined or hidden by the dominant discourse about what knowledge is important for the students based on the history of what they are expected to know (Foucault, 1972).

Eisner (1985), in describing how the null curriculum is taught, says, “We teach what we teach largely out of habit, and in the process neglect areas of study that could prove to be exceedingly useful to students” (p. 103). Eisner argues that what is *not taught*

may be as educationally significant as what is taught (Eisner, 1985; Flinders et al., 1986). The null curriculum needs to be examined, as it predicts future inexperience in physicians. A review of the literature found that medical curricula do omit certain concepts.

A commentary by Ellaway and Wyatt (2021) highlighted the absence of the concept of resistance in medical education and its importance in the CanMEDS roles of leadership and advocacy. A null curriculum existed in Ripp and Braun's (2017) research into preparatory materials for the United States Medical Licensing Examinations (USMLE). The mention of race was only used as a risk factor or as a genetic predisposition for diseases, and there was no testing on the social understandings of race and racism in medicine (Ripp & Braun, 2017). A systematic review on medical education and gender diversity in medicine⁴⁰ notes that a lack of institutional support and qualified teaching faculty are barriers for students' exposure to these issues (Dubin et al., 2018). An American survey conducted at a cancer hospital analyzes medical students' knowledge about palliative services and their comfort speaking with cancer patients (Oskvarek et al., 2016). The survey reveals that students lacked confidence discussing survivorship care. The authors concluded that a null curriculum existed within the oncology curriculum.

A full exploration on the null curriculum at my field site was beyond the scope of my research. However, medical schools' administration should consider how the lack of

⁴⁰ At the medical school of my field site, my research cohort was the first set of medical students to have gender diverse standardised patients in clinical skills.

exposure to some topics influences the developing habitus of the student and may impact the future care of patients.

9.5 Limitations

My research findings were subject to several limitations. I focus on my methodology choice for the research, and other factors which may limit the significance of my findings.

During the time of my data collection, I was still doing mandatory course work. This was during the medical students' first year. This meant that my own class schedules would have limited the time I had to observe students' classes and my availability to schedule focus groups. In the focus groups, some students were louder and more vocal than others and consequently, their voices were more often cited in the thesis. When I compared my field notes and audiotapes, there were at least three people who participated quietly and nonverbally whose perspectives were not captured on the transcripts. This was a minor impact as they still participated in the focus groups, quietly agreeing or disagreeing with expressed opinions (Lazar et al., 2010).

The data collection and analysis of findings were likely influenced by my epistemic view. Previously working in health care and UGME gave me the insider knowledge that I needed to ask questions and empathize with the students. I had to aware of my own pre-conceived ideas and I was conscious that I needed to be constantly documenting my thoughts and experiences. Using my reflexive diary was useful in bringing attention to my own involvement in the research.

An alternative methodology to a critical ethnographic case study could have been a phenomenological study; however, given that the collective culture of the medical

school drives the hidden curriculum, an ethnographic case study was deemed more appropriate. This research could have also been quantitative with periodic surveys being administered throughout the two years. These surveys would be able to quantify any changes in the students' views about their learning environment. However, being able to capture the presence of a hidden curriculum would be difficult through survey data.

I also did not consider the effect of “class politics” on the development of professional identity in the students. It was apparent in the focus groups that there were cliques in the class which I did not fully account for in my analysis. At any field site, larger social structures and contexts where the focus groups took place can influence the participants responses (Hollander, 2004). In my focus groups the research participants interacted with me, each other and “with others who are not present but whose imagined presence affects the participant” (Hollander, 2004, p. 613).

9.6 Future Research

An important limitation of my research was the lack of diversity of student participants. This is a known concern surrounding professional identity formation in medical education research (M. Hopkins et al., 2019). This limitation could not be avoided as my student population was mainly from Newfoundland and Labrador (Faculty of Medicine, Memorial University, n.d.), a generally Caucasian, Christian, homogeneous population (*National Household Survey 2011: Religion, Newfoundland and Labrador - Community Accounts*, 2011; Newfoundland and Labrador Statistics Agency, 2020). Further research at other sites may consider this a factor when looking at professional identity formation in medical education.

In my research, I interviewed faculty and administrative staff on their views of the learning environment and the UGME curriculum and its impact on the students. The voices of these groups are not prominently featured in my thesis. I chose to focus my research findings mainly on the students' voices, as my primary interest was on their professional identity development. I only used faculty and administration data if they added context to the students' words. Further research could examine these two groups' views on how medical school influences professionalism in medical students.

9.7 Final Words

I analyzed the complex and multiple relations of power and influence in pre-clerkship education and the role they play as the identity of a medical professional is constructed. I explored UGME from the students' perspectives, focusing on how the formal, informal, and hidden curriculum shaped their professional identity as they developed as emerging professionals in medicine. This dissertation illustrated how medical students experience and react to the effects of a powerful but hidden curriculum that influences their professional identity development as "the good doctor".

References

- About CACMS | CACMS*. (n.d.). Retrieved December 1, 2021, from <https://cacms-cafmc.ca/about-cacms>
- Abu-Lughod. (1990). The romance of resistance: Tracing transformations of power through Bedouin women. *American Ethnologist*, *17*(1), 41–55.
<https://doi.org/10.1525/ae.1990.17.1.02a00030>
- Agar, M., & MacDonald, J. (1995). Focus Groups and Ethnography. *Human Organization*, *54*(1), 78–86.
<https://doi.org/10.17730/humo.54.1.x102372362631282>
- Alamri, Y. (2018). Perceptions towards research and academia by Māori and Pacific preclinical medical students. *Australian Journal of Rural Health*, *26*(5), 375–376.
<https://doi.org/10.1111/ajr.12480>
- Album, D., & Westin, S. (2008). Do diseases have a prestige hierarchy? A survey among physicians and medical students. *Social Science & Medicine*, *66*(1), 182–188.
<https://doi.org/10.1016/j.socscimed.2007.07.003>
- Alers, M., Leerdam, L., Dielissen, P., & Lagro-Janssen, A. (2014). Gendered specialities during medical education: A literature review. *Perspectives on Medical Education*, *3*(3), 163–178. <https://doi.org/10.1007/s40037-014-0132-1>
- Allan, H. T. (2006). Using participant observation to immerse oneself in the field. *Journal of Research in Nursing*, *11*(5), 397–407.
<https://doi.org/10.1177/1744987106068345>

- Amen, T. B., & Nolen, L. T. (2021). Patient Dehumanization in Medical Education: Reflections on Mr. E. *Academic Medicine: Journal of the Association of American Medical Colleges*. <https://doi.org/10.1097/ACM.00000000000004356>
- American Medical Association & Council on Ethical Judicial Affairs. (2016). *Modernizing the AMA Code of medical ethics*. <https://www.ama-assn.org/about-us/code-medical-ethics>
- Amerson, R. (2011). Making a case for the case study method. *Journal of Nursing Education, 50*(8), 427–428. <https://doi.org/10.3928/01484834-20110719-01>
- Amgad, M., Tsui, M., Liptrott, S. J., & Shash, E. (2015). Medical student research: An integrated mixed-methods systematic review and meta-analysis. *Plos One, 10*(6). <https://doi.org/10.1371/journal.pone.0127470>
- Angoff, N., Duncan, L., Roxas, N., & Hansen, H. (2016). Power day: Addressing the use and abuse of power in medical training. *Journal of Bioethical Inquiry, 13*(2), 203–213. <https://doi.org/10.1007/s11673-016-9714-4>
- Angrosino, M. (2007). *Doing ethnographic and observational research*. SAGE Publications Ltd. <https://doi.org/10.4135/9781849208932>
- Anicich, E. M., Swaab, R. I., & Galinsky, A. D. (2015). Hierarchical cultural values predict success and mortality in high-stakes teams. *Proceedings of the National Academy of Sciences - PNAS, 112*(5), 1338–1343. <https://doi.org/10.1073/pnas.1408800112>
- Ansari, N. (2020). The code switch. *Journal of General Internal Medicine, 35*(4), 1311–1312. <https://doi.org/10.1007/s11606-019-05631-1>

- Anthony, S., & Jack, S. (2009). Qualitative case study methodology in nursing research: An integrative review. *Journal of Advanced Nursing*, 65(6), 1171–1181.
<https://doi.org/10.1111/j.1365-2648.2009.04998.x>
- Antiel, R. M., Kinghorn, W. A., Reed, D. A., & Hafferty, F. W. (2013). Professionalism: Etiquette or habitus? *Mayo Clinic Proceedings*, 88(7), 651–652.
<https://doi.org/10.1016/j.mayocp.2013.05.008>
- Apple, M. W. (1995). *Education and power* (2nd ed.). New York: Routledge.
- Association of American Colleges. (2015). *Critical analysis and reasoning skills section: Overview*. <https://students-residents.aamc.org/applying-medical-school/article/mcat-2015-cars-overview/>
- Association of Faculties of Medicine of Canada. (2019). *Annual Report*.
<https://afmc.ca/sites/default/files/annual-reports/2018-19-annualreport.pdf>
- Atherley, A., Dolmans, D., Hu, W., Hegazi, I., Alexander, S., & Teunissen, P. W. (2019). Beyond the struggles: A scoping review on the transition to undergraduate clinical training. *Medical Education*, 53(6), 559–570. <https://doi.org/10.1111/medu.13883>
- Babbitt, S. (1993). Feminism and objective interests: The role of transformation experiences in rational deliberation. In L. P. E. Alcoff (Ed.), *Feminist epistemologies* (Vol. 1–Book, Section, pp. 245–264). Routledge.
- Baby Names. (2020). <https://www.babynames.com/blogs/names-blog/100-trending-names-of-2020/>
- Baker, L., Egan-Lee, E., Martimianakis, M. A., & Reeves, S. (2011). Relationships of power: Implications for interprofessional education. *Journal of Interprofessional Care*, 25(2), 98–104. <https://doi.org/10.3109/13561820.2010.505350>

- Balmer, D. F., Devlin, M., & Richards, B. (2017). Understanding the relation between medical students' collective and individual trajectories: An application of habitus. *Perspectives on Medical Education*, 6(1), 36–43. <https://doi.org/10.1007/s40037-016-0321-1>
- Balmer, D. F., Richards, B. F., & Varpio, L. (2015). How students experience and navigate transitions in undergraduate medical education: An application of Bourdieu's theoretical model. *Advances In Health Sciences Education: Theory and Practice*, 20(4), 1073–1085. <https://doi.org/10.1007/s10459-015-9588-y>
- Bandiera, G., Kuper, A., Mylopoulos, M., Whitehead, C., Ruetalo, M., Kulasegaram, K., & Woods, N. N. (2018). Back from basics: Integration of science and practice in medical education. *Medical Education*, 52(1), 78–85. <https://doi.org/10.1111/medu.13386>
- Banos, J., Noah, J., Harada, C., Baños, J. H., Noah, J. P., & Harada, C. N. (2019). Predictors of Student Engagement in Learning Communities. *Journal of Medical Education and Curricular Development.*, 6. <https://doi.org/10.1177/2382120519840330>
- Barber, B. R. (2007). *Consumed: How markets corrupt children, infantilize adults, and swallow citizens whole*. W. W. Norton.
- Barbosa, J., Silva, Á., Ferreira, M. A., & Severo, M. (2016). Transition from secondary school to medical school: The role of self-study and self-regulated learning skills in freshman burnout. *Acta Medica Portuguesa*, 29(12), 803. <https://doi.org/10.20344/amp.8350>

- Baron, R. J. (2015). Professional self-regulation in a changing world: Old problems need new approaches. *JAMA*, *313*(18), 1807–1808.
<https://doi.org/10.1001/jama.2015.4060>
- Bartlett, J. (2018). Addressing the recruitment shortfall in surgery—How do we inspire the next generation? *Annals of Medicine and Surgery*, *25*, 30–32.
<https://doi.org/10.1016/j.amsu.2017.11.024>
- Beagan, B. L. (2001a). “Even if I don’t know what I’m doing I can make it look like I know what I’m doing”: Becoming a doctor in the 1990s. *The Canadian Review of Sociology*, *38*(3), 275–292. <https://doi.org/10.1111/j.1755-618X.2001.tb00974.x>
- Beagan, B. L. (2001b). Micro inequities and everyday inequalities: “Race,” gender, sexuality and class in medical school. *Canadian Journal of Sociology*, *26*(4), 583–610. <https://doi.org/10.2307/3341493>
- Beagan, B. L. (2003a). ‘Is this worth getting into a big fuss over?’ Everyday racism in medical school. *Medical Education*, *37*(10), 852–860.
<https://doi.org/10.1046/j.1365-2923.2003.01622.x>
- Beagan, B. L. (2003b). Teaching social and cultural awareness to medical students: “It’s all very nice to talk about it in theory, but ultimately it makes no difference.” *Academic Medicine*, *78*(6), 605–614. <https://doi.org/10.1097/00001888-200306000-00011>
- Beagan, B. L. (2005). Everyday classism in medical school: Experiencing marginality and resistance. *Medical Education*, *39*(8), 777–784.
<https://doi.org/10.1111/j.1365-2929.2005.02225.x>
- Beck, U. (1992). *Risk society: Towards a new modernity*. SAGE Publications.

- Becker, H. S., Geer, B., Hughes, E. C., & Strauss, A. L. (2007). *Boys in white. Student culture in medical school* (10th ed.). Transaction Publishers.
- Belsey, C. (2002a). Creatures of Difference. In *Poststructuralism: A very short introduction* (1st ed., Vol. 1–Book, Section, pp. 1–23). Oxford University Press.
- Belsey, C. (2002b). *Poststructuralism: A very short introduction*. Oxford University Press.
- Benbassat, J. (2014). Changes in wellbeing and professional values among medical undergraduate students: A narrative review of the literature. *Advances in Health Sciences Education; Theory and Practice*, 19(4), 597–610.
<https://doi.org/10.1007/s10459-014-9500-1>
- Bennett, D., Solomon, Y., Bergin, C., Horgan, M., & Dornan, T. (2017). Possibility and agency in Figured Worlds: Becoming a “good doctor.” *Medical Education*, 51(3), 248–257. <https://doi.org/10.1111/medu.13220>
- Berten, A., & Foucault, M. (1988). Entretien avec Michel Foucault. *Les cahiers du GRIF*, 37(1), 8–20. <https://doi.org/10.3406/grif.1988.1751>
- Bleakley, A. (2011a). *Medical education for the future identity, power and location*. Springer Netherlands: Imprint: Springer.
- Bleakley, A. (2011b). Professing medical identities in the liquid world of teams. *Medical Education*, 45(12), 1171–1173. <https://doi.org/10.1111/j.1365-2923.2011.04147.x>
- Bleakley, A. (2012). The proof is in the pudding: Putting Actor- Network- Theory to work in medical education. *Medical Teacher*, 2012, Vol.34; 34(6; 6), 462; 462–467; 467. <https://doi.org/10.3109/0142159X.2012.671977>

- Bleakley, A. (2014). Theorizing team process through Deleuzian rhizomatics: Becoming a medical professional in nomadic teams. In S. Lajoie & Y. Steinert (Eds.), *Patient-Centred Medicine in Transition* (pp. 183–205).
- Bleakley, A., & Bligh, J. (2009). Who can resist Foucault? *The Journal of Medicine and Philosophy*, 34(4), 368–383. <https://doi.org/10.1093/jmp/jhp028>
- Bleakley, A., Bligh, J., & Browne, J. (2011). New forms of identity in a runaway world of medicine. In A. Bleakley, J. Bligh, & J. Browne (Eds.), *Medical Education for the Future: Identity, Power and Location* (pp. 81–91). Springer Netherlands. https://doi.org/10.1007/978-90-481-9692-0_6
- Bloom, B. S. (1984). *Taxonomy of educational objectives: The classification of educational goals* (1st ed.). Longman.
- Blouin, D. (2018). Impact of interpersonal relations on learning and development of professional identity: A study of residents' perceptions. *Emergency Medicine Australasia*, 30(3), 398–405. <https://doi.org/10.1111/1742-6723.12944>
- Blumhagen, D. W. (1979). The doctor's white coat: The image of the physician in modern America. *Annals of Internal Medicine*, 91(1), 111–116. <https://doi.org/10.7326/0003-4819-91-1-111>
- Boblin, S. L., Ireland, S., Kirkpatrick, H., & Robertson, K. (2013). Using Stake's qualitative case study approach to explore implementation of evidence-based practice. *Qualitative Health Research*, 23(9), 1267–1275. <https://doi.org/10.1177/1049732313502128>
- Boland, J. W., Dikomitis, L., & Gadoud, A. (2016). Medical students writing on death, dying and palliative care: A qualitative analysis of reflective essays. *BMJ*

Supportive & Palliative Care., 6(4), 486–492. <https://doi.org/10.1136/bmjspcare-2016-001110>

Boler, M. (1999). *Feeling power: Emotions and education*. Routledge.

Bosk, C. L. (2003). *Forgive and remember: Managing medical failure*. University of Chicago Press.

Bourdieu, P. (1969). Intellectual field and creative project. *Social Science Information*, 8, 119–189. <https://doi.org/10.1177/053901846900800205>

Bourdieu, P. (1974). The school as a conservative force: Scholastic and cultural inequalities. In J. Eggleston (Ed.), *Contemporary research in the sociology of education* (pp. 32–46). Methuen.

Bourdieu, P. (1977). *Outline of a theory of practice* (Issue Vol. 16). Cambridge University Press; eBook Academic Collection (EBSCOhost).
<http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,url,uid&db=e000xna&AN=589175&site=ehost-live&scope=site>

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste*. Harvard University Press.

Bourdieu, P. (1986a). The forms of capital. In J. G. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (Vol. 241, p. 19).

Bourdieu, P. (1986b). The production of belief: Contribution to an economy of symbolic goods. In R. Collins (Ed.), *Media, culture & society: A critical reader*. SAGE Publications. <https://books.google.ca/books?id=iKXvnQEACAAJ>

Bourdieu, P. (1988). *Homo academicus*. Stanford University Press.

- Bourdieu, P. (1990). *In other words: Essays towards a reflexive sociology*. Stanford University Press.
- Bourdieu, P. (1993). Concluding Remarks: For a sociogenetic understanding of intellectual works. In C. J. Calhoun, E. LiPuma, & M. Postone (Eds.), *Bourdieu: Critical perspectives* (pp. 263–275). University of Chicago Press.
- Bourdieu, P. (1996). *The state nobility: Elite schools in the field of power* (L. C. Clough, Trans.). Stanford University Press. <http://www.sup.org/books/title/?id=2045>
- Bourdieu, P. (1998). *Practical reason: On the theory of action*. Stanford University Press.
- Bourdieu, P. (2000). *Pascalian meditations* (R. Nice, Trans.). Polity Press.
- Bourdieu, P. (2005). *The social structures of the economy*. Polity Press.
- Bourdieu, P. (2006). The forms of capital. In H. Lauder, P. Brown, J. A. Dillabough, & A. H. Halsey (Eds.), *Education, globalisation and social change*. Oxford University Press.
- Bourdieu, P. (2009). *Language and symbolic power* (J. Thompson, Ed.; G. Raymond, Trans.; Reprint). Polity; /z-wcorg/.
- Bourdieu, P., & Coleman, J. (1991). *Social theory for a changing society*. Russell Sage Foundation.
- Bourdieu, P., & Eagleton, T. (1992). *Doxa and common life*. New Left Review; New Left Rev. <https://newleftreview.org/issues/I191/articles/terry-eagleton-pierre-bourdieu-doxa-and-common-life>
- Bourdieu, P., & Passeron, J. C. (1977). *Reproduction in education, society, and culture*. London.

- Bourdieu, P., & Wacquant, L. J. D. (1992). *An invitation to reflexive sociology*.
University of Chicago Press.
- Bradbury, H., Frost, N., Kilminster, S., & Zukas, M. (2009). *Beyond reflective practice: New approaches to professional lifelong learning*. Routledge.
<http://ebookcentral.proquest.com/lib/mun/detail.action?docID=1024756>
- Brancati, F. L. (1989). The art of pimping. *JAMA*, 262(1), 89–90.
<https://doi.org/10.1001/jama.1989.03430010101039>
- Brannick, T., & Coghlan, D. (2007). In defense of being “native”: The case for insider academic research. *Organizational Research Methods*, 10(1), 59–74.
<https://doi.org/10.1177/1094428106289253>
- Branson, R. (1973). The secularization of American medicine. *Hastings Center Studies*, 1(2), 17–28. <https://doi.org/10.2307/3527510>
- Brase, G. L., & Richmond, J. (2004). The white-coat effect: Physician attire and perceived authority, friendliness, and attractiveness. *Journal of Applied Social Psychology*, 34(12), 2469–2481. <https://doi.org/10.1111/j.1559-1816.2004.tb01987.x>
- Bratich, J. (2011). Observations in a surveilled world. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (Vol. 1–Book, Section, pp. 526–545). SAGE Publications.
- Brauer, D. G., & Ferguson, K. J. (2015). The integrated curriculum in medical education: AMEE Guide No. 96. *Medical Teacher*, 37(4), 312–322.
<https://doi.org/10.3109/0142159X.2014.970998>

- Bridges, W. (2004). *Transitions: Making sense of life's changes* (2nd ed.). Addison-Wesley.
- Brosnan, C., Southgate, E., Outram, S., Lempp, H., Wright, S., Saxby, T., Harris, G., Bennett, A., & Kelly, B. (2016). Experiences of medical students who are first in family to attend university. *Medical Education*, *50*(8), 842–851.
<https://doi.org/10.1111/medu.12995>
- Brosnan, C., & Turner, B. (Eds.). (2009). *Handbook of the sociology of medical education*. Routledge.
- Brunger, F. (2016). Guidelines for Teaching Cross-Cultural Clinical Ethics: Critiquing Ideology and Confronting Power in the Service of a Principles-Based Pedagogy. *Journal of Bioethical Inquiry; An Interdisciplinary Forum for Ethical and Legal Debate*, *13*(1), 117–132. <https://doi.org/10.1007/s11673-015-9679-8>
- Brydges, R., & Butler, D. (2012). A reflective analysis of medical education research on self-regulation in learning and practice. *Medical Education*, *46*(1), 71–79.
<https://doi.org/10.1111/j.1365-2923.2011.04100.x>
- Buchanan, D., & Witlen, R. (2006). Balancing service and education: Ethical management of student-run clinics. *Journal of Health Care for the Poor and Underserved*, *17*(3), 477–485. <https://doi.org/10.1353/hpu.2006.0101>
- Buja, L. M. (2019). Medical education today: All that glitters is not gold. *BMC Medical Education*, *19*(1), 1–11. <https://doi.org/10.1186/s12909-019-1535-9>
- Burford, B. (2012). Group processes in medical education: Learning from social identity theory. *Medical Education*, *46*(2), 143–152. <https://doi.org/10.1111/j.1365-2923.2011.04099.x>

- Burke, P., & McManus, J. (2011). Art for a few: Exclusions and misrecognitions in higher education admissions practices. *Discourse*, 32(5), 699.
<https://doi.org/10.1080/01596306.2011.620753>
- Canadian Medical Association. (2018a). *Addressing gender equity and diversity in Canada's medical profession: A review*.
<https://www.cma.ca/sites/default/files/pdf/Ethics/report-2018-equity-diversity-medicine-e.pdf>
- Canadian Medical Association. (2018b). *CMA code of ethics and professionalism*.
<https://www.cma.ca/cma-code-ethics-and-professionalism>
- Canadian Residency Matching Service. (2020). *Algorithm FAQs: Strategy & Best practices*. <https://www.carms.ca/the-match/how-it-works/strategy#match-first-choice>
- Carspecken, P. F., & Walford, G. (2001). *Critical ethnography and education*. JAI Press.
- Case, G. A. (2014). Performance and the hidden curriculum in medicine. *Performance Research*, 19(4), 6–13. <https://doi.org/10.1080/13528165.2014.947120>
- Catto, G. (2014). The Hippocratic Oath: Back to the future? *Medical Education*, 48(1), 4–5. <https://doi.org/10.1111/medu.12359>
- Centre for Collaborative Health Professional Education. (2020). *Faculty of Medicine—CCHPE*. <https://www.med.mun.ca/CCHPE/Activities/Programs/Undergraduate-Interprofessional-Education-Modules.aspx>
- Chan, J. B. L. (1997). *Changing police culture: Policing in a multicultural society*. Cambridge.

- Chen, H. C., Sheu, L., O' Sullivan, P., Cate, O., & Teherani, A. (2014). Legitimate workplace roles and activities for early learners. *Medical Education*, *48*(2), 136–145. <https://doi.org/10.1111/medu.12316>
- Chen, H. C., van den Broek, W. E. S., & ten Cate, O. (2015). The case for use of entrustable professional activities in undergraduate medical education. *Academic Medicine*, *90*(4), 431–436. <https://doi.org/10.1097/acm.0000000000000586>
- Christakis, A. D., & Feudtner, A. C. (1993). Ethics in a short white coat: The ethical dilemmas that medical students confront. *Academic Medicine*, *68*(4), 249–254. <https://doi.org/10.1097/00001888-199304000-00003>
- Clark, S. (2018). The impact of the Hippocratic Oath in 2018: The conflict of the ideal of the physician, the knowledgeable humanitarian, versus the corporate medical allegiance to financial models contributes to burnout. *Cureus*, *10*(7). <https://doi.org/10.7759/cureus.3076>
- Cleland, J., MacLeod, A., & Ellaway, R. H. (2021). The curious case of case study research. *Medical Education*. <https://doi.org/10.1111/medu.14544>
- Cleland, J., Patey, R., Thomas, I., Walker, K., O'Connor, P., & Russ, S. (2016). Supporting transitions in medical career pathways: The role of simulation-based education. *Advances in Simulation (London, England)*, *1*(1), 14–14. <https://doi.org/10.1186/s41077-016-0015-0>
- Collier, R. (2012). Professionalism: The “good doctor” discussion. *Canadian Medical Association Journal (CMAJ)*, *184*(10), E517-818. <https://doi.org/10.1503/cmaj.109-4200>

- Collins, J. P., Farish, S., McCalman, J. S., & McColl, G. J. (2010). A mandatory intercalated degree programme: Revitalising and enhancing academic and evidence-based medicine. *Medical Teacher*, 32(12), e541–e546.
<https://doi.org/10.3109/0142159X.2010.528807>
- Communications. (2017). *Dean's notes: Sept. 18, 2017*.
<https://www.med.mun.ca/Medicine/Communications/News-at-Medicine/September-2017/%E2%80%8BDean's-notes-Sept-18,-2017.aspx>
- Conrad, P. (1988). Learning to doctor: Reflections on recent accounts of the medical school years. *Journal of Health and Social Behavior*, 29(4), 323.
<https://doi.org/10.2307/2136866>
- Corden, A., & Nice, K. (2007). Qualitative longitudinal analysis for policy: Incapacity benefits recipients taking part in pathways to work. *Social Policy and Society; Social Policy Society*, 6(4), 557–569. <https://doi.org/10.1017/S1474746407003892>
- Coulehan, J. (2005). Viewpoint: Today's professionalism: Engaging the mind but not the heart. *Academic Medicine*, 80(10), 892–898. <https://doi.org/10.1097/00001888-200510000-00004>
- Craig, S. R., Scott, R., & Blackwood, K. (2018). Orienting to medicine: Scripting professionalism, hierarchy, and social difference at the start of medical school. *Culture, Medicine and Psychiatry*. <https://doi.org/10.1007/s11013-018-9580-0>
- Creswell, J. W. (2015a). *30 Essential skills for the qualitative researcher* (1st ed.). SAGE Publications. <https://books.google.ca/books?id=fkJsCgAAQBAJ>

- Creswell, J. W. (2015b). Introducing qualitative designs. In *30 Essential Skills for the Qualitative Researcher* (1st ed., Vol. 1–Book, Section, pp. 257–270). SAGE Publications.
- Creswell, & Poth. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). SAGE Publications.
- Cristancho, S., & Fenwick, T. (2015). Mapping a surgeon’s becoming with Deleuze. *Medical Humanities, 41*(2). <https://doi.org/10.1136/medhum-2015-010735>
- Cronin, C. (2014). Using case study research as a rigorous form of inquiry. *Nurse Researcher, 21*(5), 19. <https://doi.org/10.7748/nr.21.5.19.e1240>
- Crossley, N. (2013). Habit and habitus. *Body & Society, 19*(2–3), 136–161. <https://doi.org/10.1177/1357034X12472543>
- Crowe, S., Clarke, N., & Brugha, R. (2017). ‘You do not cross them’: Hierarchy and emotion in doctors’ narratives of power relations in specialist training. *Social Science & Medicine, 186*, 70–77. <https://doi.org/10.1016/j.socscimed.2017.05.048>
- Cruess, R., & Cruess, S. (2008). Expectations and obligations: Professionalism and medicine’s social contract with society. *Perspectives in Biology and Medicine, 51*(4), 579–598. <https://doi.org/10.1353/pbm.0.0045>
- Cruess, R., & Cruess, S. (2016). Professionalism and professional identity formation: The cognitive base. In R. Cruess, S. Cruess, & Y. Steinert (Eds.), *Teaching Medical Professionalism: Supporting the development of a professional identity* (2nd ed., Vol. 1–Book, Section, p. 5). Cambridge University Press.

- Cruess, R., Cruess, S., Boudreau, D., Snell, L., & Steinert, Y. (2014). Reframing medical education to support professional identity formation. *Academic Medicine*, *89*(11), 1446–1451. <https://doi.org/10.1097/ACM.0000000000000427>
- Cruess, R., Cruess, S., Boudreau, D., Snell, L., & Steinert, Y. (2015). A schematic representation of the professional identity formation and socialization of medical students and residents: A guide for medical educators. *Academic Medicine*, *90*(6), 718–725. <https://doi.org/10.1097/ACM.0000000000000700>
- Cruess, R., Cruess, S., & Steinert, Y. (2016). Amending Miller’s pyramid to include professional identity formation. *Academic Medicine*, *91*(2), 180–185. <https://doi.org/10.1097/ACM.0000000000000913>
- Cruess, R., Cruess, S., & Steinert, Y. (2018). Medicine as a community of practice: Implications for medical education. *Academic Medicine*, *93*(2), 185–191. <https://doi.org/10.1097/ACM.0000000000001826>
- Cruess, R., Cruess, S., & Steinert, Y. (2019). Supporting the development of a professional identity: General principles. *Medical Teacher*, *41*(6), 641–649. <https://doi.org/10.1080/0142159X.2018.1536260>
- Cuesta-Briand, B., Auret, K., Johnson, P., & Playford, D. (2014). “A world of difference”: A qualitative study of medical students’ views on professionalism and the “good doctor.” *BMC Medical Education*, *14*(1), 77–77. <https://doi.org/10.1186/1472-6920-14-77>
- Davies, M. (2017). The risks of following the informal and hidden curriculums. *Student BMJ*, *359*. <https://doi.org/10.1136/sbmj.j3287>

- Dawson, J. (2021). Medically optimised: Healthcare language and dehumanisation. *The British Journal of General Practice : The Journal of the Royal College of General Practitioners.*, 71(706), 224–224. <https://doi.org/10.3399/bjgp21X715829>
- De Cates, P., Owen, K., & Macdougall, C. F. (2018). Warwick Medical School: A four dimensional curriculum. *Medical Teacher*, 40(5), 488–494. <https://doi.org/10.1080/0142159X.2018.1435857>
- Deer, C. (2012). Doxa. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., pp. 114–126). Routledge.
- Deleuze, G. (1977). *Anti-Oedipus: Capitalism and schizophrenia*. Viking Press.
- Deleuze, G. (1987). *A thousand plateaus: Capitalism and schizophrenia*. University of Minnesota Press.
- Dellafiore, F., Caruso, R., Conte, G., Grugnetti, A. M., Bellani, S., & Arrigoni, C. (2019). Individual-level determinants of interprofessional team collaboration in healthcare. *Journal of Interprofessional Care*, 33(6), 762–767. <https://doi.org/10.1080/13561820.2019.1594732>
<https://doi.org/10.1080/13561820.2019.1594732>
- DeLuca, J. R., & Andrews, D. L. (2016). Exercising privilege: The cyclical reproduction of capital through swim club membership. *Sociological Inquiry*, 86(3), 301–323. <https://doi.org/10.1111/soin.12113>
- DeWalt, K. M., & DeWalt, B. R. (2011). *Participant observation: A guide for fieldworkers*. AltaMira Press.
- Dharamsi, S. (2011). Moving beyond the limits of cultural competency training. *Medical Education*, 45(8), 764–766. <https://doi.org/10.1111/j.1365-2923.2011.04044.x>

- Divall, M. V., Kolbig, L., Carney, M., Kirwin, J., Letzeiser, C., & Mohammed, S. (2014). Interprofessional socialization as a way to introduce collaborative competencies to first-year health science students. *Journal of Interprofessional Care*, 2014, Vol.28; 28(6; 6), 576; 576–578; 578.
<https://doi.org/10.3109/13561820.2014.917403>
- Dommett, E., & Gardner, B. (2019). Staff and student views of lecture capture: A qualitative study. *International Journal of Educational Technology in Higher Education*, 16(1), 1–12. <https://doi.org/10.1186/s41239-019-0153-2>
- Doody, O., Slevin, E., & Taggart, L. (2013). Focus group interviews part 3: Analysis. *British Journal of Nursing (Mark Allen Publishing)*, 22(5), 266.
<https://doi.org/10.12968/bjon.2013.22.5.266>
- Doolin, B. (2002). Enterprise discourse, professional identity and the organizational control of hospital clinicians. *Organization Studies*, 23(3), 369–390.
<https://doi.org/10.1177/0170840602233003>
- Douglas, M. (2002). Secular defilement. In *Purity and danger: An analysis of concepts of pollution and taboo* (Vol. 1–Book, Section, pp. 36–50). Routledge.
- Dubin, S. N., Nolan, I. T., Jr, C. G. S., Greene, R. E., Radix, A. E., & Morrison, S. D. (2018). Transgender health care: Improving medical students; and residents; training and awareness. *Advances in Medical Education and Practice*, 9, 377–391.
<https://doi.org/10.2147/AMEP.S147183>
- Duffy, F. D., & Holmboe, E. S. (2006). Self-assessment in lifelong learning and improving performance in practice: Physician know thyself. *JAMA*, 296(9), 1137–1139. <https://doi.org/10.1001/jama.296.9.1137>

- Edgerton, J. D., & Roberts, L. W. (2014). Cultural capital or habitus? Bourdieu and beyond in the explanation of enduring educational inequality. *Theory and Research in Education, 12*(2), 193–220.
<https://doi.org/10.1177/1477878514530231>
- Eisner, E. W. (1985). *The educational imagination: On the design and evaluation of school programs* (2nd ed.). Prentice Hall.
- Ellaway, R. H., Cooper, G., Al-Idrissi, T., Dubé, T., & Graves, L. (2014). Discourses of student orientation to medical education programs. *Medical Education Online, 19*.
<https://doi.org/10.3402/meo.v19.23714>
- Ellaway, R. H., & Wyatt, T. R. (2021). What role should resistance play in training health professionals? *Academic Medicine*.
<https://doi.org/10.1097/ACM.0000000000004225>
- Emanuel, L., & Greenland, P. (2005). Peer review and professionalism at the Archives of Internal Medicine. *Archives of Internal Medicine, 165*(22), 2559–2560.
<https://doi.org/10.1001/archinte.165.22.2559>
- Emerson, R. M. (2011). *Writing ethnographic fieldnotes* (2nd ed.). University of Chicago Press.
- Emirbayer, M., & Johnson, V. (2008). Bourdieu and organizational analysis. *Theory & Society, 37*(1), 1–44. <https://doi.org/10.1007/s11186-007-9052-y>
- Emmerich, N. (2013). Sociological perspectives on medical education. In *Medical Ethics Education: An interdisciplinary and social theoretical perspective* (Vol. 1–Book, Section, pp. 21–37). Springer International Publishing.

- Engeström, Y. (2014). *Learning by expanding: An activity-theoretical approach to developmental research*. Cambridge University Press.
- Epstein, R. M. (2008). Reflection, perception and the acquisition of wisdom. *Medical Education*, 42(11), 1048–1050. <https://doi.org/10.1111/j.1365-2923.2008.03181.x>
- Ewick, P., & Silbey, S. (2003). Narrating social structure: Stories of resistance to legal authority. *The American Journal of Sociology*, 108(6), 1328–1372. <https://doi.org/10.1086/378035>
- Faculty of Medicine, Memorial University. (n.d.). *Faculty of Medicine—Admissions-Faculty of Medicine*. Retrieved August 12, 2021, from <https://www.med.mun.ca/Admissions/ApplicationEvaluationCompetitions.aspx>
- Faculty of Medicine, Memorial University. (2013). *Statement of professional attributes*. <https://www.med.mun.ca/getdoc/bd1f53d9-9b77-481a-a3c4-c01d36ab43aa/Statement-of-Professional-Attributes-April-2-2013.aspx>
- Faculty of Medicine, Memorial University. (2017a). *Essential skills and abilities required for the study of medicine*. <https://www.med.mun.ca/getattachment/045f2a16-d89d-4c63-b77b-6e0a921969d2/Essential-Skills-and-Abilities-for-the-Study-of-Medicine.pdf.aspx>
- Faculty of Medicine, Memorial University. (2017b). *Self-directed learning. Peer assessment*. <https://www.med.mun.ca/ugmecurriculum/programview.aspx?ID=3972>
- Faculty of Medicine, Memorial University. (2017c). *Student code of conduct*. <https://www.mun.ca/student/supports-and-resources/respectful-campus/student-code-of-conduct.php>

- Faculty of Medicine, Memorial University. (2018). *Attendance guidelines*. Student Handbook: An Online Reference Guide.
<https://www.med.mun.ca/StudentHandbook/Phase-1/Attendance-Guidelines.aspx>
- Faculty of Medicine, Memorial University. (2019a). *About Us—Destination Excellence: 2018-2023—Project teams—Undergraduate curriculum review*.
<https://www.med.mun.ca/Medicine/About-Us/Destination-Excellence-2018-2023/Project-Teams/Undergraduate-Curriculum-Review.aspx>
- Faculty of Medicine, Memorial University. (2019b). *Professionalism and mistreatment*.
<https://www.med.mun.ca/Professionalism/Home.aspx>
- Faculty of Medicine, Memorial University. (2019c). *Student handbook: An online reference guide*. <https://www.med.mun.ca/StudentHandbook/Curriculum-Overview.aspx>
- Faculty of Medicine, Memorial University. (2019d). *The early days of the medical school at Memorial University of Newfoundland*. <http://www.med.mun.ca/earlydays/>
- Faculty of Medicine, Memorial University. (2020a). *Course descriptions*.
<https://www.mun.ca/regoff/calendar/sectionNo=MED-0376>
- Faculty of Medicine, Memorial University. (2020b). *Division/Discipline*.
<https://www.med.mun.ca/Medicine/Division-Discipline.aspx>
- Farrell, L., Bourgeois-Law, G., Regehr, G., & Ajjawi, R. (2015). Autoethnography: Introducing 'I' into medical education research. *Medical Education*, 49(10), 974–982. <https://doi.org/10.1111/medu.12761>
- Faucett, E. A., McCrary, H. C., Milinic, T., Hassanzadeh, T., Roward, S. G., & Neumayer, L. A. (2017). The role of same-sex mentorship and organizational

- support in encouraging women to pursue surgery. *The American Journal of Surgery*, 214(4), 640–644. <https://doi.org/10.1016/j.amjsurg.2017.07.005>
- Fleming, J. (2018). Recognizing and resolving the challenges of being an insider researcher in work-integrated learning. *International Journal of Work - Integrated Learning*, 19(3), 311–320.
- Flexner, A. (1973). *Medical education in the United States and Canada: A report to the Carnegie Foundation for the Advancement of Teaching*. Heritage Press.
- Flick, U. (2014). *The SAGE handbook of qualitative data analysis*. SAGE Publications.
- Flinders, D. J., Noddings, N., & Thornton, S. J. (1986). The null curriculum: Its theoretical basis and practical implications. *Curriculum Inquiry*, 16(1), 33–42. <https://doi.org/10.1080/03626784.1986.11075989>
- Forum on Aging, D., Independence, Board on Health Sciences, P., Division on, B., Social, S., Education, Institute of, M., & National Research, C. (2014). <https://doi.org/10.17226/737>
- Foucault, M. (1972). *The archaeology of knowledge; and the discourse on language*. Pantheon Books.
- Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception* (1st ed.). Pantheon Books.
- Foucault, M. (1975). Je suis un artificier. In M. O'Farrell (Trans.), *Michel Foucault, entretiens*. Odile Jacob.
- Foucault, M. (1978). *The History of Sexuality, Volume 1: An Introduction* (R. Hurley, Trans.). Pantheon Books.

- Foucault, M. (1979). *Discipline and punish: The birth of the prison* (Vintage Books ed.).
Vintage Books.
- Foucault, M. (1982a). The subject and power. In H. Dreyfus & P. Rabinow (Eds.),
Michael Foucault: Beyond structuralism and hermeneutics. (Vol. 1–Book,
Section, pp. 208–226). Chicago University Press.
- Foucault, M. (1982b). The subject and power. *Critical Inquiry*, 8(4), 777–795.
<https://doi.org/10.1086/448181>
- Foucault, M. (1984). *The Foucault reader* (1st ed.). Pantheon Books.
- Foucault, M. (2002). *Power: The essential works of Michel Foucault 1954-1984* (3rd ed.).
Penguin.
- Foucault, M., & Hutton, P. H. (1988). *Technologies of the self: A seminar with Michel
Foucault* (L. H. Martin & H. Gutman, Eds.). University of Massachusetts Press.
- Foucault, M., Senellart, M., Ewald, F., & Fontana, A. (2007). *Security, territory,
population: Lectures at the Collège de France, 1977-78*. Basingstoke Palgrave
Macmillan.
- Frank, A. W., & Jones, T. (2003). Bioethics and the later Foucault. *Journal of Medical
Humanities*, 24(3), 179–186. <https://doi.org/10.1023/A:1026014718326>
- Frank, & Danoff. (2007). The CanMEDS initiative: Implementing an outcomes-based
framework of physician competencies. *Medical Teacher.*, 29(7), 642–647.
<https://doi.org/10.1080/01421590701746983>
- Franzen, D., Kost, A., & Knight, C. (2015). Mind the gap: The bumpy transition from
medical school to residency. *Journal of Graduate Medical Education*, 7(4), 678–
680. <https://doi.org/10.4300/JGME-D-15-00413.1>

- Freeman, M. (2013). CHAPTER SEVEN: Meaning Making and Understanding in Focus Groups: Affirming Social and Hermeneutic Dialogue. *Counterpoints (New York, N.Y.)*, 354, 131–148.
- Freidson, E. (1973). *The professions and their prospects*. SAGE Publications.
- Freidson, E. (1975). *Doctoring together: A study of professional social control*. Elsevier.
- Freidson, E. (1984). The changing nature of professional control. *Annual Review of Sociology*, 10, 1–20. <https://doi.org/10.1146/annurev.so.10.080184.000245>
- Freire, P. (1970). *Pedagogy of the oppressed*. Seabury Press.
- Friedman, Z., Hayter, M. A., Everett, T. C., Matava, C. T., Noble, L. M. K., & Bould, M. D. (2015). Power and conflict: The effect of a superior's interpersonal behaviour on trainees' ability to challenge authority during a simulated airway emergency. *Anaesthesia*, 70(10), 1119–1129. <https://doi.org/10.1111/anae.13191>
- Frishman, W. H., & Alpert, J. S. (2019). Medicine as a meritocracy. *The American Journal of Medicine*, 132(4), 401–402. <https://doi.org/10.1016/j.amjmed.2018.10.032>
- Frye, V., Camacho-Rivera, M., Salas-Ramirez, K., Albritton, T., Deen, D., Sohler, N., Barrick, S., & Nunes, J. (2020). Professionalism. *Academic Medicine*, 95(6), 860–863. <https://doi.org/10.1097/ACM.00000000000003266>
- Funston, G. M., & Young, A. M. H. (2012). Action is required to safeguard the future of academic medicine in the UK. *Nature Medicine*, 18(2), 194. <https://doi.org/10.1038/nm0212-194>

- Gale, T., & Lingard, B. (2015). Evoking and provoking Bourdieu in educational research. *Cambridge Journal of Education*, 45(1), 1–8.
<https://doi.org/10.1080/0305764X.2014.998626>
- Gallagher, S., & Little, M. (2017). Doctors on values and advocacy: A qualitative and evaluative Study. *Health Care Analysis; An International Journal of Health Care Philosophy and Policy*, 25(4), 370–385. <https://doi.org/10.1007/s10728-016-0322-6>
- Gaufberg, E. H., Batalden, M., Sands, R., & Bell, S. K. (2010). The hidden curriculum: What can we learn from third-year medical student narrative reflections? *Academic Medicine: Journal of the Association of American Medical Colleges*, 85(11), 1709–1716. <https://doi.org/10.1097/ACM.0b013e3181f57899>
- Geddes, A., Parker, C., & Scott, S. (2018). When the snowball fails to roll and the use of ‘horizontal’ networking in qualitative social research. *International Journal of Social Research Methodology*, 21(3), 347–358.
<https://doi.org/10.1080/13645579.2017.1406219>
- General Medical Council. (2013). *Good medical practice*. <https://www.gmc-uk.org/guidance/index.asp>
- Gergerich, E., Boland, D., & Scott, M. A. (2019). Hierarchies in interprofessional training. *Journal of Interprofessional Care*, 33(5), 528–535.
<https://doi.org/10.1080/13561820.2018.1538110>
- Gieryn, T. F. (1983). Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review*, 48(6), 781–795. <https://doi.org/10.2307/2095325>

- Gillon, R. (2000). Editorial: A personal view: White coat ceremonies for new medical students. *Journal of Medical Ethics*, 26(2), 83–84.
<https://doi.org/10.1136/ewjm.173.3.206>
- Glauser, W. (2018). Why are women still earning less than men in medicine? *Canadian Medical Association Journal (CMAJ)*, 190(21), E664–E665.
<https://doi.org/10.1503/cmaj.109-5576>
- Gleeson, D., & Knights, D. (2006). Challenging dualism: Public professionalism in ‘troubled’ times. *Sociology*, 40(2), 277–295.
<https://doi.org/10.1177/0038038506062033>
- Glenton, C., & Carlsen, B. (2019). When “Normal” Becomes Normative: A Case Study of Researchers’ Quotation Errors When Referring to a Focus Group Sample Size Study. *International Journal of Qualitative Methods*, 18, 160940691984125.
<https://doi.org/10.1177/1609406919841251>
- Gliatto, P., Colbert-Getz, J. M., Bhutiani, M., Cutrer, W. B., Edwards, S., Fleming, A., Keeley, M., Osterberg, L., Pilla, M. A., & Moynahan, K. (2019). Too Many Hats? Conflicts of Interest in Learning Community Faculty Roles. *Journal of Medical Education and Curricular Development*, 6.
<https://doi.org/10.1177/2382120519827890>
- Goddu, A. P., O’Conor, K. J., Lanzkron, S., Saheed, M. O., Saha, S., Peek, M. E., Haywood, C., & Beach, M. C. (2019). Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record (vol 33, pg 685, 2018). *Journal of General Internal Medicine : JGIM*, 34(1), 164–164.
<https://doi.org/10.1007/s11606-018-4583-7>

- Goffman, E. (1959). *The presentation of self in everyday life*. Doubleday.
- Goffman, E. (1961). *Encounters; two studies in the sociology of interaction*. Bobbs-Merrill.
- Goffman, E. (2003). On face-work: An Analysis of ritual elements in social interaction. *Reflections: The SoL Journal*, 4(3), 7–13.
<https://doi.org/10.1162/15241730360580159>
- Gold, R. L. (1958). Roles in sociological field observations. *Social Forces*, 36(3), 217–223. <https://doi.org/10.2307/2573808>
- Goldberg, L. J. (2008). Humanism or professionalism? The white coat ceremony and medical education. *Academic Medicine*, 83(8), 715–722.
<https://doi.org/10.1097/ACM.0b013e31817eba30>
- Goldie, J. (2012). The formation of professional identity in medical students: Considerations for educators. *Medical Teacher*, 34(9), e641–e648.
<https://doi.org/10.3109/0142159X.2012.687476>
- Goldman, J., & Wong, B. M. (2020). Nothing soft about ‘soft skills’: Core competencies in quality improvement and patient safety education and practice. *BMJ Quality & Safety*, 29(8), 619–622. <https://doi.org/10.1136/bmjqs-2019-010512>
- Good, B. (Ed.). (1993). How medicine constructs its objects. In *Medicine, rationality and experience: An anthropological perspective* (pp. 65–87). Cambridge University Press; Cambridge Core. <https://doi.org/10.1017/CBO9780511811029.005>
- Good, B., & Good, M. J. (1993). “Learning medicine”: The constructing of medical knowledge at Harvard medical school. In S. Lidenbaum & M. Lock (Eds.),

- Knowledge, power and practice: The anthropology of medicine and everyday life* (1st ed., Vol. 1–Book, Section, pp. 81–107). University of California Press.
- Goodlad, S. (1994). Introduction. In S. Goodlad (Ed.), *Education for the professions. Quis custodiet...?* (pp. 4–16). SRHE & NFER-Nelson.
- Goodwin, D., Machin, L., & Taylor, A. (2016). The social life of the dead: The role of post-mortem examinations in medical student socialisation. *Social Science & Medicine*, *161*, 100–108. <https://doi.org/10.1016/j.socscimed.2016.05.038>
- Gordon, D. R. (1988). Tenacious assumptions in western medicine. In M. Lock & D. R. Gordon (Eds.), *Biomedicine examined* (Vol. 1–Book, Section, pp. 19–56). Kluwer.
- Gordon, L. J. (2017). Moving beyond being a ‘good doctor’ to thinking about ‘good doctoring processes.’ *Medical Education*, *51*(3), 237–238. <https://doi.org/10.1111/medu.13245>
- Gordon, M. J. (1999). Commentary: Self-assessment skills are essential. *Education for Health*, *12*(2), 167–168.
- Gormley, G. J., Hodges, B., McNaughton, N., & Johnston, J. L. (2016). The show must go on? Patients, props and pedagogy in the theatre of the OSCE. *Medical Education*, *50*(12), 1237–1240. <https://doi.org/10.1111/medu.13016>
- Gormley, G. J., Johnston, J. L., Cullen, K. M., & Corrigan, M. (2020). Scenes, symbols and social roles: Raising the curtain on OSCE performances. *Perspect Med Educ.*, *2212-277X (Electronic)*. <https://doi.org/10.1007/s40037-020-00593-1>

- Gorski, P. (2011). Unlearning deficit ideology and the scornful gaze: Thoughts on authenticating the class discourse in education. *Counterpoints (New York, N.Y.)*, 402, 152–173.
- Green, J., & Thorogood, N. (2014). *Qualitative methods for health research* (3rd ed.). SAGE Publications.
- Greenhalgh, T., Wherton, J., Shaw, S., Papoutsis, C., Vijayaraghavan, S., & Stones, R. (2019). Infrastructure revisited: An ethnographic case study of how health information infrastructure shapes and constrains technological innovation. *J Med Internet Res*, 21(12), e16093. <https://doi.org/10.2196/16093>
- Grenfell, M. (1998). *Bourdieu and education acts of practical theory*. Falmer Press.
- Grenfell, M. (2014). Methodology. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., pp. 213–228). Acumen.
- Groen, J. F., Quigley, B., & Herry, Y. (2016). Examining the use of lecture capture technology: Implications for teaching and learning. *Canadian Journal for the Scholarship of Teaching and Learning*, 7(1). <https://doi.org/10.5206/cjsotl-rcacea.2016.1.8>
- Gunaratnam, Y. (2003). *Researching 'race' and ethnicity: Methods, knowledge and power*. SAGE Publications.
- Gustafson, D. L., & Reitmanova, S. (2010). How are we “doing” cultural diversity? A look across English Canadian undergraduate medical school programmes. *Medical Teacher*, 32(10), 816–823. <https://doi.org/10.3109/01421590903394595>
- Haas, J., & Shaffir, W. (1987). *Becoming Doctors: The Adoption of a Cloak of Competence*. JAI Press.

- Hafferty, F. (1998). Beyond curriculum reform: Confronting medicines hidden curriculum. *Academic Medicine*, 73(4), 403–407.
<https://doi.org/10.1097/00001888-199804000-00013>
- Hafferty, F. (2000). Reconfiguring the sociology of medical education: Emerging topics and pressing issues. In C. Bird, P. Conrad, & A. Fremont (Eds.), *Handbook of Medical Sociology* (5th ed., pp. 238–256). Vanderbilt University Press.
<https://books.google.ca/books?id=DYCayq0Fp2AC>
- Hafferty, F. (2016). Socialization, professionalism and professional identity. In Cruess, Cruess, Steinert (Ed.), *Teaching Medical Professionalism: Supporting the development of a professional identity* (Vol. 1–Book, Section, p. 54).
- Hafferty, F., & Castellani, B. (2009). The hidden curriculum: A theory of medical education. In Brosnan, C. & Turner, B. (Eds.), *Handbook of the sociology of medical education* (pp. 15–35). London: Routledge.
- Hafferty, F., & Franks, R. (1994). The hidden curriculum, ethics teaching, and the structure of medical education. *Academic Medicine*, 69(11), 861–871.
<https://doi.org/10.1097/00001888-199411000-00001>
- Hafferty, F., & Martimianakis, M. (2018). A Rose by Other Names. *Academic Medicine*, 93(4), 526–531.
- Hafferty, F., & O'Donnell, J. (Eds.). (2015). *The Hidden curriculum in health professional education*. University Press of New England.
- Hafferty, F., & Watson, R. T. (2007). The rise of learning communities in medical education: A socio-structural analysis. *Journal of Cancer Education*, 22(1), 6–9.
<https://doi.org/10.1007/BF03174367>

- Hall, L. W., & Zierler, B. K. (2015). Interprofessional education and practice Guide No. 1: Developing faculty to effectively facilitate interprofessional education. *Journal of Interprofessional Care*, 29(1), 3–7.
<https://doi.org/10.3109/13561820.2014.937483>
- Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, 19(sup1), 188–196.
<https://doi.org/10.1080/13561820500081745>
- Hanák, P., Ivanová, K., & Chráska, M. (2019). Analyzing the semantic space of the Hippocratic Oath. *Open Medicine*, 14(1), 683–693. <https://doi.org/10.1515/med-2019-0079>
- Handley, M., Bunn, F., Lynch, J., & Goodman, C. (2020). Using non-participant observation to uncover mechanisms: Insights from a realist evaluation. *Evaluation (London, England. 1995)*, 26(3), 380–393.
<https://doi.org/10.1177/1356389019869036>
- Haque, O. S., & Waytz, A. (2012). Dehumanization in Medicine: Causes, Solutions, and Functions. *Perspectives on Psychological Science*, 7(2), 176–186.
<https://doi.org/10.1177/1745691611429706>
- Harden, R. M. (1999). What is a spiral curriculum? *Medical Teacher*, 21(2), 141–143.
<https://doi.org/10.1080/01421599979752>
- Harding, S. (1993). Rethinking standpoint epistemology: What is “strong objectivity”? In L. Alcoff & E. Potter (Eds.), *Feminist epistemologies* (Vol. 1–Book, Section, pp. 49–82). Routledge.

- Harris, M. J. (2017). It is time to cancel medicine's social contract metaphor. *Academic Medicine*, 92(9), 1236–1240. <https://doi.org/10.1097/ACM.0000000000001566>
- Hartley, H. (2002). The system of alignments challenging physician professional dominance: An elaborated theory of countervailing powers. *Sociology of Health & Illness*, 24(2), 178–207. <https://doi.org/10.1111/1467-9566.00290>
- Hatem, D. S., & Halpin, T. (2019). Becoming doctors: Examining student narratives to understand the process of professional identity formation within a learning community. *Journal of Medical Education and Curricular Development*, 6, 2382120519834546. <https://doi.org/10.1177/2382120519834546>
- Haug. (1988). A re-examination of the hypothesis of physician deprofessionalization. *The Milbank Quarterly*, 66(2), 49. <https://doi.org/10.2307/3349914>
- Haug, M. R. (1973). Deprofessionalization: An alternate hypothesis for the future. *The Sociological Review*, 20(S1), 195–211. <https://doi.org/10.1111/j.1467-954X.1972.tb03217.x>
- Hays, D., & Singh, A. (2012). Understanding the researchers role. In *Qualitative Inquiry in Clinical and Educational Settings* (1st ed., Vol. 1–Book, Section, pp. 137–140). The Guildford Press.
- Hays, R. (2009). Self-directed learning of clinical skills. *Medical Education*, 43(6), 505–506. <https://doi.org/10.1111/j.1365-2923.2009.03378.x>
- Hellawell, D. (2006). Inside- out: Analysis of the insider- outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. *Teaching in Higher Education*, 11(4), 483–494. <https://doi.org/10.1080/13562510600874292>

- Hesse-Biber, S., & Leavy, P. (2004). *Approaches to qualitative research: A reader on theory and practice*. Oxford University Press.
- Hill, E., Bowman, K., Stalmeijer, R., & Hart, J. (2014). You've got to know the rules to play the game: How medical students negotiate the hidden curriculum of surgical careers. *Medical Education*, 48(9), 884–894. <https://doi.org/10.1111/medu.12488>
- Hilton, S., & Southgate, L. (2007). Professionalism in medical education. *Teaching and Teacher Education: An International Journal of Research and Studies*, 23(3), 265–279. <https://doi.org/10.1016/j.tate.2006.12.024>
- Ho, M.-J., Yu, K.-H., Hirsh, D., Huang, T.-S., & Yang, P.-C. (2011). Does one size fit all? Building a framework for medical professionalism. *Academic Medicine*, 86(11), 1407–1414. <https://doi.org/10.1097/ACM.0b013e31823059d1>
- Hochschild, A. R. (2012). *The managed heart commercialization of human feeling*. University of California Press.
- Hodges, B. (2004). Medical student bodies and the pedagogy of self-reflection, self-assessment, and self-regulation. *Journal of Curriculum Theory*, 20(2), 41.
- Hodges, B. (2009). *The Objective Structure Clinical Examination: A socio-history*. Lambert Academic Publishing.
- Hodges, B. (2015). Sea monsters & whirlpools: Navigating between examination and reflection in medical education. *Medical Teacher*, 37(3), 261–266. <https://doi.org/10.3109/0142159X.2014.993601>
- Hodges, B. (2016). Professional identities of the future: Invisible and unconscious or deliberate and reflexive? In R. Cruess, S. Cruess, & Y. Steinert (Eds.), *Teaching*

Medical Professionalism: Supporting the Development of a Professional Identity (2nd ed., Vol. 1–Book, Section, p. 277). Cambridge University Press.

Hodgson, D. (2005). ‘Putting on a professional performance’: Performativity, subversion and project management. *Organization*, 12(1), 51–68.

<https://doi.org/10.1177/1350508405048576>

Hojat, J. M., Vergare, K. M., Maxwell, A. K., Brainard, S. G., Herrine, S. S., Isenberg, S. G., Veloski, S. J., & Gonnella, S. J. (2009). The Devil is in the third Year: A longitudinal study of erosion of empathy in medical school. *Academic Medicine*, 84(9), 1182–1191. <https://doi.org/10.1097/ACM.0b013e3181b17e55>

Holden, M., Buck, E., Clark, M., Szauter, K., & Trumble, J. (2012). Professional identity formation in medical education: The convergence of multiple domains. *HEC Forum; HealthCare Ethics Committee Forum: An Interprofessional Journal on Healthcare Institutions’ Ethical and Legal Issues*, 24(4), 245–255.

<https://doi.org/10.1007/s10730-012-9197-6>

Holden, M., Buck, E., & Luk, J. (2016). Developing and implementing an undergraduate curriculum. In R. Cruess, S. Cruess, & Y. Steinert (Eds.), *Teaching Medical Professionalism* (pp. 231–243). Cambridge.

Hollander, J. A. (2004). The Social Contexts of Focus Groups. *Journal of Contemporary Ethnography*, 33(5), 602–637. <https://doi.org/10.1177/0891241604266988>

Holmes, C. A., & Smyth, W. (2011). Carspecken’s critical methodology—A theoretical assessment. *International Journal of Multiple Research Approaches*, 5(2), 146–154. <https://doi.org/10.5172/mra.2011.5.2.146>

- Hopkins, M., Haidet, P., Wolpaw, D. R., Adams, N. E., & Volpe, R. L. (2019). Is research on professional identity formation biased? Early insights from a scoping review and metasynthesis. *Medical Education*, *53*(2), 119–132.
<https://doi.org/10.1111/medu.13781>
- Hopkins, R., Pratt, D., Bowen, J. L., & Regehr, G. (2015). Integrating Basic Science Without Integrating Basic Scientists: Reconsidering the Place of Individual Teachers in Curriculum Reform. *Academic Medicine*, *90*(2), 149–153.
<https://doi.org/10.1097/ACM.0000000000000437>
- Horner, B. (2002). Critical ethnography, ethics, and work: Rearticulating labor. *JAC: A Journal of Composition Theory*, *22*(3), 561–584.
- Hsiung, P.-C. (2008). Teaching reflexivity in qualitative interviewing. *Teaching Sociology*, *36*(3), 211–226. <https://doi.org/10.1177/0092055X0803600302>
- Hunt, J. B., Bonham, C., & Jones, L. (2011). Understanding the goals of service learning and community-based medical education: A systematic review. *Academic Medicine*, *86*(2), 246–251. <https://doi.org/10.1097/ACM.0b013e3182046481>
- Hyslop-Margison, E., & Rochester, R. (2016). Assessment or surveillance? Panopticism and higher education. *Philosophical Inquiry in Education*, *24*(1), 102–109.
<https://doi.org/10.7202/1070559ar>
- Ikonne, U., Campbell, A. M., Whelihan, K. E., Bay, R. C., & Lewis, J. H. (2018). Exodus from the classroom: Student perceptions, lecture capture technology, and the inception of on-demand preclinical medical education. *The Journal of the American Osteopathic Association*, *118*(12), 813–823.
<https://doi.org/10.7556/jaoa.2018.174>

- Imafuku, R., Kataoka, R., Ogura, H., Suzuki, H., Enokida, M., & Osakabe, K. (2018).
What did first-year students experience during their interprofessional education?
A qualitative analysis of e-portfolios. *Journal of Interprofessional Care*, 32(3),
358. <https://doi.org/10.1080/13561820.2018.1427051>
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Prentice-Hall.
- Jarvis. (2007). *Globalisation, lifelong learning and the learning society: Sociological perspectives*. London; New York: Routledge.
- Jarvis-Selinger, S., MacNeil, K. A., Costello, G. R. L., Lee, K., & Holmes, C. L. (2019).
Understanding professional identity formation in early clerkship. *Academic
Medicine*, 94(10), 1574–1580. <https://doi.org/10.1097/ACM.0000000000002835>
- Jaye, C., & Egan, R. (2006). Communities of clinical practice: Implications for health
professional education. *Focus on Health Professional Education: A Multi-
Disciplinary Journal*, 8(2), 1–10.
<https://doi.org/10.3316/informit.038526705584988>
- Jaye, C., Egan, T., & Parker, S. (2006). “Do as I say, not as I do”: Medical education and
Foucault’s normalizing technologies of self. *Anthropology & Medicine*, 13(2),
141–155. <https://doi.org/10.1080/13648470600738450>
- Jenkins, T. M. (2014). Clothing norms as markers of status in a hospital setting: A
Bourdieuian analysis. *Health*, 18(5), 526–541.
<https://doi.org/10.1177/1363459314524800>
- Johnson, T. J. (1972). *Professions and power*. London, Macmillan.

- Johnson, T. M. (1985). Consultation-liaison psychiatry. In R. A. Hahn & A. D. Gaines (Eds.), *Physicians of western medicine* (pp. 269–292). Reidel D Publishing Company.
- Johnston, J., Lundy, G., McCullough, M., & Gormley, G. (2013). The view from over there: Reframing the OSCE through the experience of standardised patient raters. *Medical Education*, *47*(9), 899–909. <https://doi.org/10.1111/medu.12243>
- Jotterand, F. (2005). The Hippocratic Oath and contemporary medicine: Dialectic between past ideals and present reality? *The Journal of Medicine and Philosophy*, *30*, 107–128. <https://doi.org/10.1080/03605310590907084>
- Joynes, V. (2018). Defining and understanding the relationship between professional identity and interprofessional responsibility: Implications for educating health and social care students. *Advances in Health Sciences Education*, *23*(1), 133–149. <https://doi.org/10.1007/s10459-017-9778-x>
- Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative Health Research*, *19*(11), 1632–1641. <https://doi.org/10.1177/1049732309350879>
- Karimi, Z., Ashktorab, T., Mohammadi, E., & Abedi, H. (2014). Using the hidden curriculum to teach professionalism in nursing students. *Iranian Red Crescent Medical Journal*, *16*(3), 1–7. <https://doi.org/10.5812/ircmj.15532>
- Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power relations in qualitative research. *Qualitative Health Research*, *19*(2), 279–289. <https://doi.org/10.1177/1049732308329306>

- Karnieli-Miller, O., Vu, T. R., Frankel, R. M., Holtman, M. C., Clyman, S. G., Hui, S. L., & Inui, T. S. (2011). Which experiences in the hidden curriculum teach students about professionalism? *Academic Medicine*, *86*(3), 369–377.
<https://doi.org/10.1097/ACM.0b013e3182087d15>
- Kassam, C., Duschinsky, R., Brassett, C., & Barclay, S. (2020). 'Knowing everything and yet nothing about her': Medical students' reflections on their experience of the dissection room. *Medical Humanities*, 403–410. <https://doi.org/10.1136/medhum-2019-011708>
info:doi/10.1136/medhum-2019-011708
- Katz, P. (1999). *The scalpel's edge: The culture of surgeons*. Allyn and Bacon.
- Kaufert, P. (1988). Menopause as process or event. In M. Lock & D. Gordon (Eds.), *Biomedicine Examined* (Vol. 1–Book, Section, pp. 331–349). Kluwer.
- Kaufman, G. (1974). The meaning of shame: Toward a self-affirming identity. *Journal of Counseling Psychology*, *21*(6), 568. <https://doi.org/10.1037/h0037251>
- Kenny, P. N., Mann, V. K., & Macleod, V. H. (2003). Role modeling in physicians' professional formation: Reconsidering an essential but untapped educational strategy. *Academic Medicine*, *78*(12), 1203–1210.
<https://doi.org/10.1097/00001888-200312000-00002>
- Khalili, H., Orchard, C., Laschinger, H. K. S., & Farah, R. (2013). An interprofessional socialization framework for developing an interprofessional identity among health professions students. *Journal of Interprofessional Care*, *2013*, Vol.27; 27(6; 6), 448; 448–453; 453. <https://doi.org/10.3109/13561820.2013.804042>

- Kidd, P. S., & Parshall, M. B. (2000). Getting the focus and the group: Enhancing analytical rigor in focus group research. *Qualitative Health Research, 10*(3), 293–308. <https://doi.org/10.1177/104973200129118453>
- Kirby, S. L. (1989). *Experience research social change: Methods from the margins*. Garamond Press.
- Kirmayer, L. J. (2011). Unpacking the Placebo Response: Insights from Ethnographic Studies of Healing. *The Journal of Mind-Body Regulation, 1*(3), 112–124. <https://doi.org/10.1093/acprof:oso/9780199680702.003.0008>
- Knowles, M. (1975). *Self-directed learning: A guide for learners and teachers*. Association Press.
- Koch, T. (2019). Professionalism: An archaeology. *HEC Forum, 31*(3), 219–232. <https://doi.org/10.1007/s10730-019-09372-w>
- Kost, M. A., & Chen, M. F. (2015). Socrates was not a pimp: Changing the paradigm of questioning in medical education. *Academic Medicine, 90*(1), 20–24. <https://doi.org/10.1097/ACM.0000000000000446>
- Krautscheid, L., Williams, S., Kahn, B., & Adams, K. (2019). Untethered lecture capture: A qualitative investigation of college student experiences. *Journal of Educational Technology Systems, 48*(1), 97–111. <https://doi.org/10.1177/0047239519833690>
- Krieger, N. (1994). Epidemiology and the web of causation: Has anyone seen the spider? *Social Science & Medicine (1982), 39*(7), 887–903. [https://doi.org/10.1016/0277-9536\(94\)90202-X](https://doi.org/10.1016/0277-9536(94)90202-X)

- Kuper, A., & Whitehead, C. (2012). The paradox of interprofessional education: IPE as a mechanism of maintaining physician power? *Journal of Interprofessional Care*, 26(5), 347–349. <https://doi.org/10.3109/13561820.2012.689382>
- Kupfer, A. (2015). Symbolic violence: Education as concealed power. In A. Kupfer (Ed.), *Power and Education: Contexts of Oppression and Opportunity* (pp. 26–40). Palgrave Macmillan UK. https://doi.org/10.1057/9781137415356_3
- Kusnoor, A. V., & Stelljes, L. A. (2016). Interprofessional learning through shadowing: Insights and lessons learned. *Medical Teacher*, 38(12), 1278–1284. <https://doi.org/10.1080/0142159X.2016.1230186>
- LaDonna, K. A., Cowley, L., Touchie, C., LeBlanc, V. R., & Spilg, E. G. (2021). Wrestling With the Invincibility Myth: Exploring Physicians’ Resistance to Wellness and Resilience-Building Interventions. *Academic Medicine: Journal of the Association of American Medical Colleges*. <https://doi.org/10.1097/ACM.0000000000004354>
- Lamb, S., Chow, C., Lindsley, J., Stevenson, A., Roussel, D., Shaffer, K., & Samuelson, W. (2020). Learning from failure: How eliminating required attendance sparked the beginning of a medical school transformation. *Perspectives on Medical Education*, 9(5), 314–317. <https://doi.org/10.1007/s40037-020-00615-y>
- Lang, C. M., McNicholas, D., Wilson, M. P., Hartery, A., Probyn, L. J., & Ward, R. (2020). Canadian radiology medical student interest groups: What they are and how we can help them improve. *Canadian Association of Radiologists Journal*, 084653711988569. <https://doi.org/10.1177/0846537119885690>

- Lareau, A., & Weininger, E. B. (2003). Cultural capital in educational research: A critical assessment. *Theory and Society*, 32(5), 567–606.
<https://doi.org/10.1023/B:RYSO.0000004951.04408.b0>
- Latour, B. (2005). *Reassembling the social an introduction to actor-network-theory*. Oxford University Press.
- Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge University Press.
- Lawson, L., Knudson-Martin, C., Hernandez, B. C., Lough, A., Benesh, S., & Douglas, A. (2017). Student healthcare clinicians' illness narratives: Professional identity development and relational practice. *The American Journal of Family Therapy*, 45(3), 149–162. <https://doi.org/10.1080/01926187.2017.1322926>
- Lazar, Jonathan., Feng, J. Heidi., & Hochheiser, Harry. (2010). *Research methods in human-computer interaction*. Wiley.
- LeFort, S. (2018). *Issues related to intimidation, bullying, harassment and sexual harassment in the Faculty of Medicine, Memorial University: Unit assessment report*. Memorial University.
<https://www.med.mun.ca/Medicine/Leadership/Office-of-the-Dean/FOM-UNIT-ASSESSMENT-2018.aspx>
- Lefroy, J., Yardley, S., Kinston, R., Gay, S., McBain, S., & McKinley, R. (2017). Qualitative research using realist evaluation to explain preparedness for doctors' memorable "firsts." *Medical Education*, 51(10), 1037–1048.
<https://doi.org/10.1111/medu.13370>

- Lehmann, W. (2013). Habitus transformation and hidden injuries: Successful working-class university students. *Sociology of Education*, 87(1), 1–15.
<https://doi.org/10.1177/0038040713498777>
- Lempp, H. (2009). Medical-school culture. In C. Brosnan & B. Turner (Eds.), *Handbook of the sociology of medical education* (pp. 71–88). Routledge.
- Lempp, H., & Seale, C. (2004). The hidden curriculum in undergraduate medical education: Qualitative study of medical students' perceptions of teaching. *British Medical Journal*, 329(7469), 770–773. <https://doi-org.qe2a-proxy.mun.ca/10.1136/bmj.329.7469.770>
- Leopold, S. S., Beadling, L., Gebhardt, M. C., Gioe, T. J., Potter, B. K., Rimnac, C. M., & Wongworawat, M. D. (2014). Editorial: Words Hurt – Avoiding Dehumanizing Language in Orthopaedic Research and Practice. *Clinical Orthopaedics and Related Research*, 472(9), 2561–2563. <https://doi.org/10.1007/s11999-014-3802-8>
- Levinson, W., Ginsburg, S., Hafferty, F. W., & Lucey, C. R. (2014). The hidden curriculum and professionalism. In *Understanding medical professionalism* (1st ed., Vol. 1–Book, Section, pp. 173–187). McGraw-Hill Education.
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. SAGE Publications.
- Lindenbaum, S., & Lock, M. M. (1993). *Knowledge, power, and practice: The anthropology of medicine and everyday life*. University of California Press.
- Lingard, L. (2009). What we see and don't see when we look at "competence": Notes on a god term. *Adv Health Sci Educ Theory Pract.*, 14, 625–628.
<https://doi.org/10.1007/s10459-009-9206-y>

- Lingard, L., Garwood, K., Schryer, C. F., & Spafford, M. M. (2003). A certain art of uncertainty: Case presentation and the development of professional identity. *Social Science & Medicine*, 56(3), 603–616. [https://doi.org/10.1016/S0277-9536\(02\)00057-6](https://doi.org/10.1016/S0277-9536(02)00057-6)
- Lingard, L., Vanstone, M., Durrant, M., Fleming-Carroll, B., Lowe, M., Rashotte, J., Sinclair, L., & Tallett, S. (2012). Conflicting messages: Examining the dynamics of leadership on interprofessional teams. *Academic Medicine*, 87(12), 1762–1767. <https://doi.org/10.1097/ACM.0b013e318271fc82>
- Liu, C.-H., Tang, W.-R., Weng, W.-H., Lin, Y.-H., & Chen, C.-Y. (2016). The process of coping with stress by Taiwanese medical interns: A qualitative study. *BMC Medical Education*, 16(10), 10. <https://doi.org/10.1186/s12909-016-0534-3>
- Lock, M., & Gordon, D. (1988). *Biomedicine examined*. Springer Netherlands.
- Loewy, E. H. (2007). Oaths for physicians – Necessary protection or elaborate hoax? *Medscape General Medicine*, 9(1), 7.
- Lombarts, M. J. (2015). Competence-based education misses the essence of the medical profession. *Perspectives on Medical Education*, 4(6), 326–328. PubMed. <https://doi.org/10.1007/s40037-015-0233-5>
- Lovy, A., Paskhover, B., & Trachtman, H. (2010). Teaching bioethics: The tale of a “soft” science in a hard world. *Teaching and Learning in Medicine*, 22(4), 319–322. <https://doi.org/10.1080/10401334.2010.513196>
- Luke, H. (2003). *Medical education and sociology of medical habitus: “It’s not about the stethoscope!”* Kluwer Academic Publishers.

- MacDougall, H., & Langley, G. R. (n.d.). *Medical ethics: Past, present and future*.
https://scholar.google.ca/scholar?cluster=13486501677897357123&hl=en&as_sdt=0,5
- MacLellan, L., Levett-Jones, T., & Higgins, I. (2016). The enemy within: Power and politics in the transition to nurse practitioner. *NursingPlus Open*, 2, 1–7.
<https://doi.org/10.1016/j.npls.2016.01.003>
- MacLeod, A. (2011). Caring, competence and professional identities in medical education. *Advances in Health Sciences Education*, 16(3), 375–394.
<https://doi.org/10.1007/s10459-010-9269-9>
- MacLeod, A. (2014). The hidden curriculum: Is it time to re-consider the concept? *Medical Teacher*, 36(6), 539–540.
<https://doi.org/10.3109/0142159X.2014.907876>
- MacLeod, A., Luong, V., Cameron, P., Kovacs, G., Patrick, L., Tummons, J., & Kits, O. (2021). When I say...Human. *Medical Education*.
<https://doi.org/10.1111/medu.14537>
- Macneill, P. U. (2011). The arts and medicine: A challenging relationship. *Medical Humanities*, 37(2), 85–90. <https://doi.org/10.1136/medhum-2011-010044>
- Mak-van Der Vossen, M., Peerdeman, S., Kleinveld, J., & Kusurkar, R. (2013). How we designed and implemented teaching, training, and assessment of professional behaviour at VUmc School of Medical Sciences Amsterdam. *Medical Teacher*, 35(9), 709–714. <https://doi.org/10.3109/0142159X.2013.799637>
- Mak-van der Vossen, M., van Mook, W., van der Burgt, S., Kors, J., Ket, J. C. F., Croiset, G., & Kusurkar, R. (2017). Descriptors for unprofessional behaviours of medical

- students: A systematic review and categorisation. *BMC Medical Education*, 17(1), 164. <https://doi.org/10.1186/s12909-017-0997-x>
- Malik, B. H., Krishnaswamy, R., Khan, S., Gupta, D., & Rutkofsky, I. (2019). Are physician associates less-defined force multipliers? Comparative role definition of physician associates within the hierarchy of medical professionals. *Curēus (Palo Alto, CA)*, 11(12), e6469. <https://doi.org/10.7759/cureus.6469>
- Marisette, S., Shuvra, M. M., Sale, J., Rezmovitz, J., Mutasingwa, D., & Maxted, J. (2020). Inconsistent role modeling of professionalism in family medicine residency: Resident perspectives from 2 Ontario sites. *Canadian Family Physician / Medecin de Famille Canadien*, 66(2), e55–e61.
- Maritz, J., & Prinsloo, P. (2019). The (d)(t)oxic lifeworld of early career postgraduate supervisors. *Teaching in Higher Education*, 24(4), 563–577. <https://doi.org/10.1080/13562517.2018.1498075>
- Martimianakis, M. A., & Hafferty, F. W. (2016). Exploring the interstitial space between the ideal and the practised: Humanism and the hidden curriculum of system reform. *Medical Education*, 50(3), 278–280. <https://doi.org/10.1111/medu.12982>
- Martimianakis, M. A., Michalec, B., Lam, J., Cartmill, C., Taylor, J. S., & Hafferty, F. W. (2015). Humanism, the hidden curriculum, and educational reform: A scoping review and thematic analysis. *Academic Medicine*, 90(11), S5–S13. <https://doi.org/10.1097/ACM.0000000000000894>
- Martin, G. P., McKee, L., & Dixon-Woods, M. (2015). Beyond metrics? Utilizing ‘soft intelligence’ for healthcare quality and safety. *Social Science & Medicine (1982)*, 142, 19–26. <https://doi.org/10.1016/j.socscimed.2015.07.027>

- Maton, K. (2012). Habitus. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., Vol. 1–Book, Section, pp. 48–64).
- Mayan, M. (2016). Introduction to qualitative inquiry. In *Essentials of qualitative inquiry* (Vol. 1–Book, Section, pp. 1–21). Routledge.
- Mayer, R. E. (2008). Applying the science of learning: Evidence-based principles for the design of multimedia instruction. *American Psychologist*, *63*(8), 760.
<https://doi.org/10.1037/0003-066X.63.8.760>
- McCullough, M. B., Chou, A. F., Solomon, J. L., Petrakis, B. A., Kim, B., Park, A. M., Benedict, A. J., Hamilton, A. B., & Rose, A. J. (2015). The interplay of contextual elements in implementation: An ethnographic case study. *BMC Health Services Research*, *15*(1), 62. <https://doi.org/10.1186/s12913-015-0713-7>
- McDermid, F., Mannix, J., Jackson, D., Daly, J., & Peters, K. (2018). Factors influencing progress through the liminal phase: A model to assist transition into nurse academic life. *Nurse Education Today*, *61*, 269–272.
<https://doi.org/10.1016/j.nedt.2017.11.038>
- McDermid, F., Peters, K., Jackson, D., & Daly, J. (2014). Conducting qualitative research in the context of pre-existing peer and collegial relationships. *Nurse Researcher*, *21*(5), 28. <https://doi.org/10.7748/nr.21.5.28.e1232>
- McEvoy, J. W., Shatzer, J. H., Desai, S. V., & Wright, S. M. (2019). Questioning style and pimping in clinical education: A quantitative score derived from a survey of internal medicine teaching faculty. *Teaching and Learning in Medicine*, *31*(1), 53–64. <https://doi.org/10.1080/10401334.2018.1481752>

- McGrath, D., Crowley, L., Rao, S., Toomey, M., Hannigan, A., Murphy, L., & Dunne, C. P. (2015). Outcomes of Irish graduate entry medical student engagement with self-directed learning of clinical skills. *BMC Medical Education*, *15*(1), 21. <https://doi.org/10.1186/s12909-015-0301-x>
- McMurtry, A., Rohse, S., & Kilgour, K. N. (2016). Socio-material perspectives on interprofessional team and collaborative learning. *Medical Education*, *50*(2), 169–180. <https://doi.org/10.1111/medu.12833>
- Meah, Y. S., Smith, E. L., & Thomas, D. C. (2009). Student-run health clinic: Novel arena to educate medical students on systems-based practice. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, *76*(4), 344–356. <https://doi.org/10.1002/msj.20128>
- Medical Council of Canada. (n.d.a). *Objectives for the qualifying examination*. <https://mcc.ca/objectives/>
- Medical Council of Canada. (n.d.b). *Vision, mission and strategic goals*. <https://mcc.ca/about/vision-mission-goals/>
- Mehta, N. (2011). Mind-body dualism: A critique from a health perspective. *Mens Sana Monographs*, *9*(1), 202–209. <https://doi.org/10.4103/0973-1229.77436>
- Mercer, J. (2007). The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education*, *33*(1), 1–17. <https://doi.org/10.1080/03054980601094651>
- Mero-Jaffe, I. (2011). ‘Is that what I said?’ Interview transcript approval by participants: An aspect of ethics in qualitative research. *International Journal of Qualitative Methods*, *10*(3), 231–247. <https://doi.org/10.1177/160940691101000304>

- Merriam, S. B. (1988). Types and uses of case study research in education. In *Case study research in education: A qualitative approach* (1st ed., pp. 22–35). Jossey-Bass.
- Merton, R. K. (1972). Insiders and outsiders: A chapter in the sociology of knowledge. *The American Journal of Sociology*, 78(1), 9–47. <https://doi.org/10.1086/225294>
- Merton, R. K., Reader, G., & Kendall, P. L. (1958). The student-physician. *The American Journal of the Medical Sciences*, 235(5), 613. <https://doi.org/10.1097/00000441-195805000-00019>
- Miles, S. (2020). Addressing shame: What role does shame play in the formation of a modern medical professional identity? *BJPsych Bulletin*, 44(1), 1–5. <https://doi.org/10.1192/bjb.2019.49>
- Milne, V., Doig, C., & Dhalla, I. (2015). *Less science, more diversity: How Canadian medical school admissions are changing*. <http://healthydebate.ca/2015/12/topic/canadian-medical-schools-admissions>
- Misselbrook, D. (2013). Foucault. *British Journal of General Practice*, 63(611), 312–312. <https://doi.org/10.3399/bjgp13X668249>
- Mizrachi, N., & Shuval, J. T. (2005). Between formal and enacted policy: Changing the contours of boundaries. *Social Science & Medicine*, 60(7), 1649–1660. <https://doi.org/10.1016/j.socscimed.2004.08.016>
- Monrouxe, L. V. (2010). Identity, identification and medical education: Why should we care? *Medical Education*, 44(1), 40–49. <https://doi.org/10.1111/j.1365-2923.2009.03440.x>
- Monrouxe, L. V. (2016). Insights into the nature and nurture of professional identities. In R. Cruess, S. Cruess, & Y. Steinert (Eds.), *Teaching medical professionalism:*

Supporting the development of a professional identity (2nd ed., Vol. 1–Book, Section, pp. 37–53). Cambridge.

- Monrouxe, L. V., Rees, C. E., Dennis, I., & Wells, S. E. (2015). Professionalism dilemmas, moral distress and the healthcare student: Insights from two online UK-wide questionnaire studies. *BMJ Open*, *5*(5), e007518–e007518. <https://doi.org/10.1136/bmjopen-2014-007518>
- Moore, R. (2012). Capital. In M. Grenfell (Ed.), *Pierre Bourdieu. Key concepts* (2nd ed.). Routledge.
- Morgan, D. (1997). *Focus groups as qualitative research* (2nd ed.). SAGE Publications.
- Morgan, D. (2004). Focus Groups. In *Approaches to qualitative research* (1st ed., Vol. 1–Book, Section, p. 263). Oxford University Press.
- Morgan, H., Skinner, B., Marzano, D., Fitzgerald, J., Curran, D., & Hammoud, M. (2017). Improving the medical school–residency transition. *Clinical Teacher*, *14*(5), 340–343. <https://doi.org/10.1111/tct.12576>
- Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212–1222. <https://doi.org/10.1177/1049732315588501>
- Muddiman, E., Bullock, A. D., Hampton, J. M., Allery, L., Macdonald, J., Webb, K. L., & Pugsley, L. (2019). Disciplinary boundaries and integrating care: Using Q-methodology to understand trainee views on being a good doctor. *BMC Medical Education*, *19*(1), 1–10. <https://doi.org/10.1186/s12909-019-1493-2>
- Murphy, M. (2016). Hiding in plain sight. *Journal of Contemporary Ethnography*, *45*(3), 256–289. <https://doi.org/10.1177/0891241614556345>

- Musselman, L. J., Macrae, H. M., Reznick, R. K., & Lingard, L. A. (2005). 'You learn better under the gun': Intimidation and harassment in surgical education. *Medical Education*, 39(9), 926–934. <https://doi.org/10.1111/j.1365-2929.2005.02247.x>
- Mykhalovskiy, E., & Farrell, K. (2005). "Nothing happens in medical school that prepares you for working with anyone who's different" Informal learning and socio-clinical knowledge amongst family physicians. *Research in the Sociology of Health Care*, 23, 159–181. [https://doi.org/10.1016/S0275-4959\(05\)23008-9](https://doi.org/10.1016/S0275-4959(05)23008-9)
- Naples, J. G., Canfarotta, M., Tabtabai, R., Sparks, D., Parham, K., & Falcone, T. (2019). Otolaryngology interest groups: A potential solution to the residency match crisis. *Laryngoscope Investigative Otolaryngology*, 4(1), 24–29. <https://doi.org/10.1002/lio2.234>
- National household survey 2011: Religion, Newfoundland and Labrador—Community accounts*. (2011). https://nl.communityaccounts.ca/table.asp?_=0bfAjIydpaWrnbSth5-FvKaixaGli73AsJC1yFOnl8fJjZ2XycyVtmA_
- Neale, B. (2016). Crafting qualitative longitudinal research: Design and sampling. In *What is qualitative longitudinal research?* (1st ed., pp. 45–68). Bloomsbury Academic; Bloomsbury Collections. <http://www.bloomsburycollections.com/book/what-is-qualitative-longitudinal-research/ch3-crafting-qualitative-longitudinal-research-design-and-sampling/>
- Nelson, C. A., Frosch, Z., Lapin, J., & Kogan, J. R. (2014). Facilitating the clerkship transition through near-peer-led 'student reports.' *Medical Education*, 48(5), 532–533. <https://doi.org/10.1111/medu.12459>

- Nestel, D., & Kneebone, R. (2010). Perspective: Authentic patient perspectives in simulations for procedural and surgical skills. *Academic Medicine*, 85(5), 889–893. <https://doi.org/10.1097/ACM.0b013e3181d749ac>
- Neufeld, V. R., Maudsley, R. F., Pickering, R. J., Turnbull, J. M., Weston, W. W., Brown, M. G., & Simpson, J. C. (1998). Educating future physicians for Ontario. *Academic Medicine*, 73(11), 1133–1148. <https://doi.org/10.1097/00001888-199811000-00010>
- Neumann, M., Edelhäuser, F., Tauschel, D., Fischer, M. R., Wirtz, M., Woopen, C., Haramati, A., & Scheffer, C. (2011). Empathy decline and its reasons: A systematic review of studies with medical students and residents. *Academic Medicine*, 86(8), 996–1009. <https://doi.org/10.1097/ACM.0b013e318221e615>
- Newfoundland and Labrador Statistics Agency. (2020). *Demographics ethnic origin, 2016 and 2011*. [https://nl.communityaccounts.ca/MapCentre/dynamicmap.asp?_zozLioaVqaKtyLORiqfly6Gdu7asTLKUrYzyZS2icq7lZQ_#data_chart](https://nl.communityaccounts.ca/MapCentre/dynamicmap.asp?_=zozLioaVqaKtyLORiqfly6Gdu7asTLKUrYzyZS2icq7lZQ_#data_chart)
- Ng, S. L., Kinsella, E. A., Friesen, F., & Hodges, B. (2015). Reclaiming a theoretical orientation to reflection in medical education research: A critical narrative review. *Medical Education*, 49(5), 461–475. <https://doi.org/10.1111/medu.12680>
- Nicolson, P. (2003). Reflexivity, “bias” and the in-depth interview: Developing shared meanings. In L. Finlay & B. Gough (Eds.), *Reflexivity. A practical guide for researchers in health and social sciences* (Vol. 1–Book, Section, pp. 133–145).

- Nimmon, L., & Stenfors-Hayes, T. (2016). The “handling” of power in the physician-patient encounter: Perceptions from experienced physicians. *BMC Medical Education, 16*. <https://doi.org/10.1186/s12909-016-0634-0>
- Noble, C., Coombes, I., Shaw, P. N., Nissen, L. M., & Clavarino, A. (2014). Becoming a pharmacist: The role of curriculum in professional identity formation. *Pharmacy Practice (Granada), 12*(1). <https://doi.org/10.4321/S1886-36552014000100007>
- Noordegraaf, M., & Schinkel, W. (2011). Professionalism as symbolic capital: Materials for a Bourdieusian theory of professionalism. *Comparative Sociology, 10*(1), 67–96. <https://doi.org/10.1163/156913310X514083>
- Norander, S., Mazer, J., & Bates, B. (2011). “D.O. or die”: Identity negotiation among osteopathic medical students. *Health Communication, 26*(1), 59–70. <https://doi.org/10.1080/10410236.2011.527622>
- Norman, G., Rangachari, P., Kelton, J., Mandin, H., Sweeney, G., Neville, A., & Roper, M. (2000). The essential role of basic science in medical education: The perspective from psychology. Discussion. *Clinical and Investigative Medicine, 23*, 47–54.
- Numerato, D., Salvatore, D., & Fattore, G. (2012). The impact of management on medical professionalism: A review: The impact of management on medical professionalism. *Sociology of Health & Illness, 34*(4), 626–644. <https://doi.org/10.1111/j.1467-9566.2011.01393.x>
- Nunez-Mulder, L. (2019). Sharp scratch: Shining a light on the hidden medical curriculum. *BMJ, 365*, l2223. <https://doi.org/10.1136/bmj.l2223>

- Office of Student Affairs, Faculty of Medicine, Memorial University. (2018a).
MedCAREERS - Physician shadowing. <https://www.med.mun.ca/Student-Affairs/MedCAREERS/Physician-Shadowing.aspx>
- Office of Student Affairs, Faculty of Medicine, Memorial University. (2018b). *Student interest groups*. <https://www.med.mun.ca/StudentAffairs/Get-Involved.aspx>
- O’Leary, N., Salmon, N., & Clifford, A. (2020). The contribution of theory to an ethnographic case study on interprofessional placements in healthcare education. *International Journal of Social Research Methodology*, 1–14.
<https://doi.org/10.1080/13645579.2020.1756636>
- Olsson, C., Kalén, S., & Ponzer, S. (2019). Sociological analysis of the medical field: Using Bourdieu to understand the processes preceding medical doctors’ specialty choice and the influence of perceived status and other forms of symbolic capital on their choices. *Advances in Health Sciences Education*, 24(3), 443–457.
<https://doi.org/10.1007/s10459-018-09872-3>
- Ong, A. (1988). The production of possession: Spirits and the multinational corporation in Malaysia. *American Ethnologist*, 15(1), 28–42.
<https://doi.org/10.1525/ae.1988.15.1.02a00030>
- Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2009). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods*, 8(3), 1–21.
<https://doi.org/10.1177/160940690900800301>
- O’Reilly, K., & Bone, J. H. (2008). *Key concepts in ethnography*. SAGE Publications.

- Oskvarek, J., Braunstein, S., Farnan, J., Ferguson, M. K., Hahn, O., Henderson, T., Hong, S., Levine, S., Rosenberg, C. A., & Golden, D. W. (2016). Medical student knowledge of oncology and related disciplines: A targeted needs assessment. *Journal of Cancer Education.*, 31(3), 529–532. <https://doi.org/10.1007/s13187-015-0876-2>
- Osterberg, L. G., Goldstein, E., Hatem, D. S., Moynahan, K., & Shochet, R. (2016). Back to the future: What learning communities offer to medical education. *Journal of Medical Education and Curricular Development.*, 3, JMECD.S39420-70. <https://doi.org/10.4137/JMECD.S39420>
info:doi/10.4137/JMECD.S39420
- Pan, H., Norris, J. L., Liang, Y.-S., Li, J.-N., & Ho, M.-J. (2013). Building a professionalism framework for healthcare providers in China: A nominal group technique study. *Medical Teacher*, 2013, Vol.35; 35(10; 10), e1531; e1531–e1536; e1536. <https://doi.org/10.3109/0142159X.2013.802299>
- Paradis, E., & Whitehead, C. R. (2015). Louder than words: Power and conflict in interprofessional education articles, 1954–2013. *Medical Education*, 49(4), 399–407. <https://doi.org/10.1111/medu.12668>
- Park, I. J., Woodrow, K. S., Reznick, M. R., Beales, M. J., & Macrae, M. H. (2010). Observation, reflection, and reinforcement: Surgery faculty members' and residents' Perceptions of how they learned professionalism. *Academic Medicine*, 85(1), 134–139. <https://doi.org/10.1097/ACM.0b013e3181c47b25>
- Paterson, R. (2012). The good doctor: The ideal. In *The good doctor: What patients want* (pp. 1–24). Auckland University Press.

- Pattani, E. R., Ginsburg, E. S., Mascarenhas Johnson, E. A., Moore, E. J., Jassemi, E. S., & Straus, E. S. (2018). Organizational factors contributing to incivility at an academic medical center and systems- based solutions: A qualitative study. *Academic Medicine, 93*(10), 1569–1575.
<https://doi.org/10.1097/ACM.0000000000002310>
- Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3 ed.). SAGE Publications.
- Paul, D., Ewen, S. C., & Jones, R. (2014). Cultural competence in medical education: Aligning the formal, informal and hidden curricula. *Advances in Health Sciences Education, 19*(5), 751–758. <https://doi.org/10.1007/s10459-014-9497-5>
- Pearson, S., Ogden, K., Warnecke, E., & Howes, F. (2017). Research: Why aren't more medical students doing it? *Australasian Medical Journal (Online), 10*(12), 1063–1070. <https://doi.org/10.21767/AMJ.2017.3257>
- Pellegrino. (2002). Professionalism, profession and the virtues of the good physician. *Mount Sinai Journal of Medicine, 69*(6), 378.
- Perakyla, A., & Ruusuvuori, J. (2011). Analyzing talk and text. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., Vol. 1–Book, Section, pp. 529–530).
- Peters, K., & Ryan, M. (2014). Machismo in surgery is harming the specialty. *BMJ, 348*, g3034. <https://doi.org/10.1136/bmj.g3034>
- Phase 3 Management Team. (2018). *Phase 3 management team, October 3, 2018, minutes*. <https://www.med.mun.ca/getattachment/906410cd-6b12-4b8d-9ced-ade0109585ef/Phase-3-Oct-3,-2018.aspx>

- Pitt, M. B., & Hendrickson, M. A. (2019). Eradicating jargon-oblivion—A proposed classification system of medical jargon. *Journal of General Internal Medicine*.
<https://doi.org/10.1007/s11606-019-05526-1>
- Porter, S. (2001). *Critical realist ethnography: The case of racism and professionalism in a medical setting*. <https://doi.org/10.1177/0038038593027004003>
- Potisek, N. M., Fromme, B., & Ryan, M. S. (2019). Transform role modeling into SUPERmodeling. *Pediatrics*, *144*(5), e20192624.
<https://doi.org/10.1542/peds.2019-2624>
- Prentice, R. (2007). Drilling surgeons: The social lessons of embodied surgical learning. *Science, Technology, & Human Values*, *32*(5), 534–553.
<https://doi.org/10.1177/0895904805303201>
- Prentice, R. (2013). *Bodies in formation an ethnography of anatomy and surgery education*. Duke University Press.
- Prideaux, D., Ash, J., & Cottrell, A. (2013). Integrated learning. In K. Walsh (Ed.), *Oxford textbook of medical education* (pp. 63–71). Oxford University Press.
- Prince, K. J. A. H., Boshuizen, H. P. A., Van Der Vleuten, C. P. M., & Scherpbier, A. J. J. A. (2005). Students' opinions about their preparation for clinical practice. *Medical Education*, *39*(7), 704–712. <https://doi.org/10.1111/j.1365-2929.2005.02207.x>
- Rabinow, P., & Sullivan, W. M. (1987). *Interpretive social science: A second look*. Berkeley: University of California Press.

- Racko, G. (2017). Bureaucratization and medical professionals' values: A cross-national analysis. *Social Science & Medicine (1982)*, *180*, 76–84.
<https://doi.org/10.1016/j.socscimed.2017.03.027>
- Rae, J., & Green, B. (2016). Portraying reflexivity in health services research. *Qualitative Health Research*, *26*(11), 1543–1549. <https://doi.org/10.1177/10497323166634046>
- Reardon, C. L., Dottl, S., & Krahn, D. (2013). Psychiatry student interest groups: What they are and what they could be. *Academic Psychiatry*, *37*(3), 175–178.
<https://doi.org/10.1176/appi.ap.11100190>
- Reddy, S. T., Iwaz, J. A., Didwania, A. K., O'Leary, K. J., Anderson, R. A., Humphrey, H. J., Farnan, J. M., Wayne, D. B., & Arora, V. M. (2012). Participation in unprofessional behaviors among hospitalists: A multicenter study. *Journal of Hospital Medicine*, *7*(7), 543–550. <https://doi.org/10.1002/jhm.1946>
- Rees, C., Ajjawi, R., & Monrouxe, L. V. (2013). The construction of power in family medicine bedside teaching: A video observation study. *Medical Education*, *47*(2), 154–165. <https://doi.org/10.1111/medu.12055>
- Rees, C., & Monrouxe, L. V. (2010). Contesting medical hierarchies: Nursing students' narratives as acts of resistance. *Medical Education*, *44*(5), 433–435.
<https://doi.org/10.1111/j.1365-2923.2009.03616.x>
- Rees, C., Sheard, C., & McPherson, A. (2002). Communication skills assessment: The perceptions of medical students at the University of Nottingham: Perceptions of communication skills assessment. *Medical Education*, *36*(9), 868–878.
<https://doi.org/10.1046/j.1365-2923.2002.01300.x>

- Reeves, S, Pelone, F, Harrison, R, Goldman, J., & Zwarenstein, M. (2017).
Interprofessional collaboration to improve professional practice and healthcare
outcomes. *Cochrane Database of Systematic Reviews*, 6.
<https://doi.org/10.1002/14651858.CD000072.pub3>
- Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Hammick, M., & Koppel,
I. (2008). Interprofessional education: Effects on professional practice and health
care outcomes. *The Cochrane Database of Systematic Reviews*, 1, CD002213.
<https://doi.org/10.1002/14651858.CD002213.pub2>
- Regan de Bere, S., & Petersen, A. (2009). Crises or renaissance? A sociology of anatomy
in UK medical education. In C. Brosnan & B. Turner (Eds.), *Handbook of the
Sociology of Medical Education* (pp. 157–173). Routledge.
- Regehr, G., & Eva, K. (2006). Self-assessment, self-direction, and the self-regulating
professional. *Clinical Orthopaedics and Related Research*, 449, 34–38.
<https://doi.org/10.1097/01.blo.0000224027.85732.b2>
- Rehman, S. U., Nietert, P. J., Cope, D. W., & Kilpatrick, A. O. (2005). What to wear
today? Effect of doctor's attire on the trust and confidence of patients. *The
American Journal of Medicine*, 118(11), 1279–1286.
<https://doi.org/10.1016/j.amjmed.2005.04.026>
- Renting, N., Raat, A. N. J., Dornan, T., Wenger-Trayner, E., van der Wal, M. A.,
Borleffs, J. C. C., Gans, R. O. B., & Jaarsma, A. D. C. (2017). Integrated and
implicit: How residents learn CanMEDS roles by participating in practice.
Medical Education, 51(9), 942–952. <https://doi.org/10.1111/medu.13335>

- Ricci, C. (2002). *What to teach? How to teach? Curriculum, ethics, Freire, and the teaching of English*. English Quarterly Canada.
<https://www.proquest.com/docview/233299420?pq-origsite=gscholar&fromopenview=true>
- Rice, T. (2010). 'The hallmark of a doctor': The stethoscope and the making of medical identity. *Journal of Material Culture*, 15(3), 287–301.
<https://doi.org/10.1177/1359183510373985>
- Riles, A. (2006). *Documents: Artifacts of modern knowledge*. University of Michigan Press.
- Ripp, K., & Braun, L. (2017). Race/ethnicity in medical education: An analysis of a question bank for Step 1 of the United States Medical Licensing Examination. *Teaching and Learning in Medicine*, 29(2), 115–122.
<https://doi.org/10.1080/10401334.2016.1268056>
- Rivera, L. A. (2012). Hiring as cultural matching: The case of elite professional service firms. *American Sociological Review*, 77(6), 999–1022.
<https://doi.org/10.1177/0003122412463213>
- Rosenfield, D., Oandasan, I., & Reeves, S. (2011). Perceptions versus reality: A qualitative study of students' expectations and experiences of interprofessional education. *Medical Education*, 45(5), 471–477. <https://doi.org/10.1111/j.1365-2923.2010.03883.x>
- Roth, J. A. (1957). Ritual and magic in the control of contagion. *American Sociological Review*, 22(3), 310–314. <https://doi.org/10.2307/2088472>

- Rothlind, E., Fors, U., Salminen, H., Wändell, P., & Ekblad, S. (2020). The informal curriculum of family medicine – what does it entail and how is it taught to residents? A systematic review. *BMC Family Practice*, *21*(1), 49–10.
<https://doi.org/10.1186/s12875-020-01120-1>
- Roussel, D., Anderson, K., Glasgow, T., & Colbert-Getz, J. M. (2019). Evaluation of a pre-clerkship learning community model for delivering clinical skills curriculum. *Journal of Medical Education and Curricular Development*, *6*.
<https://doi.org/10.1177/2382120519855061>
- Rubin, H., & Rubin, I. (2005). The First Phase of Analysis: Preparing Transcripts and Coding Data. In *Qualitative Interviewing: The Art of Hearing Data* (2nd ed., pp. 201–203). SAGE Publications. <https://doi.org/10.4135/9781452226651>
- Rudland, J. (2013). Small group learning. In K. Walsh (Ed.), *Oxford textbook of medical education* (1st ed., pp. 151–162). Oxford University Press.
- Rutberg, C. P., King, M. B., Gaufberg, M. E., Brett-Maclean, M. P., Dinardo, M. P., & Frankel, M. R. (2017). Do medical students’ narrative representations of “The good doctor” change over time? Comparing humanism essays from a national contest in 1999 and 2013. *Academic Medicine*, *92*(4), 537–543.
<https://doi.org/10.1097/ACM.0000000000001531>
- Sahai, V., Eden, K., & Glustein, S. (2015). Hand hygiene and health care hierarchy by year of medical education. *Education for Health*, *28*(2), 148.
<https://doi.org/10.4103/1357-6283.170120>
- Said, E. W. (1978). *Orientalism* (1st ed.). Pantheon Books.

- Salehi, P. P., Jacobs, D., Suhail-Sindhu, T., Judson, B. L., Azizzadeh, B., & Lee, Y. H. (2020). Consequences of medical hierarchy on medical students, residents, and medical education in Otolaryngology. *Otolaryngology–Head and Neck Surgery*, *163*(5), 906–914. <https://doi.org/10.1177/0194599820926105>
- Scanlon, L. (2011). *“Becoming” a professional. An interdisciplinary analysis of professional learning*. Springer Netherlands: Imprint: Springer.
- Schei, E., Johnsrud, R. E., Mildestvedt, T., Pedersen, R., & Hjørleifsson, S. (2018). Trustingly bewildered. How first-year medical students make sense of their learning experience in a traditional, preclinical curriculum. *Medical Education Online*, *23*(1). <https://doi.org/10.1080/10872981.2018.1500344>
- Schei, E., Knoop, H. S., Gismervik, M. N., Mylopoulos, M., & Boudreau, J. D. (2019). Stretching the comfort zone: Using early clinical contact to influence professional identity formation in medical students. *Journal of Medical Education and Curricular Development*, *6*. <https://doi.org/10.1177/2382120519843875>
- Scheper-Hughes, N., & Lock, M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly (New Series)*, *1*(1), 6–41. <https://doi.org/10.1525/maq.1987.1.1.02a00020>
- Schubert, J. D. (2012). Suffering/symbolic violence. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., pp. 179–194). Routledge.
- Schumacher, K. L., & Meleis, A. L. (1994). Transitions: A central concept in nursing. *Image: The Journal of Nursing Scholarship*, *26*(2), 119–127. <https://doi.org/10.1111/j.1547-5069.1994.tb00929.x>

- Scicluna, H., Grimm, M., Jones, P., Pilotto, L., & McNeil, H. (2014). Improving the transition from medical school to internship—Evaluation of a preparation for internship course. *BMC Medical Education, 14*(1), 23.
<https://doi.org/10.1186/1472-6920-14-23>
- Scott, J. C. (1990). *Domination and the arts of resistance: Hidden transcripts*. Yale University Press.
- Scott, S. (2011). *Total institutions and reinvented identities*. Palgrave Macmillan.
- Shapiro, J., Coulehan, J., Wear, D., & Montello, M. (2009). Medical humanities and their discontents: Definitions, critiques, and implications. *Academic Medicine, 84*(2), 192–198. <https://doi.org/10.1097/acm.0b013e3181938bca>
- Sharma, M. (2018). “Can the patient speak?”: Postcolonialism and patient involvement in undergraduate and postgraduate medical education. *Medical Education*.
<https://doi.org/10.1111/medu.13501>
- Shaw, M. K., Rees, C. E., Andersen, N. B., Black, L. F., & Monrouxe, L. V. (2018). Professionalism lapses and hierarchies: A qualitative analysis of medical students’ narrated acts of resistance. *Social Science & Medicine, 219*, 45–53.
<https://doi.org/10.1016/j.socscimed.2018.10.009>
- Sheehan, D., Jowsey, T., Parwaiz, M., Birch, M., Seaton, P., Shaw, S., Duggan, A., & Wilkinson, T. (2017). Clinical learning environments: Place, artefacts and rhythm. *Medical Education, 51*(10), 1049–1060. <https://doi.org/10.1111/medu.13390>
- Shelton, W. (2013). A new look at medicine and the mind-body problem: Can Dewey’s pragmatism help medicine connect with its mission? *Perspectives in Biology and Medicine, 56*(3), 422–441. <https://doi.org/10.1353/pbm.2013.0030>

- Sherbino, J., Frank, J., Flynn, L., & Snell, L. (2011). “Intrinsic roles” rather than “armour”: Renaming the “non-medical expert roles” of the CanMEDS framework to match their intent. *Theory and Practice, 16*(5), 695–697.
<https://doi.org/10.1007/s10459-011-9318-z>
- Shochet, R., Fleming, A., Keeley, M., Shochet, R., Fleming, A., Wagner, J., Colbert-Getz, J., Bhutiani, M., Moynahan, K., & Keeley, M. (2019). Defining Learning Communities in Undergraduate Medical Education: A National Study. *Journal of Medical Education and Curricular Development, 6*.
<https://doi.org/10.1177/2382120519827911>
- Silverman, D. (2004). *Qualitative research: Theory, method and practice* (2nd ed.). SAGE Publications.
- Simon, A. F., & Aschenbrener, A. C. (2005). Undergraduate medical education accreditation as a driver of lifelong learning. *Journal of Continuing Education in the Health Professions, 25*(3), 157–161. <https://doi.org/10.1002/chp.23>
- Sims, S., Hewitt, G., & Harris, R. (2015). Evidence of a shared purpose, critical reflection, innovation and leadership in interprofessional healthcare teams: A realist synthesis. *Journal of Interprofessional Care, 29*(3), 209–215.
<https://doi.org/10.3109/13561820.2014.941459>
- Sinclair, S. (1997a). Deriving medical dispositions. In *Making Doctors: An institutional apprenticeship* (Vol. 1–Book, Section, pp. 12–38). Berg.
- Sinclair, S. (1997b). *Making doctors: An institutional apprenticeship*. Berg.

- Singer, E., & Cong, Y. (2013). The use and effects of incentives in surveys. *The Annals of the American Academy of Political and Social Science*, 645(1), 112–141.
<https://doi.org/10.1177/0002716212458082>
- Singer, E., & Kulka, R. A. (2001). Paying respondents for survey participation. In M. Ver Ploeg, R. A. Moffitt, & C. F. Citro (Eds.), *Studies of welfare populations: Data collection and research issues* (Vol. 1–Book, Section, pp. 105–128). National Academy Press.
- Skorikov, V. B., & Vondracek, F. W. (2011). Occupational identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (Vol. 1–Book, Section, pp. 693–714). Springer. <https://doi.org/10.1007/978-1-4419-7988-9>
- Small, R., Soriano, R., Chietero, M., Quintana, J., Parkas, V., & Koestler, J. (2008). Easing the transition: Medical students' perceptions of critical skills required for the clerkships. *Education for Health*, 20(2), 192–192.
<https://doi.org/10.1177/112067211002000239>
- Smith, A. C., & Kleinman, S. (1989). Managing emotions in medical school: Students' contacts with the living and the dead. *Social Psychology Quarterly*, 52(1), 56–69.
<https://doi.org/10.2307/2786904>
- Smith, S. D., Dunham, N. L., Dekhtyar, F. M., Dinh, L. A., Lanken, E. P., Moynahan, E. K., Stuber, E. M., & Skochelak, E. S. (2016). Medical Student Perceptions of the Learning Environment: Learning Communities are Associated with a More Positive Learning Environment in a Multi-Institutional Medical School Study.

Academic Medicine, 91(9), 1263–1269.

<https://doi.org/10.1097/ACM.0000000000001214>

Smith, S., Fisher, J., & Goff, I. (2017). MediLex: The medical jargon-busting game. *The Clinical Teacher*, 14(4), 273–278. <https://doi.org/10.1111/tct.12547>

Smith, S., Shochet, R., Keeley, M., Fleming, A., & Moynahan, K. (2014). The growth of learning communities in undergraduate medical education. *Academic Medicine*, 89(6), 928–933. <https://doi.org/10.1097/ACM.0000000000000239>

Sobo, E. J. (2009). *Culture and meaning in health services research: A practical field guide* (Vol. 33). Routledge.

Song, P., & Stewart, R. (2012). Reflective writing in medical education. *Medical Teacher*, 34(11), 955–956. <https://doi.org/10.3109/0142159X.2012.716552>

Southgate, E., Brosnan, C., Lempp, H., Kelly, B., Wright, S., Outram, S., & Bennett, A. (2017). Travels in extreme social mobility: How first-in-family students find their way into and through medical education. *Critical Studies in Education: The Mobility Turn and Education*, 58(2), 242–260.

<https://doi.org/10.1080/17508487.2016.1263223>

Spady, W. G. (2010). *Learning communities 2.0: Educating in the age of empowerment*. Rowman & Littlefield Education.

Spatoula, V., Panagopoulou, E., & Montgomery, A. (2019). Does empathy change during undergraduate medical education? A meta-analysis. *Medical Teacher*, 41(8), 895–904. <https://doi.org/10.1080/0142159X.2019.1584275>

- Stahler, G. J., & Cohen, E. (2000). Using ethnographic methodology in substance abuse treatment outcome research. *Journal of Substance Abuse Treatment, 18*(1), 1–8. [https://doi.org/10.1016/S0740-5472\(99\)00029-X](https://doi.org/10.1016/S0740-5472(99)00029-X)
- Stalmeijer, R. E., McNaughton, N., & Van Mook, W. N. K. A. (2014). Using focus groups in medical education research: AMEE Guide No. 91. *Medical Teacher, 2014, Vol.36; 36*(11; 11), 923; 923–939; 939. <https://doi.org/10.3109/0142159X.2014.917165>
- Starman, A. B. (2013). *The case study as a type of qualitative research*. Journal of Contemporary Educational Studies. https://www.researchgate.net/publication/265682891_The_case_study_as_a_type_of_qualitative_research
- Stenberg, M., Mangrio, E., Bengtsson, M., & Carlson, E. (2021). Formative peer assessment in higher healthcare education programmes: A scoping review. *BMJ Open, 11*(2), e045345–e045345. <https://doi.org/10.1136/bmjopen-2020-045345>
- Stephens, G. C., Rees, C. E., & Lazarus, M. D. (2019). How does Donor Dissection Influence Medical Students’ Perceptions of Ethics? A Cross-Sectional and Longitudinal Qualitative Study. *Anatomical Sciences Education, 12*(4), 332–348. <https://doi.org/10.1002/ase.1877>
- Stergiopoulos, A. E., Fernando, A. O., & Martimianakis, A. M. (2018). “Being on both sides”: Canadian medical students’ experiences with disability, the hidden curriculum, and professional identity construction. *Academic Medicine, 93*(10), 1550–1559. <https://doi.org/10.1097/ACM.0000000000002300>

- Stern, D. T. (1998). In search of the informal curriculum: When and where professional values are taught. *Academic Medicine*, 73(10 Suppl), S28–S30.
- Stone, J. P., Charette, J. H., McPhalen, D. F., & Temple-Oberle, C. (2015). Under the knife: Medical student perceptions of intimidation and mistreatment. *Journal of Surgical Education*, 72(4), 749–753. <https://doi.org/10.1016/j.jsurg.2015.02.003>
- Storesund, A., & McMurray, A. (2009). Quality of practice in an intensive care unit (ICU): A mini-ethnographic case study. *Intensive & Critical Care Nursing*, 25(3), 120–127. <https://doi.org/10.1016/j.iccn.2009.02.001>
- Suelzle, M., & Pasquale, J. (1981). How to record observations: Writing field notes. In L. Borzak (Ed.), *Field study. A sourcebook for experiential learning* (Vol. 1–Book, Section). SAGE Publications.
- Sugand, K., Abrahams P Fau - Khurana, & Khurana, A. (2010). The anatomy of anatomy: A review for its modernization. *Anat Sci Educ.*, 3(2), 83–93. <https://doi.org/10.1002/ase.139>
- Swartz, D. (1997). *Culture & power: The sociology of Pierre Bourdieu*. University of Chicago Press.
- Swenson, J. D., Griswold, W. F., & Kleiber, P. B. (1992). Focus groups. *Small Group Research*, 23(4), 459–474. <https://doi.org/10.1177/1046496492234002>
- Tapper, E. B. (2010). Doctors on display: The evolution of television’s doctors. *Proceedings - Baylor University Medical Center*, 23(4), 393–399. <https://doi.org/10.1080/08998280.2010.11928659>
- Tawney, R. H. (1920). Industry as a profession. In *The acquisitive society* (Vol. 1–Book, Section, p. 91). Harcourt, Brace and World.

- TCPS 2. (2014). *Tri-Council policy statement ethical conduct of research involving humans, 2nd edition*. <http://www.pre.ethics.gc.ca/eng/panel-group/tor-cdr/>
- Tervalon, M., & Murray-García, J. (1998). *Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education*. 9(Generic), 117–125. <https://doi.org/10.1353/hpu.2010.0233>
- Teunissen, P. W., & Westerman, M. (2011). Opportunity or threat: The ambiguity of the consequences of transitions in medical education. *Medical Education*, 45(1), 51–59. <https://doi.org/10.1111/j.1365-2923.2010.03755.x>
- The Royal College of Physicians and Surgeons of Canada. (2014). *The CanMEDS framework*. <http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>
- The Royal College of Physicians and Surgeons of Canada. (2015). *CanMEDS milestones*. <http://canmeds.royalcollege.ca/en/milestones>
- The Royal College of Physicians and Surgeons of Canada. (2018). *Royal College Strategic Plan 2018-2020*. RCPSC. <http://www.royalcollege.ca/rcsite/about/strategic-plan-2018-2020-e>
- The Royal College of Physicians and Surgeons of Canada. (2019). *The maintenance of certification program*. <http://www.royalcollege.ca/rcsite/cpd/cpd-educators-e>
- The Royal College of Physicians and Surgeons of Canada. (n.d.a). *Collaborator*. <http://www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-collaborator-e>
- The Royal College of Physicians and Surgeons of Canada. (n.d.b). *Medical expert*. <http://www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-medical-expert-e>

- The Royal College of Physicians and Surgeons of Canada. (n.d.c). *Professional*.
<http://www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-professional-e>
- The Royal College of Physicians and Surgeons of Canada. (n.d.d). *Scholar*.
<http://www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-scholar-e>
- Thomas, J. (1993). *Doing critical ethnography*. SAGE Publications.
- Thompson, S. (1996). Paying respondents and informants. *Social Research Update*, 14.
- Thomson, P. (2012). Field. In M. Grenfell (Ed.), *Pierre Bourdieu: Key concepts* (2nd ed., Vol. 1–Book, Section, p. 76). Acumen.
- Tisdell, E. J., & Cooper, A. B. (2020). Embodied aspects of learning to be a surgeon. *Medical Teacher*., 1–8. <https://doi.org/10.1080/0142159X.2019.1708289>
- Todhunter, S., Cruess, S. R., Cruess, R. L., Young, M., & Steinert, Y. (2011). Developing and piloting a form for student assessment of faculty professionalism. *Advances in Health Sciences Education*, 16(2), 223–238. <https://doi.org/10.1007/s10459-010-9257-0>
- Tolich, M. (2004). Internal confidentiality: When confidentiality assurances fail relational informants. *Qualitative Sociology*, 27(1), 101–106.
<https://doi.org/10.1023/B:QUAS.0000015546.20441.4a>
- Turner, V. W. (1967). *The forest of symbols: Aspects of Ndembu ritual*. Cornell University Press.
- Ulrich, C. M., Taylor, C., Soeken, K., O'Donnell, P., Farrar, A., Danis, M., & Grady, C. (2010). Everyday ethics: Ethical issues and stress in nursing practice. *Journal of*

Advanced Nursing, 66(11), 2510–2519. <https://doi.org/10.1111/j.1365-2648.2010.05425.x>

Undergraduate Medical Education, Faculty of Medicine, Memorial University. (2013).

Changes to MD program.

<https://www.med.mun.ca/Medicine/CommunicationsNews/NewsMedicine/August-2013/Changes-to-MD-program.aspx>

Undergraduate Medical Education, Faculty of Medicine, Memorial University. (2018a).

Assessment information. <https://www.med.mun.ca/StudentHandbook/Information-for-Learners/Assessment-Information.aspx>

Undergraduate Medical Education, Faculty of Medicine, Memorial University. (2018b).

Diversity, culture and ethics. Faculty of Medicine.

<https://www.med.mun.ca/ugmecurriculum/programview.aspx?ID=2664>

Undergraduate Medical Education, Faculty of Medicine, Memorial University. (2018c).

Phase 2, March 14, 2018. <https://www.med.mun.ca/getattachment/fb730d3b-6e59-4c56-a127-92ac7654379b/Phase-2-minutes-March-14,-2018.aspx>

Undergraduate Medical Education, Faculty of Medicine, Memorial University. (2019).

Undergraduate curriculum map overview.

<https://www.med.mun.ca/ugmecurriculum/>

Underman, K. (2015). Playing doctor: Simulation in medical school as affective practice.

Social Science & Medicine, 136–137, 180–188.

<https://doi.org/10.1016/j.socscimed.2015.05.028>

Uygur, J., Stuart, E., De Paor, M., Wallace, E., Duffy, S., O’Shea, M., Smith, S., &

Pawlikowska, T. (2019). A best evidence in medical education systematic review

to determine the most effective teaching methods that develop reflection in medical students: BEME Guide No. 51. *Medical Teacher*, 41(1), 3–16.
<https://doi.org/10.1080/0142159X.2018.1505037>

van Gennep, A. (1960). *The rites of passage*. University of Chicago Press.

van Gessel, E., Nendaz, M. R., Vermeulen, B., Junod, A., & Vu, N. V. (2003). Development of clinical reasoning from the basic sciences to the clerkships: A longitudinal assessment of medical students' needs and self-perception after a transitional learning unit. *Medical Education*, 37(11), 966–974.
<https://doi.org/10.1046/j.1365-2923.2003.01672.x>

Vanstone, M., & Grierson, L. (2019). Medical student strategies for actively negotiating hierarchy in the clinical environment. *Medical Education*, 53(10), 1013–1024.
<https://doi.org/10.1111/medu.13945>

Veatch, R. M. (2002). White coat ceremonies: A second opinion. *Journal of Medical Ethics*, 28(1), 5. <https://doi.org/10.1136/jme.28.1.5>

Veazey Brooks, J., & Bosk, C. L. (2012). Remaking surgical socialization: Work hour restrictions, rites of passage, and occupational identity. *Social Science & Medicine*, 75(9), 1625–1632. <https://doi.org/10.1016/j.socscimed.2012.07.007>

Vinson, A. H. (2018). Short white coats: Knowledge, identity, and status negotiations of first-year medical students: Short white coats. *Symbolic Interaction*, 42(3), 395–411. <https://doi.org/10.1002/symb.400>

Vinson, A. H. (2019). Surgical identity play: The anatomy lab revisited. *Symbolic Interaction*, 43(3), 452–471. <https://doi.org/10.1002/symb.465>

- Volpe, R. L., Hopkins, M., Van Scoy, L. J., Wolpaw, D. R., & Thompson, B. M. (2019). Does pre-clerkship medical humanities curriculum support professional identity formation? Early insights from a qualitative study. *Medical Science Educator*., 29(2), 515–521. <https://doi.org/10.1007/s40670-018-00682-1>
- Wacquant, L. J. D. (1989). Towards a reflexive sociology: A workshop with Pierre Bourdieu. *Sociological Theory*, 7(1), 26–63. <https://doi.org/10.2307/202061>
- Wagner, P., Hendrich, J., Moseley, G., & Hudson, V. (2007). Defining medical professionalism: A qualitative study. *Medical Education*, 41(3), 288–294. <https://doi.org/10.1111/j.1365-2929.2006.02695.x>
- Wald, H. S., Borkan, J. M., Taylor, J. S., Anthony, D., & Reis, S. P. (2012). Fostering and evaluating reflective capacity in medical education: Developing the REFLECT rubric for assessing reflective writing. *Academic Medicine*, 87(1), 41–50. <https://doi.org/10.1097/ACM.0b013e31823b55fa>
- Wald, H. S., Reis, S. P., Monroe, A. D., & Borkan, J. M. (2010). “The loss of my elderly patient:” Interactive reflective writing to support medical students’ rites of passage. *Medical Teacher*, 32(4), e178–e184. <https://doi.org/10.3109/01421591003657477>
- Wear, D. (1998). On white coats and professional development: The formal and the hidden curricula. *Annals of Internal Medicine*, 129(9), 734–737. <https://doi.org/10.7326/0003-4819-129-9-199811010-00010>
- Wear, D. (2009). The medical humanities: Toward a renewed praxis. *Journal of Medical Humanities*., 30(4), 209–220. <https://doi.org/10.1007/s10912-009-9091-7>

- Wear, D., Kokinova, M., Keck-McNulty, C., & Aultman, J. (2005). Pimping: Perspectives of 4th year medical students. *Teaching and Learning in Medicine*, 17, 184–191. https://doi.org/10.1207/s15328015t1m1702_14
- Wear, D., Zarconi, J., Garden, R., & Jones, T. (2012). Reflection in/and writing: Pedagogy and practice in medical education. *Academic Medicine*, 87(5), 603–609. <https://doi.org/10.1097/ACM.0b013e31824d22e9>
- Weaver, R. M. (1953). *The ethics of rhetoric*. H. Regnery Co.
- Weaver, R., Peters, K., Koch, J., & Wilson, I. (2011). ‘Part of the team’: Professional identity and social exclusivity in medical students. *Medical Education*, 45(12), 1220–1229. <https://doi.org/10.1111/j.1365-2923.2011.04046.x>
- Weinstein, R. S., Brandt, B. F., Gilbert, J. H. V., & Schmitt, M. H. (2013). Bridging the quality chasm: Interprofessional teams to the rescue? *The American Journal of Medicine*, 126(4), 276. <https://doi.org/10.1016/j.amjmed.2012.10.014>
- Westberg, J., & Jason, H. (2001). *Fostering reflection and providing feedback helping others learn from experience*. Springer Pub.
- Westerman, M. (2014). Mind the gap: The transition to hospital consultant. *Perspectives on Medical Education*, 3(3), 219–221. <https://doi.org/10.1007/s40037-013-0104-x>
- Westerman, M., & Teunissen, P. W. (2016). Transitions in medical education. In K. Walsh (Ed.), *Oxford textbook of medical education* (1st ed., pp. 372–383). Oxford University Press.
- White, M., Borges, N., & Geiger, S. (2011). Perceptions of factors contributing to professional identity development and specialty choice: A survey of third- and

- fourth-year medical students. *Annals of Behavioral Science and Medical Education*, 17(1), 18–23. <https://doi.org/10.1007/BF03355144>
- Whitehead, C. (2011). *The good doctor in medical education 1910–2010: A critical discourse analysis* [Doctoral]. University of Toronto.
- Whitehead, C., Austin, Z., & Hodges, B. (2011). Flower power: The armoured expert in the CanMEDS competency framework? *Advances in Health Sciences Education*, 16(5), 681–694. <https://doi.org/10.1007/s10459-011-9277-4>
- Whitehead, C., Hodges, B., & Austin, Z. (2013). Dissecting the doctor: From character to characteristics in North American medical education. *Advances in Health Sciences Education*, 18(4), 687–699. <https://doi.org/10.1007/s10459-012-9409-5>
- Whitehead, C., Selleger, V., Kreeke, J., & Hodges, B. (2014). The ‘missing person’ in roles-based competency models: A historical, cross-national, contrastive case study. *Medical Education*, 48(8), 785–795. <https://doi.org/10.1111/medu.12482>
- Wilkinson, J. T., Wade, B. W., & Knock, D. L. (2009). A blueprint to assess professionalism: Results of a systematic review. *Academic Medicine*, 84(5), 551–558. <https://doi.org/10.1097/ACM.0b013e31819fbaa2>
- Wilson, I., Cowin, L. S., Johnson, M., & Young, H. (2013). Professional identity in medical students: Pedagogical challenges to medical education. *Teaching and Learning in Medicine*, 25(4), 369–373. <https://doi.org/10.1080/10401334.2013.827968>
- Witman, Y. (2014). What do we transfer in case discussions? The hidden curriculum in medicine. *Perspectives on Medical Education*, 3(2), 113. <https://doi.org/10.1007/s40037-013-0101-0>

- Wong, A. (2011). Culture in medical education: Comparing a Thai and a Canadian residency programme. *Medical Education*, 45(12), 1209–1219.
<https://doi.org/10.1111/j.1365-2923.2011.04059.x>
- Wong, A., & Trollope-Kumar, K. (2014). Reflections: An inquiry into medical students' professional identity formation. *Medical Education*, 48(5), 489–501.
<https://doi.org/10.1111/medu.12382>
- Wong, B. O., Blythe, J. A., Batten, J. N., Turner, B. E., Lau, J. N., Hosamani, P., Hanks, W. F., & Magnus, D. (2020). Recognizing the role of language in the hidden curriculum of undergraduate medical education: Implications for equity in medical training. *Academic Medicine*, 9(6), 842–847.
- Wood, N. (2019). Departing from doctor-speak: A perspective on code-switching in the medical setting. *Journal of General Internal Medicine*, 34(3), 464–466.
<https://doi.org/10.1007/s11606-018-4768-0>
- Woods, N. N., Brooks, L. R., & Norman, G. R. (2005). The value of basic science in clinical diagnosis: Creating coherence among signs and symptoms. *Medical Education*, 39(1), 107–112. <https://doi.org/10.1111/j.1365-2929.2004.02036.x>
- World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. World Health Organization.
<https://apps.who.int/iris/handle/10665/70185>
- Wright, S. (2015). Medical school personal statements: A measure of motivation or proxy for cultural privilege? *Advances in Health Sciences Education: Theory and Practice*, 20(3), 627–643. <https://doi.org/10.1007/s10459-014-9550-4>

- Yang, Y., Li, J., Wu, X., Wang, J., Li, W., Zhu, Y., Chen, C., & Lin, H. (2019). Factors influencing subspecialty choice among medical students: A systematic review and meta-analysis. *BMJ Open.*, 9(3), e022097. <https://doi.org/10.1136/bmjopen-2018-022097>
- Yin, R. K. (1981). The case study crisis: Some answers. *Administrative Science Quarterly*, 26(1), 58. <https://doi.org/10.2307/2392599>
- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). SAGE Publications.
- Yin, R. K. (2017). *Case study research and applications: Design and methods*. SAGE Publications. <https://books.google.ca/books?id=6DwmDwAAQBAJ>
- Yin, R. K., & Davis, D. (2007). Adding new dimensions to case study evaluations: The case of evaluating comprehensive reforms. In G. Julnes & D. Rog (Eds.), *Informing federal policies for evaluation methodology*. (Vol. 2007, pp. 75–93). John Wiley & Sons, Ltd. <https://doi.org/10.1002/ev.216>
- Young, A. (1982). The anthropologies of illness and sickness. *Annual Review of Anthropology*, 11(1), 257–285. <https://doi.org/10.1146/annurev.an.11.100182.001353>

Appendix A: Approval Letter



August 7, 2017

ICEHR Number:	20180513-ME
Approval Period:	August 7, 2017 – August 31, 2018
Funding Source:	Not Funded
Responsible Faculty:	Dr. Fern Brunger Faculty of Medicine
Title of Project:	<i>The development of Professional Identity amongst pre-clerkship medical students at Memorial University</i>

Dr. Jinelle Ramlackhansingh
Division of Community Health and Humanities, Faculty of Medicine
Memorial University of Newfoundland

Dear Dr. Ramlackhansingh:

Thank you for your correspondence of August 1, 2017 addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) concerning the above-named research project.

ICEHR has re-examined the proposal with the clarification and revisions submitted, and is satisfied that the concerns raised by the Committee have been adequately addressed. In accordance with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2)*, the project has been granted *full ethics clearance* to August 31, 2018. ICEHR approval applies to the ethical acceptability of the research, as per Article 6.3 of the *TCPS2*. Researchers are responsible for adherence to any other relevant University policies and/or funded or non-funded agreements that maybe associated with the project.

If you need to make changes during the project, which may raise ethical concerns, please submit an amendment request with a description of these changes for the Committee's consideration. In addition, the *TCPS2* requires that you submit an annual update to ICEHR before August 31, 2018. If you plan to continue the project, you need to request renewal of your ethics clearance, and include a brief summary on the progress of your research. When the project no longer involves contact with human participants, is completed and/or terminated, you are required to provide the annual update with a final brief summary, and your file will be closed. Annual updates and amendment requests can be submitted from your Researcher Portal account by clicking the *Applications: Post-Review* link on your Portal homepage.

We wish you success with your research.

Yours sincerely,

[Redacted Signature]
[Redacted Name]
[Redacted Title]
Human Research Ethics in

cc: [Redacted] Supervisor – Dr. Fern Brunger, Division of Community Health and Humanities, Faculty of Medicine

Appendix B: Script Read to Medical Students

Script to read to Class 2021(intended to be conversational style with class)

Good morning/afternoon everyone my name is Jinelle Ramlackhansingh and I am a PhD student Community Health. For my research, I want to talk students about their medical school experiences -how the culture in medical school shapes you.

I am hoping to get volunteers to take part in focus groups. We will talk about what's happening in medical school-your medical school experiences, your curriculum, experiences with your lectures, assignments, the way faculty and administration treat you, getting ready for Monte Carlo -and how all these shapes your professional development.

We will meet once a month over the course of your pre-clerkship i.e Phases 1,2 and 3. A pizza lunch will be provided, and a \$10 Tim's Card will be given to each participant in the focus group i.e every time you come to focus group you will be given a Tim's card and Pizza for lunch. But really what you will get is an opportunity to vent about your experiences both good and bad. This information will be used to try and make the medical school at Memorial University a better place.

Any data will be anonymized and kept confidential. Only myself and my supervisor Dr Fern Brunger, who is a Professor in Community Health will have access to the data. The session will be audiotaped, and any data will be anonymized and kept confidential. You will be free to withdraw/leave at any time during the session however your data will not be destroyed.

This is an opportunity for you to vent over pizza!

I have distributed flyers to everyone here today with my contact information-please contact me if you have any questions/interested in joining the study. Space is limited as I can only accept a maximum of 24 people so don't delay!!! If you want to be in a group with your (a) friend(s) let me know and I will try to accommodate if possible. Space is limited so please contact me as soon as possible!

Also everyone-if you have any concerns with this research that I am doing and your rights as a participant you can contact ICEHR which is part of Health Research Ethics Board in St John's – the contact details are on the flyer that I have passed around.

Thanks!

Appendix C: Recruitment Flyer

**Are you a Medical Student
in the Class of 2021?**

Then you are eligible to participate in exciting research
on

The “hidden” curriculum in pre-clerkship

This is an opportunity to be heard and to shape UGME

Participate in **monthly** focus groups

*What do you think about the medical school environment?
Lectures? The Administration?*

What’s helping you and what’s holding you back?

We will meet for 45 minutes **once a month during** over lunch
hour (pizza provided).

As a thank you for your sharing your experiences
**each participant will receive a \$10 Tim’s Card at each focus
group.**

SPACE IS LIMITED!!!

Please contact Jinelle at

jramlackhans@mun.ca or 709-351-6633

to hear more or be part of this research!

Jinelle Ramlackhansingh, PhD student

Division of Community Health & Humanities

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University’s ethics policy. If you have ethical concerns about the research, such as your rights as a participant, you may contact the Chairperson of the ICEHR at icehr.chair@mun.ca or by telephone at 709-864-2861

Appendix D: Students Focus Group Discussion Guide

1. Introductions, welcome, remind about the purpose of the research project, the session is being audiotaped, data will be anonymized and kept confidential and free to withdraw at any time.
2. Opening questions:
 - a. Open ended questions- like? How has your week/day/month been?
 - b. What has been the good things happening?
 - c. What challenges have you had recently?
3. Transition questions:
 - a. What do you think could have been different?
 - b. What learning did you take away from the experience?
4. Key questions:
 - a. Do you think about the functioning of the medical school?
 - b. Do you think the medical school environment will help you to become a professional doctor?
 - c. What do you think about your lectures?
5. Ending questions and wrap up:
 - a. All things considered if you had to change/alter XXX what would you do?
 - b. So just in summary today we spoke about...Have I missed anything?
 - c. Is there anything else you would like to add that we haven't covered?

Thank you for your time and I shall be in contact with a summary of today's discussion and plans for the next meeting.

Appendix E: Faculty Members Interview Guide

1. Welcome, remind about the purpose of the research project, the session is being audiotaped, data will be anonymized and kept confidential and free to withdraw at any time.
2. Opening questions:
 - a. Open ended questions- like- How has your week/day/month been?
 - b. What has been the good things happening?
 - c. What challenges have you had recently?
3. Transition questions:
 - a. What do you think could have been different?
 - b. What learning did you take away from the experience?
4. Key questions:
 - a. What has been the greatest challenge this semester in the medical school?
 - b. Have there been any successes?
 - c. What do you think about the *Phase 1/2/3* students?
 - d. What do you think of the overall atmosphere in the medical school?
 - e. What do you think could have happened differently this semester/academic year?
5. Ending questions and wrap up:
 - a. All things considered if you had to change/alter XXX what would you do?
 - b. So just in summary today we spoke about...Have I missed anything?
 - c. Is there anything else you would like to add that we haven't covered?

Thank you for your time and I shall be in contact with a summary of today's discussion and plans for next meeting if required.

Appendix F: Administrative Staff Focus Group Guide

1. Introductions, welcome, remind about the purpose of the research project, the session is being audiotaped, data will be anonymized and kept confidential and free to withdraw at any time.
2. Opening questions:
 - a. Open ended questions- like? How has your week/day/month been?
 - b. What has been the good things happening?
 - c. What challenges have you had recently?
3. Transition questions:
 - a. What do you think could have been different?
 - b. What learning did you take away from the experience?
4. Key questions:
 - a. What has been the greatest challenge this semester in the medical school?
 - b. Have there been any successes?
 - c. What do you think about the *Phase 1/2/3* students?
 - d. What do you think of the overall atmosphere in the medical school?
 - e. What do you think could have happened differently this semester/academic year?
5. Ending questions and wrap up:
 - a. All things considered if you had to change/alter XXX what would you do?
 - b. So just in summary today we spoke about.....have I missed anything?
 - c. Is there anything else you would like to add that we haven't covered?

Thank you for your time and I shall be in contact with a summary of today's discussion and plans for next meeting.

Appendix G: Policy and Other Documents Reviewed

American Medical Association:

1. American Medical Association & Council on Ethical Judicial Affairs. (2016). Modernizing the AMA Code of medical ethics.

Canadian Medical Association:

1. Canadian Medical Association. (2018). Addressing gender equity and diversity in Canada's medical profession: A review.
2. Canadian Medical Association. (2018). CMA code of ethics and professionalism.

Canadian Residency Matching Service:

1. Canadian Residency Matching Service. (2020). Algorithm FAQs: Strategy & Best practices.

Faculty of Medicine, Memorial University:

1. Faculty of Medicine, Memorial University. (n.d.). Faculty of Medicine—Admissions-Faculty of Medicine. Retrieved August 12, 2021, from
2. Faculty of Medicine, Memorial University. (2013). Statement of professional attributes.
3. Faculty of Medicine, Memorial University. (2017). Essential skills and abilities required for the study of medicine.
4. Faculty of Medicine, Memorial University. (2017). Self-directed learning. Peer assessment.
5. Faculty of Medicine, Memorial University. (2017). Student code of conduct.
6. Faculty of Medicine, Memorial University. (2018). Attendance guidelines. Student Handbook: An Online Reference Guide.
7. Faculty of Medicine, Memorial University. (2019). About Us—Destination Excellence: 2018-2023—Project teams—Undergraduate curriculum review.
8. Faculty of Medicine, Memorial University. (2019). Professionalism and mistreatment.
9. Faculty of Medicine, Memorial University. (2019). Student handbook: An online reference guide
10. Faculty of Medicine, Memorial University. (2019). The early days of the medical school at Memorial University of Newfoundland.
11. Faculty of Medicine, Memorial University. (2020). Course descriptions.
12. Faculty of Medicine, Memorial University. (2020). Division/Discipline.

General Medical Council (U.K.):

1. General Medical Council. (2013). Good medical practice.

Meeting Minutes:

1. Phase 3 Management Team. (2018). Phase 3 management team, October 3, 2018, minutes.

Office of Student Affairs, Faculty of Medicine, Memorial University:

1. Office of Student Affairs, Faculty of Medicine, Memorial University. (2018a). MedCAREERS - Physician shadowing.
2. Office of Student Affairs, Faculty of Medicine, Memorial University. (2018b). Student interest groups.

The Royal College of Physicians and Surgeons of Canada:

1. The Royal College of Physicians and Surgeons of Canada. (2014). The CanMEDS framework.
2. The Royal College of Physicians and Surgeons of Canada. (2015). CanMEDS milestones.
3. The Royal College of Physicians and Surgeons of Canada. (2018). Royal College Strategic Plan 2018-2020.
4. The Royal College of Physicians and Surgeons of Canada. (2019). The maintenance of certification program.
5. The Royal College of Physicians and Surgeons of Canada. Collaborator.
6. The Royal College of Physicians and Surgeons of Canada. Medical expert.
7. The Royal College of Physicians and Surgeons of Canada. Professional.
8. The Royal College of Physicians and Surgeons of Canada. Scholar.