



THE UNIVERSITY OF QUEENSLAND  
AUSTRALIA

***Unpacking Affective Learning: A Longitudinal,  
Qualitative Study Exploring How Junior Doctors Learn  
To Be Compassionate Through Practice.***

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*A thesis submitted for the degree of Doctor of Philosophy at  
The University of Queensland in 2015  
School of Medicine.*

## **Abstract**

This thesis provides a rich understanding of how junior doctors learn 'to be' compassionate through working in a complex community of practice. Despite compassion being considered a core attribute of a 'good doctor' and the existence of a considerable body of literature addressing the transition of medical students into medical practice - many questions continue to go unanswered. Researchers continue to question how, and why, for many medical students and junior doctors, their humanistic attributes decline as they undertake their studies and engage in practice.

This thesis asked junior doctors how they learned to express compassion in the clinical setting.

Eight medical students elected to participate in this qualitative, longitudinal study. Reflecting the interpretative nature of this exploratory study, narrative was generated from reflective journals and unstructured interviews to interpret meaning from the lived experience of the eight interns as they completed their first year of medical practice.

In interpreting the interns' narratives, answers were sought as to how the junior doctors learned to express compassion. The interns' stories illustrated how they struggled to maintain their compassionate aspirations when confronted with the complexity and competing demands of daily practice. Their emotional distress was not hard to discern, forming a dominant discourse woven throughout their narratives, but more difficult to determine and disentangle from the texts, was how and why their emotional distress came to frame the way in which they provided compassionate care. Emotional vulnerability emerged as the over-riding theme to frame this learning trajectory.

The interns' reflections uncover an untold narrative of how emotional vulnerability underpinned by a fear of failure and imperfection, a search for certainty, and a diminished self-efficacy resulted in risk aversion. This risk aversion triggered the safety ethic of the participating interns resulting in their compassion, a prosocial moral emotion, being replaced for a more reductionist approach where patient care is reified as patient management.

This study provides new insights into medical professional identity, shedding light on what novice doctors bring to medicine, what they aspire to be, and what they fear they will become. The data provides a nuanced exploration of the enabling and inhibiting factors in providing compassionate care as a commodity embedded in practice and provides

scaffolding on which to explore and respond to the shifting culture of medical professionalism and the expression of emotion in a complex community of practice.

Findings from this research provide an original and significant contribution to the research field. This study emphasises novice doctors' relationships with their patients as significant influences on how they provide care. These complex sociocultural issues are previously untold in this context. This study is providing a fresh interpretation of the social dimensions of contemporary medical practice and education. It further legitimises the work of other scholars who have theorised the need for an alternative more inclusive discourse which embraces the imperfections of medicine as a practice and doctors as people.

Responding to the research findings, both educational and clinical practice implications are explored in the context of individual agency and collective practice. Strategies for safe engaged connection, where self-understanding replaces self-criticism and self-compassion is cultivated to guard against contempt and cynicism, are proposed in the recommendations.

## **Declaration by author**

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

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### **Publications during candidature**

Lorna M. Davin and Jill E. Thistlethwaite: (2014) Compassion: Wherefore Art Thou? *International Journal of Practice-based Learning in Health and Social Care* 2(1), 142-146. DOI: 10.11120/pblh.2013.00024

### **Published Abstracts and Conference Presentations**

When you don't like your patient or think they are undeserving – the triaging of compassionate care. Davin L, Thistlethwaite J, Parker M, Eley D, Bartle E. ANZAHPE, Newcastle, NSW, April, 2015

A hell of a way to learn... compassion in practice. Davin L, Thistlethwaite J, Bartle E, Parker M, Eley D. 19th National Pre-Vocational Medical Education Forum, Hunter Valley, NSW. Nov, 2014

'Thrown in the deep end' - graduating University of Queensland students' transition to medical practice. Davin L, Thistlethwaite J, Bartle E, Parker M, Eley D. *ANZAPHE, Gold Coast, June 2014*

Taking medical professionalism seriously: shifting the cultural landscape. Davin L, Thistlethwaite J, Bartle E, Parker M, Eley D. *18th National Pre-Vocational Medical Education Forum, Adelaide, Nov, 2013*

Developing the compassionate practitioner: how do medical students and junior doctors learn to show they care? Davin L, Thistlethwaite J, Bartle E, Parker M, Eley D. *ANZAHPE Rotorua NZ, June 2012*

### **Occasional paper**

To Err On the Side of Coldness – How 4th Year Medical Students Learn to Express Compassion in the Clinical Context. *CMEDRS UQ SOM* Davin L, Thistlethwaite J, Parker M, Eley D, Bartle E, Herston Nov, 2012

**Publications included in this thesis**

No publications included.

### **Contributions by others to the thesis**

**Prof. Jill Thistlethwaite** - provided critical revision and expert guidance in theoretical perspective, methodology and methods throughout the development and completion of the thesis (principal supervisor).

**Dr. Emma Bartle** - provided critical revision throughout writing, during milestone reviews and proofreading of the final draft (co-supervisor).

**Assoc. Prof. Diann Eley** - provided guidance in ethics application, recruitment and critical revision during milestone reviews and final drafts (co-supervisor).

**Prof. Malcolm Parker** – provided guidance in ethics application, recruitment and critical revision during milestone reviews and final drafts (co-supervisor).

**Statement of parts of the thesis submitted to qualify for the award of another degree**

None



## **Acknowledgements**

Anyone who has undertaken a PhD will understand how enormous the commitment, and as with any worthwhile achievement, that the effort is much greater than the sum of one.

To “my” eight interns who generously participated in this study, baring their vulnerability; thank you. Your journal entries have given the narrative a heart and soul. You chose to undertake the study because you cared, and in doing so, you showed both your compassion and your courage – your patients are fortunate indeed.

I wish to thank The School of Medicine at the University of Queensland for supporting my dissertation in a number of ways. The initial scholarship I was awarded provided me with the financial assistance to reduce my work days and apply myself to my research. The supervision of my research has been generous indeed. Thank you to Professor Jill Thistlethwaite for so generously sharing her expertise in qualitative research. For her breadth of knowledge, advocacy and insight as my principal supervisor, and for making herself freely available to provide support to me, regardless of where she was in the world. To Dr Emma Bartle, who dedicated many hours to reading numerous drafts, provided helpful feedback and spent endless days proof-reading the final draft; thank you. Associate Professor Diann Eley and Professor Malcolm Parker, my appreciation to both of you for your support in guiding my way initially, for reviewing my study during my milestone reviews and also for reading much of my final draft.

To my readers, Professor Chris Roberts and Dr Wendy Green, and chair of my milestone committee, Dr Allyson Mutch, my heartfelt thanks for being generous with your time, encouragement and thoughtful feedback. Wendy, your initial input started me on the path of narrative inquiry. Chris, your detailed feedback in my final milestone has added to the scholarship of my thesis. Allyson, thank you for your advocacy and support in your role as Chair of my milestone committee.

My initial interest in compassion was sparked when first working in medical education at John Hunter Hospital in Newcastle, NSW, with Professor Kichu Nair. As we walked between meetings one day, he spoke about the ability to ‘always care if not always cure’. This piqued my interest in the notion of care. Since that time I have worked across an additional six different hospitals, finding treasures of learning and friendship. To my friends at John Hunter, Rankin Park, Royal Children’s, Royal Brisbane and Women’s, The Gold Coast University and King Edward Memorial Hospitals, I thank you for caring, listening, laughing and sharing.

Special thanks to the following, in no particular order, for being there for me (often over time and distance) as friends, colleagues and perfectly imperfect role models: Jennifer White, Louise Jordan, Donna Feeney, Kichu Nair, Elaine White, Louise and David Remilton, Ruth and Alan Peacock, Vicki Gottardo, Suzanne Young (formerly White), Alan Gale, Graham Steel, Christy Noble, Victoria Brazil, Shahina Braganza, Anne Ronan, Rob Yates, MJ and Craig Dalton, Mark Fisher (Sharkey) Ellen Cumberland, Elissa Christie and Louise Slavin.

To my late parents, Thomas Frances Davin (a survivor of Changi Prison and the Burma Railway) and my mother Ursula Mary Davin, your love, compassion and courage lit the way forward for me.

To each of my eight siblings, Maurice, Hugh, Valentine, Elizabeth (Small), Thomas, Rory, Patrick and Veronica (Harrison), I thank you. As the 7th child and first to go to Uni, I am fully aware it is nothing to do with IQ and all to do with opportunity. Thanks to each of you for the support and encouragement you have given to me. Being the middle sister of three 'girls' really is one of the joys of my life, here's to the 'sistahood' Liz and Von. My love and thanks always – the 'girls' rule!

And of course there is New Farm parkrun – a true community (shelter) of practice - which every Saturday morning for a couple of years was a happy escape from my desk, both welcoming and fun. The support of my dear parkrun friends has been immeasurable; I will always be indebted to your kindness.

The conversational (and culinary) delights of my "Brissie" book club also provided me with sustenance for my heart and soul - thanks for forgiving me when I hadn't read the book, but still shared my opinion... So too, our splinter walking group; our Sunday morning chats meant a lot to me. Thank you, Maureen Dewaal, Jolanda Jetten and Cath Haslam.

When I commenced this thesis in 2011, my son Sam was 14 years old, a budding philosopher packaged as a rebellious teenager. To you Sam Davin Dixon thanks for asking me how many words I had to write and calculating how that meant I had to write 136 words a day and reminding me that is quite doable. All this from a child who when asked to write sentences for his homework developed an art-form in writing 3 word sentences with aplomb! You have grown from a school boy to a university student, one who still gives me a hug and laughs kindly at my jokes. A big, loving hug of thanks; I will always hold you dearly in my heart. To his Dad, Chris Dixon, thank you for your encouragement when I first chose this path.

To my dearest and oldest friends, Deanna and Chris Shanahan and Mel and 'Q' Quekett, thank you for listening and being there for me over the last 30 odd years (especially the last year or two), for shared laughter (and tears), atrocious singing and wild dancing - especially in the rain.

My life has taken a very unexpected trajectory over the last two years with death (my mum's), divorce (mine), illness (my son's), and displacement – feeling untethered from all that was meaningful to me. Fortunately for me I reconnected with one particular friend, a dear friend, our friendship spanning 34 years, Ian Whitehouse who has restored my faith in the knowledge that there are good and kind people in the world. His support to me in recent months has been immeasurable, kindness is his greatest attribute alongside his ability to format a lengthy document and resurrect my crashed bibliography ...

When I started this research I had very neat and tidy ideas about what direction I thought the study (and my life) would take. My interns would tell me about role models and turning points and how they learned from the good and the bad. Instead, it has been incredibly messy and complex, but yet simple. A journey where connection and engagement are the currency of value, both for 'my' interns, and for me.

Walt Whitman asks 'what will your verse be'?

This is my verse. My wish being that this study cultivates a safe place and space for doctors to share their stories of vulnerability, to share in our common humanity, perfectly imperfect. For each of us to take a responsibility to start a conversation, asking not just what did you think, but also how did you feel?

NB. On a final post-submission note, I would like to thank my examiners; their generous feedback has extended the scholarship of this thesis enormously and I am most grateful.

I dedicate this thesis to my late Mum,

Ursula Mary Davin (nee Gordon)

7<sup>th</sup> May 1924 – 3<sup>rd</sup> January 2013

A more compassionate soul I have not known.



Our last photo together.

November 2012

**Key words**

compassion, identity, vulnerability, emotion, self-efficacy, safety ethic, common humanity

**Australian and New Zealand Standard Research Classifications (ANZSRC)**

ANZSRC code: 130209, Medicine, Nursing and Health Curriculum and Pedagogy, 100%

**Fields of Research (FoR) Classification**

FoR code: 1303, Specialist Studies in Education 100%

Forget your perfect offering  
There is a crack in everything  
That's how the light gets in.

(Cohen, 1992)

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# LIST OF ABBREVIATIONS

Abbreviation	Full Terminology
ABIM	American Board of Internal Medicine
ACGME	Accreditation Council for Graduate Medical Education
AHPRA	Australian Health Professional Registration Authority
AI	Appreciative Inquiry
AIDS	Acquired Immune Deficiency Syndrome
ANZAHPE	Australian and New Zealand Association for Health Professional Educators
ANZSRC	Australian and New Zealand Standard Research Classifications
CMEDRS	Centre for Medical Education Research and Scholarship
COP	Community of Practice
COPD	Chronic Obstructive Pulmonary Disease
CORD_EM	Council of Emergency Medicine Residency Directors
CPMEC	Confederation of Postgraduate Medical Education Committee
DEM Reg	Department of Emergency Medicine Registrar
DOI	Digital Object Identifier
ED	Emergency Department
FoR	Fields of Research
GP	General Practitioner
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
ID	Identity
IQ	Intelligence Quotient
IV	Intravenous
IVDU	Intravenous Drug User
MCA	Middle Cerebral Artery
MH	Mental Health
NFR	Not For Resuscitation
NSW	New South Wales
NZ	New Zealand
OT	Occupational Therapy (ist)
QCS	Queensland Core Skills
SOM	School of Medicine
SQR	Single Question Reflection
UNE	University of New England (AUST)
UQ	University of Queensland
US	United States

# INTRODUCTION AND BACKGROUND

Even at its scientific best, medicine is always a social act.

(Davidoff, 1996, p. 518)

This introduction begins with a singular reflection of one doctor's experience as a student. This reflection provides the scaffolding to introduce the complexity and depth of the research question posed.

*During medical school we were taught how to break bad news and how to communicate with patients, but the real turning point for me was during a surgical rotation in my final year.*

*I was in theatre, anxiously scrubbing up and trying to do the right thing, when I turned to see the most senior person in the room, a surgeon, holding the patient's hand and stroking her arm, talking, comforting her before she went under.*

*Seeing this had a major impact on me and how I treat my patients. As a consultant I treat all my patients in that way. It takes only a few minutes longer and lets the patient know I care about them.*

*Consultant, 2010 (Royal Brisbane and Women's Hospital)*

This reflection provides a lens into the learning which unfolds when the learner engages in practice, capturing the interplay between, what is taught in the lecture theatre and what is learned in the lived experience of the surgical theatre. The influence of the role model's behaviour, acting as a turning point, is pivotal in shaping the learner's ongoing practice. Key themes identified in the reflection include the learner's feelings, the actions and behaviours of the role model, the nuance of touch, the use of time and talk, the concept of everyday routine practice and the influence of place. While many questions go unanswered about the role model's actions and behaviours and whether he/she was consciously aware of their influence, what is invisible in this reflection is why the student found this specific role model so influential and what preceded this observation. Were they actively seeking a role model, and if so, what characteristics were they seeking? If not, then why did this observation become such a turning point for them? Most importantly, how did

they translate their observations into their own practice? Was it a case of trial and error? Did the individual patient, peers, or specific place influence this process and if so, how? How were touch, talk, listening and silence used? This is the substance of this study – how do learners accept or reject the values and attitudes they observe in the clinical setting framed by specific social and cultural norms? How do they interpret meaning from the sociocultural context of their lived experience of people, place and events, and how do they then translate that meaning into practice in the clinical context?

A considerable body of literature has been built around the socialisation of medical students and junior doctors into the culture of medicine. A continuous theme throughout the literature reflecting this professional acculturation is the interplay between the various curricula: the perceived disconnect between the formal, informal, hidden and the null curricula (Hafferty and Hafler, 2011), (Hundert, Hafferty and Christakis, 1996), (Karnieli-Miller et al., 2010), (Shapiro et al., 2009), (Wear and Castellani, 2000).

Research continues to highlight the contradictions inherent in how the medical curriculum is framed with 'explicit commitment to traditional values of doctoring – empathy, compassion and altruism among them – and a tacit commitment to behaviours grounded in an ethic of detachment, self-interest and objectivity' (Coulehan and Williams, 2001, p. 598).

Novice doctors are greatly influenced by the culture of medicine and the implied messages conveyed through, role models, expectations, informal conversations, overt behaviours, and social norms. The doctors construct meaning from those influences which may then influence their future practice (Kumagai, 2008). The following literature review illuminates understanding of these issues to-date and unearths the continuing gaps in the research, thereby informing our understanding of affective learning in the context of the expression of compassionate care.

(This literature review chapter has not been updated since completing the interpretation of findings. It demonstrates the starting point with the study and reflects how the interns' narrative took the study in a very different direction. More recent sources are embedded in the thematic analysis, discussion, interpretation of findings and recommendations.)

## 2 LITERATURE REVIEW

### 2.1 A HISTORICAL CONTEXT

In researching the historical roots of professionalism, Arnold and Stern (2006, p. 16) conclude that the 'core values of professionalism derive from the universality of disease and begin with caring or compassion'. To understand the role of compassionate care in the context of patient care I begin by locating the concept of compassion in the broader literature on humanism and professionalism, laying the foundations for our understanding of the teaching and learning of attitudes and values, and the expression of emotion in practice.

Today, across the western world, the relationship between the doctor and the patient as a social contract is being dramatically questioned and transformed (Cruess and Cruess, 2008). There is a growing disenchantment with medicine. An increasing emphasis on cost efficiencies leads to a negative impact on the continuity of care and growth in the 'anonymous consultant'. Patients are becoming increasingly dissatisfied and turning to alternative, predominately unscientific treatment paths (Taylor, 1997). This transformation is driven, in part, by a diminished trust in the medical profession (Smith, 1998). Media headlines and major legal cases alert the community to the need to be cautious in choosing their healthcare provider. This has resulted in a changed, and at times, fractured relationship between doctor and patient. Concerns have contributed towards the re-framing of the notion of medical professionalism, stimulating a whole new area of medical education scholarship (Arnold, 2002) (Arnold and Stern, 2006) (Borrero et al., 2008) (Branch, 1998) (Branch, 2010) (Cohen, 2007) (Coulehan and Williams, 2001) (Coulehan and Williams, 2003) (Cruess, Cruess and Steinert, 2008) (Goldberg, 2008) (Jha et al., 2007) (Kenny, Mann and MacLeod, 2003) (Klein et al., 2003) (Larkin et al., 2002) (Lynch, Surdyk and Eiser, 2004) (Markakis et al., 2000) (McLachlan, 2010) (Misch, 2002) (Rabow, Wrubel and Remen, 2007) (Rabow, Wrubel and Remen, 2009) (Rademacher, Simpson and Marcdante, 2010) (Rowley et al., 2000) (Stupans, Scutter and Sawyer, 2011) (Swick, 2000) (Wagner et al., 2007).

Until the 1970s, the concept of professionalism in medical education was in its infancy. Interest was limited to the non-cognitive attributes of the medical school applicant, student and graduate rather than an understanding of how these attributes influenced professional practice (Arnold, 2002). However, the early 1980s witnessed the start of major change. The American Board of Internal Medicine (ABIM) initiated its Humanism Project, influencing medical education across the western world. The Board defined humanism as 'an entity consisting of respect, compassion and integrity', (Arnold, 2002, p. 502) and recommended it as a topic in undergraduate medical humanities education. The terminology itself stimulates debate. The terms professionalism and humanism are at times used synonymously (Cohen, 2007). However, Cohen highlights the difference by suggesting 'professionalism... is a way of acting' while 'humanism, by contrast is a way of being', as 'humanism provides the passion that animates authentic professionalism' (Cohen, 2007, p. 1029). While professionalism can imply a distance between the doctor and patient, humanism, according to Ludwig (2011, p. 98), is about 'stressing not the distinction of being professional but the sameness of being another member of the human family'. The term 'humanistic medicine', was developed to remind clinicians of their need to provide compassionate, empathetic care (Little, 2002). However, Little (2002) suggests the term 'values-based medicine' is a more appropriate term as it encompasses the breadth of values that underpin the nature of health care and is inclusive of the scientific paradigms within medicine. Patient centred care, identified by the Institute of Medicine, as one of six goals shaping the US health system in the 21<sup>st</sup> century (Lown, Rosen and Marttila, 2011), is another phrase used to capture the essence of medical care as 'intervention with a sense of compassion' (Stevenson, 2002, p. 1106). Taylor (1997, p. 521) discusses the discomfort one has in discussing compassion in a scientific context with no objective measure, suggesting, the 'nearest surrogate is the soulless "continuity of care"'. According to Lown (2011, p. 1172), 'medical care without compassion cannot be truly patient-centred'. Kumangai (2008) refers to medicine being, at its core, a form of applied humanism that is science, embedded in the recognition of human values and in the service of human needs.

The Humanism Project led to 'Project Professionalism' in the mid 1990s and to the plethora of teaching and learning initiatives which formally placed professionalism in the curriculum (Bonic, 2004) (Branch et al., 2001) (Branch et al., 2009) (Cohen, 2007) (Demehri, 2011) (Dornan, 2014) (Fishbein, 1999) (Goldberg, 2008) (Gracey et al., 2005) (Hart, 2011) (Hartzband and Groopman, 2009) (King, 1970) (Kumagai, 2008) (Logio et al., 2011) (Maheux et al., 2000) (Marcus, 1999) (Markakis et al., 2000) (Misch, 2002) (Moyer et al., 2010) (Packer et al., 2008) (Pellegrino, 1974) (Rizzolo, 2002) (Swick, 2007) (Wasserstein, 2007) (Wear and Castellani, 2000) (Wilson, 2004). These learning initiatives have become bound together with the range of attempts by regulating bodies, individuals and professional organisations to codify the professional values, aspirations and societal commitments of the medical profession. Ceremonies, contracts and codes of conduct (Rabow, Wrubel and Remen, 2009) have been developed and implemented. Attempts at measuring and assessing professional qualities and the effectiveness of the teaching initiatives (Markakis et al., 2000) in the belief that 'professionalism must be taught' (Cruess and Cruess, 2007, p. 1674) and therefore assessed, have challenged medical educators.

In 2007, the American Medical Association identified gaps in the delivery of medical education, and developed ten key recommendations for positive change. The seventh recommendation attends to the learning environment focusing on the development of appropriate attitudes, behaviours and values, as well as knowledge and skills (Papadimos and Murray, 2008), emphasising the increasing need for medical education and practice to reach beyond the confines of the bioscientific constraints of medicine.

This continuing shift in emphasis has placed teaching and learning of attitudes and values firmly on the agenda; recognising that the doctor patient relationship is too often perceived as the disposable 'wrapping on the box' containing clinical knowledge (Wear and Castellani, 2000).

Australian undergraduate and postgraduate medical curricula have been heavily influenced by the North American emphasis on professionalism and humanism. Guidelines such as CanMEDS 2000 have been adopted by many colleges (Paltridge, 2006), and problem based learning has buttressed patient



centred teaching. The Australian Curriculum Framework for Junior Doctors, within the context of communication skills for breaking bad news, identifies 'shows empathy and compassion', as a desired learning outcome for junior doctors undertaking their first two years of prevocational training (CPMEC, 2006). Despite the rich and textured place humanism holds, historically embedded within medical practice and medical professionalism as 'an enduring ideal of mainstream Western medicine' (Rabow, Wrubel and Remen, 2007, p. 1422), in the context of medical education, we need to develop a more in-depth understanding of how humanism unfolds through clinical practice and how compassionate care manifests in the clinical setting.

## 2.2 COMPASSIONATE CARE IN CONTEXT

This study is specifically exploring the nature of compassionate care, a core concept which weaves its way through medical and nursing literature on professionalism and humanism (Back et al., 2009) (Bonic, 2004) (Burnell, 2009) (Cooney, 2005) (Dewar, Pullin and Tocheris, 2011) (Gelhaus, 2012) (LeBaron, 2004) (Lown, Rosen and Marttila, 2011) (Marcum, 2011) (McClenon, 1996) (Redelmeier, Molin and Tibshirani, 1995) (Van Der Cingel, 2009) (Wiggins, Coker and Hicks, 2009) (Wilson, 2004).

Compassionate care, 'not being the stuff of law' or mandatory codes of conduct (Paterson, 2010), escapes formal regulation within practice guidelines. Despite being considered a core competency of professionalism and an essential attribute of the caring, competent physician (The Lancet, 2007), the underlying emotion of compassion, as expressed through compassionate care, is not easily articulated and defies easy definition. A simple gesture like a smile, a reassuring look, a touch of the hand, or a silence, may all represent the complex processes that frame 'compassionate care' (Dewar, Pullin and Tocheris, 2011). Lown et al (2011, p. 1172), embedding compassionate care within the individual patient's context and perspective, suggest compassionate care, 'lies at the intersection' of empathy (understanding) and sympathy (feeling), identifying and responding to the distress of others and having a desire to alleviate (acting) that distress. Central to Lown et al's (2011, p. 1172) definition of compassionate care is the

'patient's innate need for connections and relationships' and the care providers 'desire to understand the patient's context and perspective'. For the purpose of this study, I define compassion as, the ability to recognise the patient is suffering, embodying the human connection, and embracing the willingness to act on it through the provision of compassionate care; as an act of showing you care. The affective learning process which underpins this expression of compassionate care is the focus of this research.

Intertwined with our understanding of compassion is the notion of care. Like compassion, care is a complex construct which cannot be easily defined by reducing it down to a 'classification of actions' (Phillips, 1993). Derived from the Latin *cura*, which means 'attitude of care, devotion for a loved one or object' and relating to concern and commitment to other', the word care has multiple meanings (Boff, 2008, p. 58). In the healthcare context, Reich (1995) describes care as having two principal meanings: technical care, which describes taking care of the sick person without emotional engagement and which is reliant on the carer's technical competence, as distinct from taking care for, or about, the sick person, which encompasses an emotional engagement. Common to this definition, are the moral values which underpin humanistic care (Reich, 1995) and which are reflected in the concepts of concern, compassion and interest in another human being (Leininger, 1988). Donabedian (1979), defines patient care through two components: the technical and interpersonal. Boorse (1975) separates disease from illness by distinguishing between, the disease as the needs of the physical condition, and illness being the patient's subjective response to the disease. The notion of care that this thesis addresses, is the interpersonal care provided by the doctor to the patient in response to their illness.

According to Gelhaus (2012, p. 132), 'compassionate care as an attitude is exactly compassion... to care about, is to be compassionate with... caring is not defined by feeling and wanting, it is essentially also doing'. I will use the words compassion, compassionate care and care interchangeably, but ultimately the definition of compassionate care, as a social construct, will be defined by each of the research participants in their own words and interpreted through their own experiences and behaviours.

An anonymous editorial in the Lancet (2007, p. 630), laments that, 'although compassion is often cited as one of the core values of professionalism, there remains a continuous and inconclusive debate about whether compassion is innate or whether it can be taught?' Pence (1983), Wear and Zarconi (2008) and Johnson (2008) all, at times, consider this question in their research. In exploring the question 'can you teach students to care?', Treadway and Chatterjee (2011) suggest we are asking the wrong question. They contend that most students come to medicine caring, but through neglect and silence, they are taught not to care. They conclude that the focus of medical education and training should be on the 'how' of caring.

The Lancet (2007, p. 630) editorial concludes 'to make care more than a manufactured product there also needs to be compassion – the ability to feel for someone in trouble'.

### 2.2.1 TOUCH

In clarifying the construct of professionalism, the Accreditation Council for Graduate Medical Education (ACGME) stated that the resident must demonstrate compassion. Acknowledging the subjective nature of this statement, The Council of Emergency Medicine Residency Directors (CORD) facilitated a collaborative process defining actual behaviours which could underpin this aspect of professionalism, for example, 'uses touch appropriately to reassure patient' (Larkin et al., 2002, p. 1250).

Touch is a nuanced behaviour, involving a 'blending of attention, compassion, and skill' (Leder and Krucoff, 2007, p. 321) with different strategies being required by different patients. Nursing journals have a wealth of literature on the nuance of touch in the caring context, which is notably absent from medical education literature. In the context of nursing, caring touch is defined as a form of non-verbal communication, (Estabrooks and Morse, 1992), as a positive affective touch (Fredriksson, 1999), and as expressive touch or non-procedural forms of touch (Morales, 1994) representing a crucial aspect of the act of caring. This type of care creates a connection with the patient and recognition of the patient as an individual (Morales, 1994) (Tommasini, 1990).

Being perceived as too close to your patient inhibits the way in which doctors use touch, as captured in the following quote:

*What's the most common complaint about their doctors? "He doesn't talk to me" only followed by "he doesn't touch me". You get accused of being too close to your patients, that it affects your objectivity. Well nobody has to be taught how to keep their distance from another human being. That comes naturally, we all know how to do that. What you have to be taught is how to get close to somebody else, and most doctors are unbelievably terrible at that.*

*(Meldrum, 2011, p. 156)*

Effective communication in the use of touch is paramount since, what is communicated by the doctor and what is interpreted by the patient, can be open to misinterpretation (Fredriksson, 1999). A focus of the medical education literature is on maintaining appropriate touch but there is a corresponding paucity of research providing medical students and junior doctors with ways in which to use touch as a way for creating a personal connection with the patient.

A surgeon describing his original attraction to his role states:

*You have to touch your patients... change their dressings, look at their wounds. You can't just stand there and talk to them, you have to physically have an interaction as well as an emotional interaction...*

*(Meldrum, 2011, p. 156)*

We do not know how medical students or junior doctors learn to use touch, except to create professional boundaries when undertaking a physical examination of a patient, and yet touch is a cornerstone of compassionate care.

## 2.2.2 TIME TO LISTEN, TIME FOR SILENCE

Lack of time is perceived as a major obstacle in the delivery of compassionate care. A recent observational study in a 1700 bed academic teaching hospital in Germany investigated how physicians spend their time, determining how much is spent in patient and/or family communication and how much allocated to other specific tasks. The study concluded each physician had 4 minutes and

17 seconds available per day for each patient and just 20 seconds for the patient's relatives (Becker et al., 2010).

In 2008, an observational time and motion study in a Sydney hospital found similar time constraints with interns spending almost double the time on documentation than they did engaged in patient care (Westbrook et al., 2008). On average, doctors are interrupted in their work every 21 minutes (Westbrook et al., 2008).

Time demands, in tandem with reduced working hours, fatigue and legislation, limit the number of hours spent in the clinical setting. However, research suggests that patients, if not listened to, will retell their stories until they feel they are being heard, resulting in an inefficient use of resources (Platt and Platt, 1998).

We know from a study undertaken by Beckman and Frankel (1984), that within a mean interval of 18 seconds of a patient's opening statement, a doctor will interrupt the patient. However, we also know that patients would feel listened to if they were allowed to speak uninterrupted for one minute, talking for no more than three minutes on average (Beckman and Frankel, 1984). Listening is captured within the literature on compassion and caring as a crucial attribute for a doctor to connect with their patient, as illustrated within the quotes below:

*Listening can be the first step to connect with a patient... or to enter the world of the patient... simply hearing is not enough to achieve a connection*

*(Fredriksson, 1999, p. 1173).*

*I've learned to that to sit in there and listen to people is many ways more healing than the things I can do with a knife... one of the reasons I really liked surgery when I first started.*

*Surgeon (Meldrum, 2011, p. 156)*

The complexity of compassionate care is highly nuanced. Silence itself may be a compassionate act. Back and colleagues (2009) define a typology of silence, both the awkward silence and invitational silence being more familiar than what they describe as the compassionate silence. They describe the

compassionate silence as an active, intentional silence which enables empathy and compassion, providing the patient with 'a profound kind of being with, standing with, and contact in a difficult moment' (Back et al., 2009, p. 1114).

### 2.2.3 PLACE

Place also influences the expression of compassion. Shedding light on the transfer of learning across specific environments, research within the environmental psychology of the emotions suggests physical surroundings have an effect on cognitive interpretation (McLeod, 1997). In exploring the consequences of the influence of environment on affect, McLeod suggests 'it is easier to become angry in a bar than a church, to be frightened at night than during the day, to be jovial at a party than in a classroom' (1997, p. 39). The research suggests that the expression of emotion is not shaped just by cultural and social norms and expectations, but also the particular social settings in which the expression of emotion is situated. So, how does this translate into the expression of compassionate care in the medical context?

Compassionate, humanistic care is often framed in terms of specific patient group needs and clinical contexts. Palliative and aged care is frequently seen as an appropriate setting for compassionate care but it can just as easily be marginalised in other clinical contexts. However, Lown's research suggests both physicians and patients desire compassionate care across the spectrum of care, 'compassion is as important in helping patients manage chronic and acute conditions as it is at the end of life' (Lown, Rosen and Marttila, 2011, p. 1772).

A study undertaken by O'Reilly (2003) and his emergency care colleagues attests to the viability of compassionate care in all caring contexts. In their thought provoking narrative of Harry the Hobo, O'Reilly (2003) and colleagues demonstrate the commitment to kindness and compassion as core elements of care. Despite all the pressures placed on staff in a busy clinical environment and the constraints, fiscal and fatigue related, core to the care provided is the belief that 'the service that is being provided is one of human kindness and compassion – the basis of a civilised society. This human aspect of medical

care should be acknowledged and celebrated, rather than measured' (O'Reilly, Mori and Cameron , 2003, p. 650).

There is also research evidence for the role of compassion in the Emergency Department. In one of the few randomised control trials researching compassionate care, Rendemeier (1995) randomised homeless patients, who were regular visitors to a Canadian emergency room into two groups, one receiving standard care and the other receiving compassionate care provided by volunteers. The study tracked the participants over five years. Surprisingly, those that received compassionate care (represented in this study as providing comfort through the provision of food and individual attention) had a reduced number of return visits. These studies support the conviction that 'Compassionate care is more than just good ethical behaviour. It is good medicine' (Epstein, 2000, p. 208).

To better understand the 'how' of compassionate care, we need to better understand affective learning.

## 2.2.4 THE INFLUENCE OF THE CLINICAL ROLE MODEL

When I ask an educated person, what is the most significant experience in your education?  
I almost never get back an idea, but almost always a person.

(Tosteson, 1979, p. 693).

The power of the role model in acculturating students and junior doctors to their construction of meaning is not to be underestimated. Role modelling continues to be the primary method by which clinical supervisors teach and junior medical students and staff learn to practice the humanistic elements of care (Cruess, Cruess and Steinert, 2008) (Curry, Cortland and Graham, 2011) (Karnieli-Miller et al., 2010) (Kenny, Mann and MacLeod, 2003) (Paice, Heard and Moss, 2002).

The mantra, 'see one, do one, teach one' is not only unique to the acquisition of clinical skills but also a powerful determinant in learning what is acceptable, professional behaviour (Wearn et al., 2010). Historically, students and novice

doctors have both consciously, and unconsciously, patterned their behaviour on practitioners whom they hold in high esteem and trust, senior colleagues respected for their ways of being and acting as professionals (Cruess, Cruess and Steinert, 2008).

Within the clinical environment, acquiring the 'know how' to behave appropriately and professionally has always been considered a strength of the learning acquired through observing positive role models (Kenny et al., 2003). Despite time constraints, the increasing number of students and interns, the diminishing number of clinical supervisors and the tensions between teaching and service delivery, the underlying assumption is that we embed our students and novice doctors in clinical settings in order for them to immerse themselves in learning to become 'competent, caring physicians', and to learn from 'competent caring physicians' (Wear and Zarconi, 2008, p. 948).

Abraham Flexner (1912) wrote an influential report reforming the delivery medical education in the early 20<sup>th</sup> century. The report initiated a dramatic shift in the nature of medical education with the existing, unregulated apprenticeship model replaced by a science-based university education and subsequent internship (Kenny, Mann and MacLeod, 2003).

Unfortunately, while students look to role models for clues on how to act in the clinical setting, they are often confronted with less than the ideal (Branch, 2000a) (Branch, 2000b). A common reflection from medical students and junior doctors being 'I learn (what to do) from "good" docs and I learn what not to do from "bad" ones!' (Hojat et al., 2009, p. 1189).

Looking for exemplars of compassion, integrity and patient centred care, students become dismayed, frustrated and cynical by the unprofessional and unethical behaviour of some of their more senior colleagues (Burack et al., 1999) (Paice, Heard and Moss, 2002). Research studies continue to highlight concerns that many role models reflect poor levels of professionalism in their interactions with patients and junior staff alike (Bloch, 2003) (Burack et al., 1999) (Karnieli-Miller et al., 2010).

Burack et al's research (1999), explores the response of senior physicians to junior doctors when the latter demonstrate or articulate negative attitudes



towards patients. The study findings highlights the difficulties physicians have in articulating constructive feedback within the professional domain, especially when dealing with affective attributes. This study suggested passive role modelling appeared to be the norm with physicians questioning their own moral authority to challenge inappropriate behaviour. Expecting physicians to recognise, assess and mould the attitudes of their junior colleagues without providing supportive system and training incentives was considered unreasonable by participants in this study. With no moral pedagogy guiding their informal teaching practices, participating physicians turned to a passive conception of role modelling, simply performing the desired behaviours hoping that learners would somehow absorb them. However, to Burack et al 'compassion and respect are not discrete, specifiable behaviours; rather, they are expressed in highly complex and contextualised social interactions' (1999, p. 54) which require active role models clearly articulating the values and attitudes which underpin these nuanced behaviours.

The authenticity of behaviour is also questioned in the literature. Pence (1983) questions whether imitating a positive role model is authentic behaviour, 'merely imitating compassionate behaviour is not compassion because real compassion stems from deeper, internal attitudes and emotions' (Pence, 1983, p. 190).

Despite the centrality of the role model to the novice in shaping professional character formation in the clinical setting, standards are elusive (Kenny, Mann and MacLeod, 2003). Neither students nor medical educators are fully cognisant of the complexities of the role and the intrinsic impact it has on the way in which care is patterned across the generations.

While role modelling is perceived as the means by which values are predominantly taught, we still have little, in-depth, understanding of how the intention of the teacher translates into understanding and assimilation by the learner (Stern, 2000). Kenny et al (2003) refer to role modelling as a conceptual 'black box' for both teachers and learners. Through a closer analysis of the relationship between the learner and the teacher, this study seeks to enhance our understanding of what motivates a learner to accept or reject the values and attitudes they observe being modelled in practice.

Specifically, the focus of this study is how the learner operationalises the notion of compassionate care, into practice.

## 2.3 LOCATING LEARNING IN THE RESIDENT YEARS - THE SEARCH FOR IDENTITY AND CORE VALUES

Someone call a doctor.

New intern after patient went into shock (Colgan, 2009, p. 43)

The transition from student to doctor is intense, with the search for identity and the development of core values as a physician being common themes in the literature (Ackerman et al., 2009) (Brady, Corbie-Smith and Branch, 2002) (Kilminster et al., 2011). Interns report struggling with the demands of the role and balancing responsibility with expectations, managing uncertainty, feeling 'pulled in many directions' while aspiring to be the 'ideal physician' (Ackerman et al., 2009, p. 28). Cognitive demands and the need to understand the expectations and requirements of their new roles and responsibilities, are emphasised in the literature as creating stress for new interns who feel ill prepared for the transition from student to doctor (Kilminster et al., 2011) (Tallentire et al., 2011).

A longitudinal, prospective study undertaken in the mid 1980s, sought to ascertain whether the self-reported negative emotions and attitudes developed during internship continued through the early years of residency. Using a Likert scale, 40 internal medicine students (two classes each of 20 students) were followed every 2-3 months for 4 years. Questions explored levels of career satisfaction, emotional states and what experiences the residents found to be satisfying and dissatisfying. The results showed that the unease experienced by the residents during the intern year was significant; however, as they progressed into their second and third years, their satisfaction levels and psychological wellbeing improved with a more positive outlook being more typical (Girard et al., 1991). These results reflect a continuing pattern of increased satisfaction with years of experience recognised by later studies.

The results of a second, longitudinal study, undertaken 15 years later were consistent with this earlier research. Brady and colleagues (2002), seeking to understand the influence of prevocational training (training provided to doctors before they choose their specific career path) on junior doctors as they develop into physicians, followed a cohort of residents across the first three years of their prevocational training. This prospective, longitudinal, qualitative study using narrative essays, demonstrated a marked shift in attitudes and values experienced by the participants as they transitioned across the years (Brady, Corbie-Smith and Branch, 2002). According to the study, during early internship, residents were motivated by the search for identity and core values. Later internship witnessed a period of transition; the novice doctors struggling with a sense of disillusionment which became the dominant theme of their second year. However, year three was found to be defined by feelings of hope and reconciliation. Significantly, this longitudinal study also showed the shift of influence. Peers were the dominant influence for the residents in the early years of the study, whereas, in the final phase of the study, a common human bond with the patients had a much greater influence on the participants perceptions and values and feelings (Brady, Corbie-Smith and Branch, 2002).

The emotional stress felt by interns is not a recent phenomenon. A study undertaken in the 1980's by Smith et al, explored the stress and emotional impairment encountered during the early years of residency. A questionnaire was circulated to 436 directors of internal medicine in an attempt to identify the scope of the emotional problems junior medical staff encountered during their residency years (Smith, Denny and Witzke, 1986). Their research reflected a higher level of emotional impairment in the intern year, suggesting the stresses of the role are most acute during this period, and that coping mechanisms are not yet established (Smith, Denny and Witzke, 1986). While undertaken in the 1980's, their observations resonate with similar findings identified in later studies; internship is a time when junior doctors may feel emotionally fragile.

Using a qualitative, longitudinal perspective and further enhancing our understanding of the intern experience, Levine and colleagues (2006) collected written narratives from 32 interns across nine United States (U.S.) medical schools as responses to eight weekly emails sent to participants. The

thematic analysis of the subsequent narrative provided insights and a more in-depth understanding of how the powerful experiences of internship fostered personal growth (Levine et al., 2006).

Emotion, and the challenge to the interns' beliefs, attitudes, actions and sense of self, were all identified as key triggers central to the interns' experiences (Levine et al., 2006). The study demonstrates that, supportive relationships, opportunities for reflection and commitment to core values, assist in creating positive personal growth from the transformative trigger moments. Internship is perceived as a time when novice doctors struggle to identify and confirm their values in clinical practice (Levine et al., 2006). An acknowledged limitation of the study included the focus of the questions on positive personal growth and not on inhibitors to personal growth. The study also focussed on powerful experiences as triggers for growth which may have resulted in small, incremental growth not being detected (Levine et al., 2006).

In the period since the 1990's when Hafferty (1998) applied the notion of a hidden/informal curriculum to the socialisation of medical students, there has been a sustained effort to redress this imbalance. However, recent research continues to highlight the contradictions inherent in what is taught formally, and what is learned informally, as they transition from the classroom to the clinical context, and attempt to translate their knowledge into practice. These ongoing tensions can create confusion for the intern who is attempting to show their care for the patient in the clinical context, without compromising their professional relationship or clinical competence.

## 2.4 TURNING POINTS

Our world is structured by the stories we tell and conversations we have about it.

(Swanwick, 2005)

Most doctors, if asked, can describe an event in their training or novice years, which has had a major influence on the way in which they practice medicine. These events are referred to as a 'seminal event', or 'critical incident'

(Ackerman et al., 2009) (Branch, 2005) (Kilminster et al., 2011) (Rademacher, Simpson and Marcdante, 2010) and, regardless of whether they are perceived as positive or negative experiences, are seen as turning points in influencing the way in which the doctor approaches their future practice (Brady, Corbie-Smith and Branch, 2002) (Branch, 2005) (Gracey et al., 2005) (Karnieli-Miller et al., 2010) (Rademacher, Simpson and Marcdante, 2010). Seminal events have a lasting impact on the learner and usually have a strong emotional context, suggesting a strong interplay between values and attitudes underpinning the learning experience (Gracey et al., 2005).

Central to the influence of the seminal event, is an opportunity to debrief and reflect on the learning inherent in the experience, to glean meaning from the experience possibly shaping future behaviour or practice. The exploration of assumptions that are exposed when reflecting on critical incidents facilitates personal growth. Mezirow (1991) refers to this process as transformational learning. According to Branch (2005) a key element of transformative learning is discovering something. Reflection, sharing and reframing experience from the negative, to a more constructive framework, can assist in facilitating this new learning. Branch (2005) uses the expression of compassion as an example to illustrate the nature of discovery within a learning context. A student or junior doctor who struggles with wanting to express compassion to a patient, who has evoked the ire of the team by behaving disrespectfully, may discover that compassion is a healing force (Branch, 2005). This transformative learning process can act as a catalyst for a shift in deeply held beliefs (sometimes long forgotten), shaping medical students' professional values and attitudes (Branch, 2005) (Branch et al., 1993).

In a study reviewing over 300 critical-incident reports written by third year medical students, Branch (2000a) and colleagues identified empathy and compassion for patients as two key themes which emerged in the data. Reflecting a continuous theme throughout the research, medical students, when given the opportunity to reflect on an important experience with a patient, sideline clinical reasoning instead choosing compassionate, empathetic care (Branch, 2000a). Gracey and colleagues (2005) explored the seminal event as a strategy for encouraging preceptors to exploit and create mini-seminal events, such as: breaking bad news, patient's or learner's

emotions or psychosocial problems, as a way of fostering humanism within care.

Many questions go unanswered in exploring the relationship between the learner, their aspirations, and motivations and the perceived relevance and impact of the seminal event.

Are professional, humanistic values core to the learning? Was the learner seeking, looking for an answer? Why are some students/novice doctors affected and not others? How do these learning experiences relate to the formal and informal curriculum? We know seminal events and critical incidents provide opportunities for reflection and transformative learning and these events are often the catalyst for a shift in deeply held beliefs which shape medical students' professional values and attitudes (Branch et al., 1993). Yet, we have little understanding as to why one student's day to day routine may be another student's seminal event.

## 2.5 THE RULES OF ENGAGEMENT – FRAMING THE EXPRESSION OF EMOTION

These early experiences marked the beginning of my confusion about which patient, in which specialties, I was expected to care...  
I became increasingly unsure of when I could express my true compassion, when I would have to manufacture concern...  
and when I would be ridiculed for being too caring...  
shuffling through medical school from one rotation to the next, feeling like an emotional chameleon.

(Dalfen, 1999, p. 182-183)

The provision of compassionate care is firmly embedded in the unwritten code of practice and the unspoken rules of engagement. Dalfen's (1999, p. 182-183) letter (above) to the editor highlights the confusion students and junior doctors feel when trying to express their emotions in the different clinical settings. Hafferty (1991, p. 4) depicts medical training as a continuous collision between issues such as 'detachment and concern, certainty and uncertainty, humanism and technology' framing the rules for the expression of emotion. He

posits that the process of socialisation starts with the anatomy class and the way in which students are taught to respond to the cadaver, as captured in his quotes as follows: 'if each time the cadaver raised its 'humanistic' head the medical student beats it back with the bludgeon of scientific detachment, then we may expect that such a student will come to associate the reduction of situational stress with scientific distance and neutrality' (Hafferty, 1991, p. 112). Trainees are driven by the desire to conform to vague standards of affective behaviour. They fear unintentionally crossing over some ill-defined boundary, thereby becoming identified as someone who is emotionally ill-equipped to become a physician (Hafferty, 1991).

Emotionally detached concern has been a critical value underpinning the biomedical model of patient care, with affective neutrality being a key feature of the physicians response (Marcum, 2008). Marcum (2008, p. 276) posits that the 'biomedical model brackets emotions of both the physician and the patient... whereas humanistic models embrace them as important components of an ethical structure that composes medical practice...' According to McMillan (1996, p. 223), detached concern 'doesn't cut it anymore. Patients don't care how much you know until they know how much you care'.

Halpern (2007) states emotions have been excluded in patient interactions to prevent burnout, to maintain objectivity, to prevent over identifying with the patient and to avoid negative emotions interfering with the care provided. Yet, Halpern (2003, p. 670) contends 'patients want genuine empathy and care and doctors want to provide it'. Recent research suggests emotional connection may provide protection from compassion fatigue and burnout whereas suppression of emotion or emotional detachment may actually be a contributing factor (Shapiro, 2011). Empathy, according to Marcum (2008, p. 266) has become 'a rallying point for some medical professionals to reshape the emotionally detached clinical gaze and to reconnect the patient and the physician, especially at the emotional level'. The expression of empathy, as a stepping stone to compassion, (Bailey, 2001), or, as defined by Gelhaus (2012), as the cognitive capacity to understand a patient's feelings, as a pre-condition to compassion, has, after years of neglect, become a closely studied phenomena within the literature; providing us with a window in which to explore the expression of emotion within the clinical context. A basic search

in Google for 'empathy and medical students' results in over 8 million hits, Google Scholar narrows it to 99,000. The literature is complex and at times conflicting.

A dominant theme within the literature concerns the perceived erosion of empathy. Medical students enter medical school motivated by self-professed humanistic virtues such as compassion and altruism (Coulehan and Williams, 2001) but self-report a significant decline by their third year (Hojat et al., 2009) and continuing into their years of residency. Unfortunately, these studies do not tell us how this decline in empathy manifests itself in the way in which care is provided in the clinical setting.

A provocative essay by Shapiro (2011, p. 326) explores the issues surrounding empathy by questioning whether medical education promotes professional alexithymia (difficulty in acknowledging and expressing emotion) and reflects on the fate of empathy within the culture of medicine. When deconstructed through the lens of the bioscientific medical model, empathy is redefined with an emphasis on the measurable, cognitive and behavioural elements; distancing itself from the affective emotional aspects linked to sympathy which is perceived as destructive for both the patient and the physician (Hojat et al., 2011). This focus on the cognitive and behavioural aspects of learning to care appears to contribute to the discomfort the medicinal culture continues to have in framing and responding to emotion in the clinical setting, reinforcing the deeply embedded constructs of emotional detachment and resulting in thoughts and behaviours which emphasise the distancing of one's emotions (Shapiro, 2011).

Colliver and colleagues (2010) have questioned the validity of the self-reporting scales used to measure empathy and the subsequent interpretation of results, suggesting the concern over the perceived erosion of empathy is exaggerated. Smajdor and colleagues (2011), challenge the co-existence of scientific competence and the more subjective humanism, questioning whether empathy is necessary or beneficial to the doctor/patient relationship. Determining whether the perceived perception of the decline in empathy exists, or not, fails to shed light on understanding how the medical graduate, who survives with their humanistic traits either, well-honed, or



battered and bruised, then moves on to translate those motivations into practice once in the clinical setting.

## 2.6 CONCLUDING SUMMARY

This document began with a quote reminding us that all medical care is a social interaction. While agreement on the definition of medical professionalism continues to challenge medical educators, most would agree with the emerging consensus that medical professionalism, in its broadest sense straddles the divide between personal and professional values and behaviours. My literature review provides a historical context for professionalism, capturing the key themes which illuminate the interface between humanism and professionalism. This thesis embraces the subjectivity of humanism. It is about the nuance of care, the expression of compassionate care. It is about the learning of the unwritten rules of engagement and detachment. It is about the practice of touch and talk (listening and silence) in the context of both time and place.

In more recent years, when viewed through the bioscientific lens of the medical model, medical professionalism has resulted in a reductionist reframing of professionalism into discrete, measurable chunks. The questions asked are: 'what can be taught?' and 'what can be assessed?'. Yet, we have little understanding how situational and contextual factors influence the novice in the way in which they learn in the work environment, and in the way in which care subsequently unfolds into practice. If we do not understand how medical students or junior doctors learn to translate the affective aspects of learning into practice, how then can we presume to teach and assess these very skills and concepts?

This study seeks to unpack the black box of compassionate care as a way of exploring the way in which the social and cultural context of the clinical setting influences the interpretation and translation of affective learning. We know junior doctors struggle in their early years to develop their professional identity. Central to this struggle is the dissonance felt in attempting to accommodate, frequently conflicting workplace values, with their own personal values and beliefs. The role of the social and cultural context of medical training has long

been recognised as having a major influence on the developing professionalism of the junior doctor. However, several gaps are found in the literature. Vagueness is manifest around the means by which junior doctors internalise their values and attitudes and model their new learning in their practice. The research is painted with broad brushstrokes. We know that the complementary and often competing curricula are major contributors to the way in which doctors learn, the role model being a cornerstone element of this learning. We know many doctors have turning points which frame their ongoing practice. Yet, we fail to comprehend why one doctor's everyday practice is another doctor's turning point. We have taxonomies and classifications which provide us with a graded sequence of learning in the affective domain but still lack understanding as to the how and why of affective learning.

This study responds to this specific gap in the literature. Medical educators need to have a deeper, nuanced understanding, of how the qualitative, humanistic aspects of care, are learned through practice. Through this understanding we can then work to ensure these learning opportunities continue to be nurtured and valued.

### 3

## CONFLICTING AND COMPLEMENTARY THEORIES

He who loves practice without theory  
is like the sailor who boards a ship  
without a rudder and compass  
and never knows where he may cast.

Leonardo da Vinci cited in (Rees and Monrouxe, 2010, p. 334)

Over the last decade there has been a growing emphasis on medical educators and researchers being more cognisant of theory in the development and practice of medical education (Bleakley, Bligh and Brice, 2011) (Bunniss and Kelly, 2010) (Rees and Monrouxe, 2010) (Reeves et al., 2008) (Swanwick, 2005). Medical educators and researchers have been accused of being light on theory, focussed on positivist or narrow theoretical approaches (Mann, 2011), (Swanwick, 2005) and of being dependent on learning theories and adult learning principles that are criticised, by some, for their lack of empirical evidence and scientific rigour (Colliver, 2002). To better understand the learner, we need to understand different learning theories, and their relevance and application to medical education. This chapter, in placing learning theory in a medical education context, explores a number of these themes as a backdrop to exploring how junior doctors learn to be compassionate in practice.

There are many definitions of learning theory; for the purposes of this thesis I use the succinct, but inclusive, definition of (Kaufman and Mann, 2010, p. 16): 'a set of ideas and assumptions which help us explain some phenomena'. The embedding of theory in medical education practice is complex as the significance and relevance of different theoretical approaches are fraught with contradictions and ambiguity. This presents a challenge to both the novice and expert alike, who may struggle to grasp the multiple meanings and complexity of the definitions and understandings and their, at times, conflicting and/or complementary attributes. Compounding these difficulties is the lack of consistency in the use of terminology in the medical education literature.

Scholars, across many disciplines, have puzzled over learning, and the nexus between, the mind, and meaning making, in practice, leading to a range of theories. Some theories emphasise the inner development of the maturing mind while others focus on the influence of the environment, choosing to either foreground the individual or the collective influence of the learner's socio-cultural context of their learning environment. Learning theory literature lacks consistency and can, at times, be confusing, using, as it does frequently, the terms for significant learning paradigms such as constructivism and constructionism interchangeably. For clarity, Crotty (1998, p. 58) suggests using constructivism when focusing on 'the meaning-making of the individual mind' and to use constructionism where the focus is on 'the collective generation (and transmission) of meaning'. (Webster-Wright, 2010, p. 20) explores the role of constructivism in her work on professional learning and development suggesting that, as a paradigm it 'views knowledge as actively constructed by the learner whilst being influenced by past experience and present interactions with the social learning context... social constructivism tends to foreground the individual in the making of meaning and construction of knowledge with others'. Constructionism, on the other hand, recognises the primacy of human beings as active agents in building their construction of reality (Holloway, Freshwater and Wiley-Blackwell, 2009). According to Holloway et al (2007, p. 20), 'culture, inclusive of language, role and rules, becomes the filter through which individuals perceive their experiences and attach meaning to them'.

Compounding our understanding of how we learn is the frequently perceived simplistic explanation of learning theories as separate entities when, in reality, they borrow from each other in contributing to the learning process (Yardley, Teunissen and Dornan, 2012). This is evident in Knowles' Adult Learning Theory (1978) which, while providing significant insights into how adults learn, in separating child and adult learning, is now perceived as too unsophisticated a dichotomy. It is now recognised that adults, at times, learn like children, and children learn like adults; a continuum of learning from child to adult is considered far more helpful (Yardley, Teunissen and Dornan, 2012). This complexity is heightened once a student transitions to clinical practice where much of the learning is undertaken informally within the workplace. Swanwick

(2005) proposes a shift from cognitivism (the process of thought and thinking) to 'culturism', a word coined by Bruner acknowledging the mind cannot exist independent of culture.

Some theories which, on face value, appear to be about the sociocultural context are, on closer examination, predominantly individualistic in the way in which they frame the learning process. Swanwick (2005, p. 859) suggests that the approach to the informal learning which takes place in the workplace often frames the learning as undertaken by the learner's 'mind as an independent processor of information'. He posits that medical educators in their approach to informal learning tend to foreground the cognitive, viewing the meaning making of the mind as independent of its sociocultural milieu. He includes andragogy (the principles underpinning adult education), experiential learning, and reflective and reflexive learning as well as the traditional apprenticeship model within his definition of cognitive approaches. Swanwick (2010, p. 860) argues social cognitive theory (formerly referred to as social learning theory) also frames learning in this way; 'observed behaviours, attitudes or emotions are codified, reproduced and assessed by the individual for value (valence) before being adopted or rejected'.

The means by which the internalisation of attitudes and values has been framed within the medical education research literature provides a case in point (Krathwohl, Bloom and Masia, 1964). This is important in the context of this thesis which initially intended to unpack the affective learning domain. However, it is this very separation of domains which has, in part, contributed to our diminished understanding of affective learning.

Bloom's taxonomy (1956), separates learning into three separate domains, providing educators with a guide to developing learning objectives across the cognitive/psychomotor domains which directly align teaching with assessment. Expanding on Bloom's taxonomy, Krathwohl (1964) developed a taxonomy for the affective domain which explores the learner's internalisation of an attitude or value using a graded level of difficulty, as follows:

- Selected attention to phenomena (willingness to receive an experience)
- Beginning response to the phenomena

- Recognising the value of the phenomena
- Organisation (prioritisation) of values; and
- Internalising of the value (becomes part of behaviour – professional identity)

This taxonomy simplifies the internalisation of an attitude or value as a one directional construction by the individual learner. Criticism has focussed on its dependence on the cognitive domain, the limitations of its scope, and its being too abstract and too broadly defined (Martin and Briggs, 1986). Piaget (McLeod, 1997) recognising the shared interdependence between the cognitive and affective domains, stated that no behaviour can be purely cognitive or purely affective. This notion of the artificial separation of learning into the three domains of knowledge, skills and attitudes denies (Krathwohl, Bloom and Masia, 1964) the complexity of the learning process. This multifaceted dynamic has more recently been addressed within medicine 'as a complex professional practice in which the separation of cognition (thinking), conation (will), affect (feeling) and skill (doing) is impossible and unnecessary and in which individual cognition is secondary to social effects such as distributed cognition' (Bleakley, Bligh and Browne, 2011, p. 38).

While the dominant theories currently used in medical education practice and research, including behaviourist, cognitivist, humanist and social learning theories, contribute to the design and instruction of learning, there is a need to recognise and use additional perspectives (Mann, 2011). Broadening our theoretical approach to embrace sociocultural theories allows us to nurture the development of knowledge, skills and professional identity in what is a highly complex environment where novice doctors are socialised into the culture and profession of medicine.

Studying affective learning adds complexity to what is already a multidimensional phenomenon. However, the subjective nature of the non-cognitive aspects of the affective learning has been notoriously difficult for the scientific community to agree on and define (McLeod, 1997). Affect has become a generic term referring to any non-cognitive, non-technical or non-skills based aspects of learning, including emotions, attitudes, beliefs, moods, motivations, and intuition (Martin, 1999). The response to this challenge has been addressed by reframing what are perceived as emotions

such as empathy - a stepping stone to compassion (Bailey, 2001) (Halifax, 2011) - as cognitive attributes (Hojat et al., 2011) or as an 'intellectual rather than an emotional form of knowing' (Halpern, 2003, p. 670). Through the continued emphasis on the acquisition and assessment of knowledge and skills (Kumagai, 2008), we allow the more quantifiable aspects of learning to dominate. The artificial separation of the domains provides a narrow lens to focus on what can be taught and assessed rather than on how affective learning unfolds within the social context. It is in this sociocultural learning context that the expression of compassionate care is located.

A study undertaken by Burack et al (1999) identified some reluctance on the part of clinical educators to take responsibility for shaping affective learning. The discomfort medical educators feel in judging another's values, attitudes and beliefs, and the lack of appropriately valid assessment instruments, are both seen as possible contributing factors (Cate, 2000). In the field of medical education research, these factors have contributed to the principle of internalisation, the process where an attitude or value becomes increasingly a part of the individual (Martin, 1999), being neglected in the research undertaken, and thereby resulting in medical educators having limited evidence on which to base educational initiatives which address affective learning.

In a qualitative study undertaken by Karnieli-Miller et al (2010) in which they explored the narratives of third year medical students, only a fifth of the 272 students explicitly recorded how they felt in response to their experiences despite students being asked to record their emotional response to their clinical experiences. The researchers theorised that this may have been in response to medical socialisation of students to the point where students quell their emotional response, or they regard feelings as such a taboo topic to a point where they are not even conscious of their affective response (Karnieli-Miller et al., 2010). This fear of being seen as being emotional (conscious or not) can hinder research into affective learning, as participants may be reluctant to share their feelings, contributing to the difficulty in understanding the student and junior doctor experience in the emotional context.

It is increasingly evident that affective learning cannot be understood in isolation from the broader learning theories and principles of social learning theory. Approaching affective learning in the broader context of the learner engaged in practice in a social community and cultural context allows for a more in-depth understanding of the complexities of the learning process which should more aptly depict the way in which learning unfolds. Research from management and business studies reinforces our understanding that for newcomers to a workplace, it is their co-workers who have the most influence in how they learn about what they term 'emotional information' (Filstad, 2004) (Vernon and Jablin, 1991). While observation may play a role in this understanding of emotional information, connection and engagement with others also plays a pivotal role.

Eraut's (2000) work on distributed cognition suggests that in some situations, individuals are dependent on the knowledge of other people or other things to act effectively. Vygotsky (1978) also theorised the relational nature of learning. His emphasis on social relationships as a major influence on meaning making foregrounded social rather than individual construction.

These sociocultural learning theories offer a different theoretical perspective providing a fresh gaze on the learner's journey as they transition to work-based practice. Lave and Wenger (1991) developed their understanding of learning by studying five apprenticeships. Their findings emphasised the role of 'engagement', and 'engaging in practice' as central tenets for learning.

The apprenticeship model continues to be a dominant focus in medical educators' understanding of the learner's journey from medical student to novice doctor. However, according to Swanwick (2005), when based predominantly on observation, it too, is underpinned by learning wherein the mind functions independently from the social context. Despite recognising the centrality of the role model and the act of learning by doing, the traditional apprenticeship model continues to reinforce the simplistic belief that learning is achieved through the reframing or restructuring of inputs learned through modelling and reflection (Swanwick, 2005). Goldie (2008, p. 518) describes situated learning theory 'as an elaboration of the apprenticeship model'.



These understandings of learning theory have implications for the way in which we approach the delivery and assessment of medical education. Hafferty (2006) emphasises the lessons learned through the impact of the hidden curriculum which he perceives as inseparable from practice and the novice doctor's developing identity within the social context of medical practice. He emphasises the development of the 'professional self' which embraces the 'internalisation of the values and virtues of medicine as a discipline and a calling' and frames medicine as a 'moral community, the practice of medicine a moral undertaking, and professionalism a moral commitment' (Hafferty, 2006, p. 2152). Bleakley (2002, p. 9), in his study of novice doctors as apprentices, laments that much of what has been studied in the medical education field has neglected the 'cultural process of socialisation into attitudes and values informing professional practice', the dominant discourse being driven by educational psychology with an over emphasis on the individual's attainment of knowledge and skills and an emphasis on personality rather than role.

These descriptions and interpretations of learning theory emphasise the influence of the learning environment in the way in which the novice not only thinks and behaves, but also how they feel and subsequently, act. This change in emphasis sees a shift in the understanding of the apprenticeship role. Traditionally the apprentice was tethered to a more experienced colleague whom they would observe and model. The Cognitive Apprentice (Rogoff, 1990) focuses on making thinking more transparent. However, this reframing of the apprenticeship continues to neglect the way in which junior doctors learn to frame, articulate and express the way in which they feel.

The development and provision of medical education has been strongly influenced by the positivist roots of science and medicine, which according to (Mann, 2011, p. 61), place 'high value on understanding the world through objective study and on the development of knowledge that is value and context free'. Mann (2011) identifies the shift to constructivism as one of the most important and influential shifts in medical education since the introduction of the Flexner Report (Flexner, 1912) over a century ago. Recognising the contribution constructivism has made, Yardley et al (2012, p. 108) extend this

shift in culture by building our understanding of the role the sociocultural theories have in building our understanding of 'experience as learning'.

This thesis uses constructivism and constructionism as key theories and paradigms on which to interpret the lived experience of the participating interns.

To ensure methodological consistency, the following chapter explores how these theoretical and methodological underpinnings frame this study and the assumptions, I, as the researcher, bring to this study.

## 4

# LOCATING THIS STUDY IN A RESEARCH PARADIGM

Medicine is not science. Instead it is a rational, science using, inter-level, interpretive activity undertaken in the care of a sick person...

As a human enterprise medicine speaks primarily through narratives... discerned in the text that is the patient.

(Montgomery Hunter, 1991, p. 25-26)

The research paradigm in which you choose to locate your research is an important consideration for any study. Your thinking as a researcher needs to be transparent and justifiable. The previous chapter provided an overview of two research paradigms and several theories that influence medical education practice. This chapter extends that foundational chapter to narrow the focus and show how both the research paradigm and learning theory are specifically applied to my research questions.

The initial intention for this thesis was to provide a window of understanding into the affective learning domain using the expression of compassion as a way to unpack how novice doctors learn to show they care in the clinical context. The starting point was to explore the influence of role models, turning points and seminal events in the context of putting flesh on the bones of Krathwohl, Bloom and Masia's (1964) affective taxonomy on how doctors learn to accept or reject values as they internalise new experiences. However, insights from the narratives provided by the participating interns has broadened the scope of the study and reframed this approach.

Education as a field of study does not lend itself easily to a reductive research paradigm, with the range of confounding variables creating difficulty in generalising outcomes to broader populations (Mann, 2004), (Mann, 2011) (Wong et al., 2012). When studying affect, these issues are amplified as the very definitions of attitudes, values, beliefs and emotion are open to interpretation.

Interpreting the complex data generated by the participating interns over the year was complicated. Interpretation through a single theoretical lens

appeared inadequate, an artificial fit of the data to an imperfect paradigm whether constructivist or constructionist. This is exacerbated in the context of medical education when no one learning theory can explain the complexity of learning, and a growing number of medical education researchers have concluded 'learning is both collective and individual' (Mann, 2011, p. 60).

Swanwick (2005, p. 859) posits, it is not just a matter of the application of learning theories but also a complex matter of 'fitting a culture to the needs of its members and their ways of knowing to the needs of the culture'. Singling out one theory as 'the' best theory, and privileging it over another is unhelpful, whereas, considering a theory as fit for purpose due to its explanatory powers is much more useful in building understanding (Bleakley, 2005, p. 51).

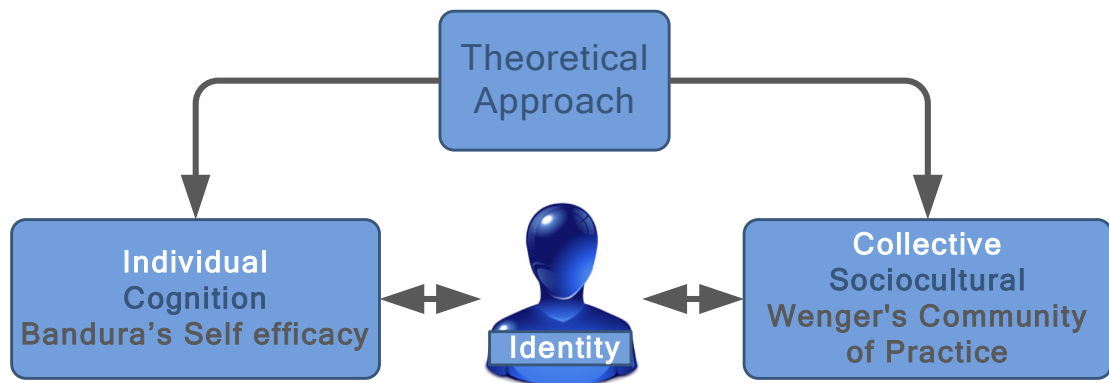
In consideration of these factors, and for the purpose of my study, I have interpreted the individual meaning making of the intern broadly using Bandura's Self-efficacy Theory (Bandura, 1994). Self-efficacy Theory is a constructivist theory which allows us to better understand and interpret the individual meaning making related to the sociocultural influences of the learning environment. These influences are inextricably linked with the development of the novice doctor's fledgling professional identity within their community of practice (Wenger, 2007) which belongs to the constructionist theoretical perspective.

This repositioning of the theoretical approach allows the interpretive lens to move back and forth reframing the exploratory nature of this study, embracing individual agency within the collective sociocultural influences of learning through practice.

In this context, I have used both constructivist and constructionist paradigms to interpret the data. While some would argue the theoretical perspectives are incompatible, Kohler Reissman (2003, p. 23) posits in her re-interpretation of her own identity and illness narratives, 'understanding complex lives requires more than one theoretical lens', and so too for this study.

Central to this interpretive approach is the understanding that medical education is no longer only about the acquisition of knowledge, skills and attitudes; it is about the construction of a professional identity (Bleakley, 2002)

(Mann, 2004) (Rees and Monrouxe, 2010) (Reeves et al., 2008) (Swanwick, 2005). I have illustrated my theoretical approach in Figure 1 which demonstrates how identity acts as a link between the two theoretical models.



**Figure 1 – Relational Theoretical Approach**

In the interpretation of the participating doctors' narratives in this study, sociocultural theories, as originally developed by Vygotsky (1978) and further developed by Lave and Wenger's (1991) Situated Learning Theory as an extension of constructivism and constructionism, provide an avenue in which to explore the engagement between the individual's mind and social context. The notion of engagement is significant in this context. It is through engagement and connection, that care and compassion, are expressed within practice.

I now summarise the key parameters within each theory as applied to my study which broadly frame my interpretation.

#### 4.1 SITUATED LEARNING THEORY/COMMUNITY OF PRACTICE

As discussed in the previous chapter, a central tenet held across the many interpretations of learning theory is the belief that it is participation in social activities, by which individuals learn and develop (Moen, 2006).

Situated Learning Theory, developed by Lave and Wenger (1991), provides a framework for exploring the shift from observer to participant. The theory uses the concepts of 'community of practice' and 'legitimate peripheral participation' to describe the process a novice or newcomer undertakes as they enter a new

community or, in the context of medical education, as a medical student transitions from the classroom to the clinical context (Lave and Wenger, 1991).

Initially, the novice begins at the periphery of a community by observing and undertaking basic tasks. As they develop skills, they move closer to the centre of the community. Participation, active engagement and increasing responsibility are seen as central tenets in how the individual learner acquires the roles, skills, norms and values of the culture within the community (Mann, 2011).

Alongside practice and community, identity is an integral aspect of Wenger's theory of Community of Practice (COP). 'Identity serves as a pivot between the social and the individual ... it avoids the simplistic individual – social dichotomy' (Wenger, 2007, p. 145). It is the interplay between the person and the community that has primacy in the development of identity: 'we cannot become human by ourselves' (Wenger, 2007, p. 146).

Another key construct within the COP is the notion of trajectories – defined by (Wenger, 2007) as continuous motion. Trajectories define a range of paths and places within a community – peripheral, inbound, insider, boundary and outbound - providing an increased understanding of the level of participation of the individual in their practice. Reification, a central tenant of the COP, is defined as to 'make into a thing' (Wenger, 2007, p. 58). Embracing both the process and object, the act of reification shapes our experience, creating a 'thingness', reflecting practices around which meaning is negotiated (Wenger, 2007).

## 4.2 SELF-EFFICACY

Bandura's Self-efficacy Theory (1994), a social cognitive theory, used in tandem with COP as a sociocultural learning theory, sheds light on the relationship between the learner, their environment and meaning making.

Judgements about self-efficacy are derived from four principal sources which create expectations of self (Bandura, 1994) (Kaufman and Mann, 2010) as summarised below:

- Performance attainment - defined as one's perception of one's own performance as a new learner and measured by succeeding or failing in undertaking a specific task (Bandura, 1994). This construct is especially influential since being successful raises mastery expectations, whereas, repeated failures result in the individual learner lowering their expectations, particularly if the error occurs early in their learning (Bandura, 1977).
- Vicarious experience - observing others, in a similar role, perform an activity without negative consequences, is another source of information which influences a person's sense of self-efficacy (Bandura, 1977). The influence of role modelling within medical education is significant as it is a pivotal source of learning (Branch et al., 2001) (Karnieli-Miller et al., 2010) (Kenny, Mann and MacLeod, 2003) (Paice, Heard and Moss, 2002).
- Verbal persuasion – providing encouragement and support which leads the learner to believe they can accomplish the role also influences a person's self-efficacy (Bandura, 1977). Within medical practice, giving constructive feedback is a crucial role of peers and supervisors in shaping the learning of the novice doctor.
- Physiological states - (Bandura, 1994) or emotional arousal (Bandura, 1977) can affect self-efficacy, especially when coping with difficult or threatening situations. The stress induced from feeling anxious and vulnerable can be perceived as having a debilitating effect on performance. Individuals are more likely to expect success when they are calm in their approach rather than when they are feeling agitated. Fear reactions generate further fear, creating a cycle of anticipatory self-arousal and an expectation of performing poorly (Bandura, 1977).

### 4.3 FRAMING THE RESEARCH QUESTIONS

In unpacking the interns' lived experience, I use Wenger's Community of Practice (2007), alongside Bandura's Self-efficacy Theory (1994) to create a nexus between the meaning making of individuals and the learning inherent

within their collective sociocultural milieu. The following discussion outlines the more specific research questions which flow from my broad thesis topic.

Within medicine, the bioscientific nature of the medical model continues to be a dominant force, not only in shaping the way in which doctors are taught to practise and to undertake clinical research, but also in what to value in the research domain. Through the lens of the bioscientific model, evidence based research is predominantly quantifiable, objective and hypothesis driven. This is the basis of the positivist model that seeks to find the one truth (Greene, 2007), through 'placing high value on understanding the world through objective study and on the development of knowledge that is value and context-free' (Mann, 2011, p. 61).

The intention of my research is to gain a window of understanding on how novice doctors act on their values, attitudes and beliefs when transitioning to practice. I chose to investigate this research area using the expression of compassionate care as the lens in which to explore factors that influence how junior doctors construct meaning through being embedded in a complex community of clinical practice, and how this meaning making subsequently shapes their practice. To study such an amorphous concept as the expression of compassionate care adds additional layers of complexity.

As a researcher, I'm interested in increasing my understanding of the nuance of compassionate care in practice. I want to explore, through the eyes of 'my' interns, what the enabling and inhibiting influences are in expressing compassionate care. When, and where, is it acceptable to spend time connecting with the patient's emotional journey, allowing time to listen to the patient, and to talk about their fears and feelings as well as their symptoms, diagnosis and treatment? I am interested in knowing how a novice doctor acts on their compassionate feelings and subsequently how their behaviours change over time, in diverse places and with different people influenced by the sociocultural context within their community of practice.

My research questions are:

- How do interns describe and interpret the expression of compassionate care within their community of clinical practice?



- From the interns' perspective, what are the enabling, or inhibiting, factors in the expression of compassionate care?
- How does the expression (or suppression) of compassionate care unfold in practice and change over time as the learners complete the intern year transitioning from student to doctor?

In exploring the expression of compassionate care, I am entering a foreign terrain with unsure footing and poor visibility, where feelings and emotions bound with thoughts, both conscious and unconscious, are difficult to pin down and to articulate. These questions are not easily answered by tick boxes or checklists, generating numbers for statistical analysis: 'they represent the subtle and unique things that make a difference beyond the points on a standardised scale...' (Patton and Herman, 1987, p. 30). These questions relate to the human face of care. They explore the connection or human bond between the patient and the clinician. They require in-depth and holistic descriptions that represent people in their own terms, providing a firsthand understanding of the learning processes dependent on the nuances of the environment (Patton and Herman, 1987). Subjective experience is the focus of this study, exploring how we frame our stories from our experiences with people, place and events. These are the stories of interpretation embracing multiple truths. In response to the complex and nuanced nature of the research questions, and building on the interpretive nature of medicine, this study will be embedded in an interpretive theoretical framework. I use narrative inquiry as both a research method and as a way of interpreting and illustrating the study results, which I discuss in more detail below.

## 5 METHODOLOGY

Narrative inquiry has been the primary methodology used to interpret the interns' data. Recognising its primacy in this study, I have provided an overview of the key tenets as background.

### 5.1 BACKGROUND TO NARRATIVE INQUIRY

Storytelling, narrative, narrative inquiry, and narrative analysis are all terms used when describing the art and craft of sharing and interpreting stories. However, there is a difference; people tell stories, not narratives, the narrative is the analysis of the story (Frank, 2000). According to Freeman (2003) stories are always about something, which he refers to as the narrative element of 'aboutness', the referential point when a researcher asks 'tell me about...' is a key element in narrative inquiry.

Montgomery Hunter (1991) reminds us that medicine itself is an interpretive act. While narrative is not a scientific construction, Holloway (2007) argues that, as it provides an insight into how people feel and think, it is a form of evidence. In telling their experience people integrate events and happenings into a whole and in this context, they often embed their feelings (Holloway, Freshwater and Wiley-Blackwell, 2009). According to Sikes et al (2006) the 'essence of narratives is to make connections, to link events, feelings, experiences into a neat, tidy, logical and consequential sequence'. Narrative inquiry provides a way to examine and build understanding in how novice doctors' compassionate behaviour is related to the social context in which they work, and how this changes over time. Most significantly, it contextualises their affective experience, providing insights into how they respond emotionally to their evolving roles and developing doctor identity. For these reasons I have chosen narrative inquiry as my research method, to inform both my data collection and analysis, in building an understanding of the way in which novice doctors construct their stories around the expression of compassionate care. In using narrative inquiry to inform this study I extend the role of the doctor as interpreter of the patient story, to the doctor as the teller of their own

story: narrating their journey as a novice entering a community of practice and developing their identity as a doctor.

Narrative is understood to be 'an iterative process where the self is constructed, deconstructed and reconstructed through and by the telling of narrative... the end result is not a fixed identity; rather it is the new starting point' (Holloway and Freshwater, 2007, p. 42).

Narrative has a rich history which dates back to Aristotle and ancient times (Reissman, 2008). More recently, Russian folklorist Propp, is credited with the move to the study of narrative in the 20<sup>th</sup> century (Holloway and Freshwater, 2007). Originally, it was the traditional discipline of literary scholars with a focus on grand narratives. It is only since the 1980s that the social sciences have embraced narrative and have acquired their own tradition and conventions (Holloway and Freshwater, 2007).

In the context of medical education there is a growing acceptance of narrative inquiry, capturing the patient's story, the medical student's story and the doctor's story (Bleakley, 2005) (Brady, Corbie-Smith and Branch, 2002) (Charon, 2001) (Charon, 2004) (Dyrbye, Harris and Rohren, 2007) (Gaufberg et al., 2010) (Greenhalgh, 1999) (Hemsley, Balandin and Togher, 2007) (Holloway and Freshwater, 2007) (Holmes, 2005) (Hurwitz, 2000) (Karnieli-Miller et al., 2010) (Kelly and Howie, 2007) (Levine, Kern and Wright, 2008) (Montgomery Hunter, 1991) (Waring, 2009).

Bleakley (2005, p. 535) describes medicine as having a 'self-imposed institutional autism'. He compares medicine's inability to recognise the role of storytelling to a young boy with Asperger's syndrome in the Mark Haddon novel titled *The Curious Incident of the Dog in the Night-Time* (Haddon, 2003). The child connects to the world through numbers, understanding very little about people as human beings. Medical education research in Australia is not immune to this, so-called, institutionalised autism. Despite a growing culture in the moral and ethical understanding of medical education, the research is still largely driven by the positivist framework where the expression of emotion is bracketed, creating a separation from mainstream research. Research in medical humanities framed by post-positivist interpretative studies is in its infancy in Australia resulting in a missing piece of the puzzle, no more or less

important that the positivist paradigm; but essential nonetheless, to complete the picture.

## 5.2 NARRATIVE INQUIRY AS METHODOLOGY

Narrative inquiry has no agreed upon methodology, according to Holloway and Freshwater (2007) you find your own way. Consequently my approach as a researcher must be clearly articulated.

The way in which stories are defined ranges from the simplest form as a 'continuous story with connected elements that include a plot, a stated problem and a cast of characters', to (Holloway and Freshwater, 2007, p. 4) a highly structured narrative analysis.

Narrative analysis within the health sciences, appears to be categorised into two main approaches: socio-linguist or sociocultural (Grbich, 2007). These two approaches influence the way in which stories are gathered and interpreted.

The sociocultural approach used in this thesis extends beyond the 'structure of the language to the broader interpretive framework that people use to make sense of everyday happenings/episodes' (Grbich, 2007, p. 130). The process provides an opportunity to explore the context and content of the story and to provide a window into the emotions and feelings portrayed (Grbich, 2007).

Regardless of the analytic approach taken, there are several key elements which underpin narrative inquiry and interpretive research which must be considered as outlined below:

### 5.2.1 UNIVERSALITY

While there are numerous ways to describe narrative as a concept, core to its influence is its universality. Narrative transcends culture, language, class, gender, disability, power and generational boundaries. According to Hiles (1994), narrative is universally embraced by all human cultures, woven through our social and cultural experience. Narrative allows the researcher to 'view cultural and social patterns through the individual experience' (Sullivan, 2009).

## 5.2.2 TEMPORALITY

Temporality is a constant element of storytelling. In the context of narrative inquiry, the term is used to refer to the way in which stories are based in a timeframe. The story often provides a means to link the present with the past or the future (Holloway and Freshwater, 2007). According to Connelly and Clandinin (2006) stories under study and the events which take place are continuously under temporal transition. They suggest temporality directs the attention of the listener, or reader, to past, present and future, linking place, people, events and things.

## 5.2.3 WHOLENESS

One of the strengths of narrative inquiry as a qualitative research method is that it produces a 'coherent story' in contrast to other forms of analysis which produce fragments of the story, what is referred to as 'fractured texts' (Riessman, 2003). Interpreting the story as a whole allows for recognition of change over time and provides the context for actions and behaviours and a shift in thinking and feeling. In understanding the elements of a story Holloway (2007) states it must be 'worthy' of the telling. In other words it is more than an account of everyday events. The story instead relies on the dramatic, the telling of critical events or behaviours.

Narrative is embedded in the social and cultural context of the storyteller (Holloway and Freshwater, 2007). According to Lieblich et al (1998, p. 8), through 'studying and interpreting self-narratives, the researcher can access not only the individual identity and its systems of meaning but also the teller's culture and social world'.

## 5.2.4 IDENTITY FORMATION

If you want to know me, then you must know my story,  
for my story defines who I am.

(McAdams, 1996, p. 11)

The concept of identity formation as a psychosocial construction, co-authored by people within their specific cultural context, (McAdams and Janis, 2004) weaves its way through the literature on narrative. Narrative is perceived as integral to identity formation. It is through storying-telling that 'identities are both lived and told, and individual and social' (Clandinin, Cave and Cave, 2011, p. 1). McAdams et al. (2004, p. 161) argue 'identity itself takes the form of an inner story, complete with setting, scenes, character, plot, and themes'. While it is the particular cultural frame which provides context for a life story, it is also the storied narrative which differentiates one person experience from others (McAdams and Janis, 2004).

'When a particular story is recorded and transcribed, we get a "text" that is like a single, frozen, still photograph of the dynamically changing identity. We read the story as a text, and interpret it as a static product, as if it reflects the "inner", existing identity, which is, in fact, constantly in flux' (Lieblich, Tuval-Mashiach and Zilber, 1998, p. 8).

Narrative inquiry provides a window into how individuals, through relationships and interactions with a range of people and events, make sense of their world (Riley and Hawe, 2005). The learning of the novice doctor is intertwined with his/her developing sense of identity as a doctor, professional and individual. This narrated journey provides a strong platform from which to explore compassionate care.

### 5.2.5 "TRUTH"

There is no neutral position... from which a narrator, cleansed of bias, may see "truth" or "reality" in all its uncluttered purity... narrative may be most valuable as a guarantee against this positivist assumption, for an awareness of narrative and its workings is a constant reminder that there is no absolute truth, no certainty.

(Montgomery Hunter, 2004, p. 1879)

'Transforming a lived experience into language and constructing a story from it is not straightforward... narratives are composed for particular audiences at moments in history and draw on taken for granted discourse and values

circulating within a particular culture' (Reissman, 2008, p. 3). As a researcher using narrative inquiry, I am an active participant in the creation of 'my' data, influencing both the unfolding of the story and its interpretation. The subjective nature of both the telling and interpreting raise two key issues: truth and bias.

The meaning and nature of truth is both highly complex and highly contested. To claim something is true is to 'claim that it accurately accounts for and explains events that actually occur in the real world' (Schwandt, 2007, p. 301). However, even the most transparent of stories is framed by the teller and interpreted by the audience (Montgomery Hunter, 2004).

The goal, according to Montgomery Hunter (2004, p. 1879), is 'not a synthesis or a determination of a "truth" that will swallow up other accounts, but a sustainable representation... a consensus that may be acted upon'. In the context of narrative inquiry the storyteller and the researcher are in dialogue. If the storyteller or narrator emphasises, exaggerates, or consciously, or unconsciously embellishes a story, this is of interest to me as a researcher, as these aspects illuminate the narrator's experience and interpretation, and highlight what is of importance to the narrator. As the researcher facilitating the telling of the story, and as the listener as audience, I am interested in hearing what is important to the interns: how they shape meaning from their experience, what they emphasise. Their stories are from and about the past as they remember, recall and interpret it: they are not the past.

Verisimilitude or the perceived truthfulness of a story is important to narrative inquiry. What we want from narrative is for the story to resonate with the reader. For the story to shine a light of recognition. For the reader to consider could that be me? To reflect on, what would I do in this situation? Would I have done the same? What would I do differently? What can I learn from this story? How, or what can we improve on for next time?

## 5.2.6 BUILDING THE TRUSTWORTHINESS OF FINDINGS

This chapter would be incomplete without discussion on a further two factors which arise in all research but which again are treated differently in the context of qualitative research. The validity and reliability of the research process and

the subsequent generalisability of the interpretations of the results are concepts which do not sit comfortably with the qualitative research domain and are difficult to apply to narrative inquiry. However, this discomfort does not allow us to dismiss these important concepts without building an understanding of how they are interpreted and applied in the context of this study.

Tension exists in the literature regarding the way in which qualitative research is judged. Some argue for the retention of concepts such as reliability and validity, albeit with a changed meaning to how these terms are used in the quantitative domain. Others argue for these terms to be rejected (Holloway and Freshwater, 2007). Responding to this discord, the alternative concepts of trustworthiness and authenticity have been suggested. Trustworthiness is made transparent through an audit trail showing how decisions were made and how the study design was developed, the data collected and interpreted including how conclusions were formulated. Authenticity examines a range of concepts. Was the study fair to the participants? Was consent considered throughout the study, not just at the beginning? Has the study benefited participants' understandings of their social context and practice? Has the study empowered the participants and provided opportunities for improved practice? (Holloway and Freshwater, 2007).

If, and how, results can be generalised to other settings and participants is a key consideration of this study. 'My' students' and interns' stories are unique to them as individuals. Their stories are, however, related to a specific social and cultural framework. Lincoln and Guba (cited in Holloway et al, 2007) suggest the knowledge and theory developed from one context are transferable to another similar context, with similar types of participants. Context in narrative inquiry is a crucial concept. What Holloway and Freshwater call 'context stripping' is considered inappropriate in the qualitative domain. Context is considered a strength of this research approach (Holloway and Freshwater, 2007, p. 112). Stoddard (2004, p. 309) developed a model which emphasises social processes and activities, which he refers to as 'processual generalisability'. This model promotes the generalisability of social processes from one setting to the next. The concept of transferability and processual generalisability both broaden and reframe the way in which we measure how



we can apply the interpretations and results of a narrative inquiry study to similar contexts and cohorts.

### 5.2.7 CONCLUDING COMMENTS

According to Holloway (2007), one of the less explicit outcomes of storytelling is the relief of suffering, with a healing function being performed. Charon (2004, p. 862) also places emphasis on this influence of storytelling stating 'only in the telling is the suffering made evident'.

According to Graham (2006), the dominant trend in medical sociology focuses on power dynamics within health and medicine rather than understanding emotional labour within the social context of the medical profession. This results in an unbalanced representation of the role of the doctor. Graham (2006), argues for a more compassionate, all embracing perspective; we cannot separate the patient journey from the junior doctor's journey as a learner - their stories are intertwined.

It is through a better understanding of this world that I, as the researcher sitting as an outsider and gazing inwards towards the community of practice, hope to develop innovative ways to promote positive change. By shining a light on compassion as a key attribute of professionalism and humanistic care we can use what we learn from these interns' stories to build an understanding of ways to cultivate compassionate care within the clinical context, with the goal of improving the journey for both the patient and the novice doctor.

### 5.3 SITE AND COHORT SELECTION

The following section explains where study participants were recruited and how they came to participate in the study. The eight participating interns were drawn from an initial student study which is not part of this thesis except for recruitment and providing some context for each of the narratives crafted for the eight participants.

### 5.3.1 PARTICIPATING UNIVERSITY

The University of Queensland, School of Medicine, Herston, Brisbane, offers a four year graduate entry program across several campuses, offering both rural and overseas clinical rotations. This university was used to undertake an initial single question reflection as a student recruitment strategy.

### 5.3.2 PARTICIPATING TEACHING HOSPITALS

The eight interns participating in the longitudinal study completed their internships in eight different teaching hospitals. Seven of these hospitals are in Queensland, three of them are located in the city and the other four are based in regional locations. One intern moved to an interstate regional hospital.

### 5.3.3 PARTICIPATING INTERN COHORT

In the single question reflection, all final year students were invited to participate in a longitudinal, qualitative study once they transitioned to being an intern undertaking their conditional year of training in a teaching hospital in 2012. If they consented to participate in the longitudinal study, they were asked to provide their name and an email address for future contact by the Chief Investigator. (See Section 12, Appendix B. Ethics Approval). A group of 22 student initially responded, Due to a range of reasons 14 dropped out, and eight self-selected final year medical students consented to participate in the study for 12 months.

As previously agreed with Queensland Health, this intern phase of the study has been undertaken by individuals, independent to their employment by Queensland Health (The State Health Department), in their own time, using resources (location/computers) separate from Queensland Health,.

## 5.4 DATA COLLECTION

### 5.4.1 SINGLE QUESTION REFLECTION (SQR)

An email invited all 401 Year 4, UQ SOM students to participate in the following reflection, 'What have been the main influences (positive and/or negative) in how you have learned to express compassion for your patients when working in the clinical context?'

### 5.4.2 IN-DEPTH INTERVIEWS

Participating students were invited to continue in a longitudinal prospective study as they moved to their intern year in a teaching hospital in Queensland or interstate. This phase of the study required interns to participate in three in-depth interviews with the Chief Investigator (every four months for 12 months).

The data provided by the interns' journals was used to facilitate more in-depth discussion in the interviews. Exploring how the junior doctors constructed meaning from their clinical experiences in the context of compassionate care, I asked the interns to tell me their story. I initiated this discussion by asking them what initially attracted them to study medicine. This question usually captured their 'personal' story. From this I asked each about the term (10-12 week rotation they undertake over the year) they had just completed. Then, using both the content from their journal entries and their interview stories, I prompted them, asking them to tell me about their reflections; inviting them to explore their journal reflections in more detail and asking for clarification where their stories were incomplete or had evolved or changed over time. At an opportune time during the interview I also asked each of the interns (if not already addressed in discussion) 'what compassionate care meant to them as a doctor and as an individual?', and whether they used non-clinical touch in their provision of patient care?

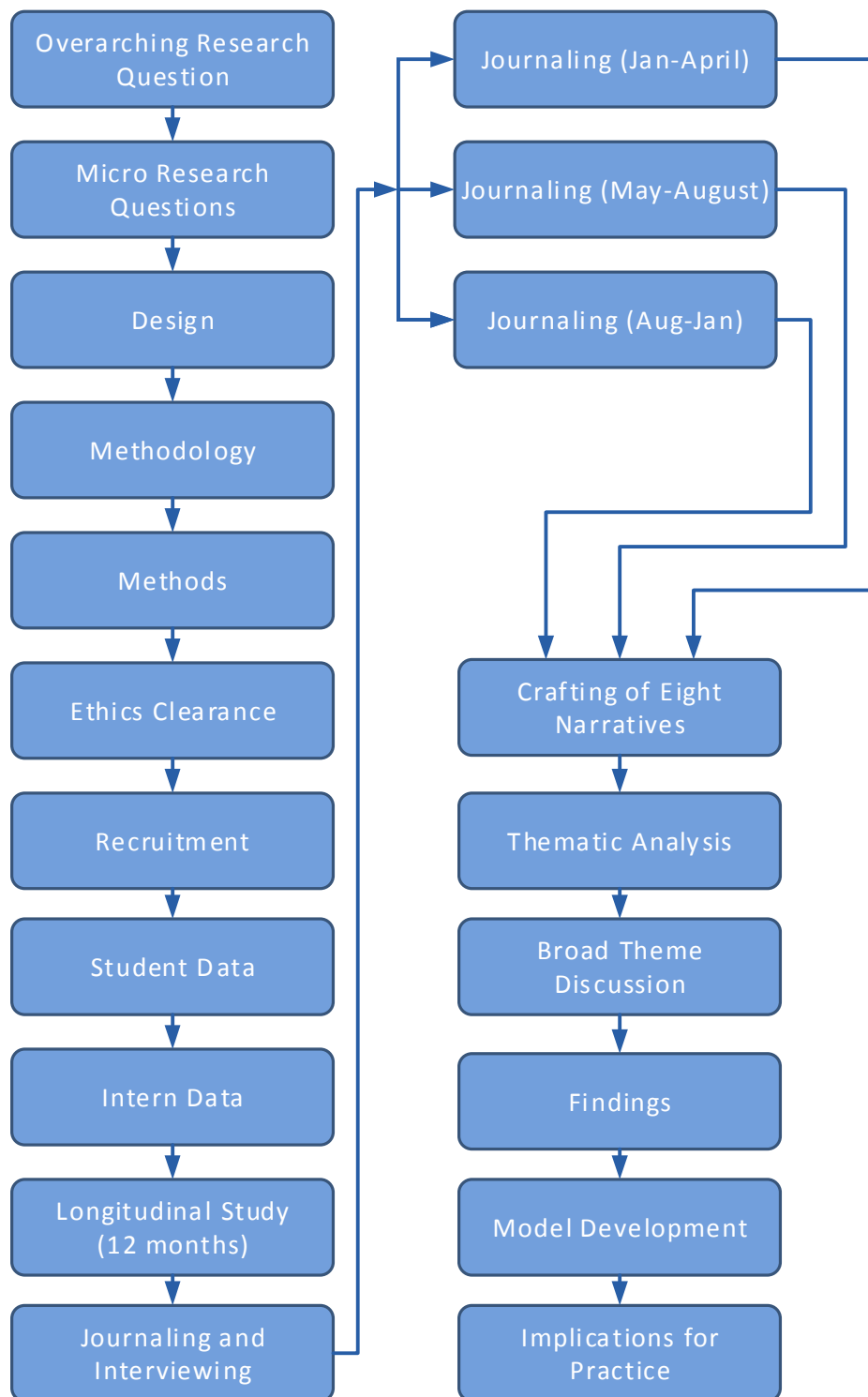
### 5.4.3 JOURNALING

Anchored in the overarching research question, 'how do doctors learn to express compassion in the clinical setting?' the Interns were asked to reflect on their intern year by journaling any relevant experiences which they found meaningful in their day to day clinical practice. Beyond requesting they journal their experiences no other specific directions were given. Participants were free to choose how they would record their journal. A range of media were used, including typed electronic journals, blogs, video and audio journal which they sent to me by email. Participants also chose how often, and how much, they shared. If necessary, the participants received reminders about their journal, through a friendly email. Two weeks prior to the face-to-face interview participants were asked if they would like to make a journal contribution (if not already received), to inform the interview process.

### 5.4.4 INTERPRETATION OF DATA

As discussed, this interpretative study is underpinned by both constructionist and constructivists theoretical frameworks (Crotty, 1998), (Webster-Wright, 2010).

In my study, the eight participating interns wrote reflective journals and participated in extensive interviews over twelve months to explore how they learnt to express compassion in the clinical context. Their learner's journey is shaped by the lens of compassionate care. It is these data which makes up my research database. Figure 2 below illustrates the flow of the research process.



**Figure 2 – Research Flow Diagram**

My methodological approach is two-fold. Through using narrative inquiry I developed storied episodes of each intern's transition to practice. In the thematic analysis I identified commonalities across the interns' narratives to inductively develop theory.

## 5.5 NARRATIVE APPROACH

Drawing on Polkinghorne's (1995) guidelines for narrative analysis, I integrated and interpreted the data - journal entries, reflections and unstructured interviews - to produce emplotted narrative. Polkinghorne (1995) recommends that the researcher must have 'a bounded system for study'. In this study the bounded system is the first year of conditional registration of an intern who studied medicine at the SOM at the UQ.

Unlike thematic analysis or paradigmatic narrative inquiry, in narrative analysis, a coherent account rather than a separation of parts (Polkinghorne, 1995) is the aim of the interpretive inquiry. The events and actions in the data are configured in building a plot. The temporal unfolding of the story is the end product of the narrative analysis.

Similar to the use of the hermeneutic circle (Heidegger, 1962), the story is created through the 'to-and-fro movement from parts to whole' that is involved in composing a complete text (Polkinghorne, 1995, p. 16). The completed story must reflect the data, while providing order to the learner's journey (Polkinghorne, 1995).

Polkinghorne (1995), suggests Dollard's seven criteria for judging life history in developing a storied history or case study. I have used the criteria as a guide as outlined below through:

- providing a description of the cultural context of the hospital setting to enhance understanding of meaning and relevance of the events
- attending to the 'embodied nature of the protagonist', by including the interns' descriptions of their embodied response to the events they experienced
- being inclusive of the interns' relationships with others, both their colleagues and patients, as they significantly affect actions and behaviours
- concentrating on the choices and actions of each intern as the central character of the individual narratives

- providing some personal details (where relevant and agreed upon) of each intern to shed light on how their past experiences may influence how they think, feel and act
- ensuring the story has a beginning, a middle and an end – a bounded temporal period – being their first year of being a doctor – their internship
- ensuring the story is plausible, and understandable

In developing the eight stories, I followed Polkinghorne's (1995, p. 18) recommended steps as described below:

- starting with the denouement, the final outcome
- arranging the journals and interviews in chronological order
- identifying which elements were contributors to the outcome
- looking for connections of cause and influence among the events and beginning to identify actions and elements by providing the 'because of' and 'and in order to' reasoning
- finally writing the story, 'drawing together into a systemic whole'

In developing the stories, I have used the participants' own words, using my voice to provide context and flow. As I have focused on the participants' actual words and text, I have also chosen to provide an analysis of each of the stories through providing a commentary for each of the stories and a summarising commentary across the narrated stories at the end.

## 5.6 THEMATIC APPROACH

In keeping with the interpretive nature of this study, drawing on existing literature and methods, the data are analysed using a thematic analysis informed by broad guidelines developed by Braun et al. (2006) and specific constructs defined by Schultz (1970). Within this framework, first order constructs are those provided by the research participant and second order constructs are those defined by the researchers (Schutz, 1970). To enable the students to construct their own meaningful understanding of compassion their reflections were not limited by a specific definition provided by the researcher.

However, in undertaking this research, for the researcher, compassion, in its many and nuanced manifestations, is identified as a pro-social, moral emotion (Haidt et al., 2003).

The collective thematic analysis is informed by the work of Titchen et al's (1993) work as used by Ajjawi and Higgs (2007) and (McAllister, 2001) as outlined below:

#### Stages of Data Analysis

- a. Transcribed – checked accuracy of reflections/journals/interviews
- b. Immersed - ordered data into texts, iterative reading of texts
- c. Restoryed – the eight individual intern's journey to represent dominant discourse within the narrative and to illustrate their personal, professional and official accounts.
- d. Undertook - a collective thematic analysis as informed by Titchen and McIntyre (1993) using the following steps:
  - a. Understanding – identified first order constructs (interns), coded data
  - b. Abstraction – identified second order constructs (researcher) – and grouped into sub-themes
  - c. Synthesised - theme and theory development
  - d. Illumination – linked themes into literature, further theory development
  - e. Integration and critique – critiqued themes/discussion and developed final interpretation and representative model

#### 5.6.1 PARTICIPANT VALIDATION OF NARRATIVES

The participating interns were recruited for the study in November 2011 and commenced their internship, mid-January 2012. At this point they also commenced journaling their twelve month experience as an intern anchored in the context of research question on how they learn to express compassion. They were each interviewed three times during the year. The final interviews took place in December 2012/January 2013. Two and a half years later I contacted each of them by email, providing them with their draft narrative. I asked their permission to use the narrative alongside my interpretive discussion and specifically asked them to ensure I had not provided too much identifying personal detail. I also asked them to provide a pseudonym or agree



to mine. I stated that they did not have to agree with my interpretation, explaining that as an interpretive study, it was neither right nor wrong. I was seeing their narratives through the lens of an outsider and that this would be made clear to the reader. I offered to exclude their specific narrative if they preferred to have it used only in the collective thematic analysis, or to remove specific parts if they felt strongly about my interpretation or inclusion of specific text.

Apart from asking for a few of their hesitations to be removed, e.g. ums and ahs, all eight approved the use of their narrative. Seven of the eight, specifically stated that they felt it was a 'true' interpretation of what they experienced and how they felt; the eighth participant wrote he was happy for me to use his narrative as I wished. With permission from the participating doctor, I have provided feedback which is representative of the nature of the comments I received in their return emails.

*It's strange seeing my thoughts from my intern year and reflecting on what I was like back then, and how I am now! I have to admit, reading about my first death brought a few tears to my eyes - rehashing all the fears and memories!*

*I think you've done a brilliant job putting my words into context and I enjoyed reading the analysis! I'm quite happy with it and the details that are included...*

*Intern Paul*

## 6 FINDINGS AND DISCUSSION

### 6.1 THE INTERNS' NARRATIVES

This study seeks to build understanding as to how junior doctors learn to be compassionate in the clinical context. In the following chapter there are eight stories which respond to my research question 'how do novice doctors learn to express compassion in the clinical context?'. These stories provide a depth of understanding to the novice doctors' experience of translating knowledge, bound with attitudes and values and a desire to be a caring and compassionate doctor, into practice.

Using narrative inquiry as a way of analysing, illustrating and interpreting the participating doctors' texts has allowed me to 'observe' how junior doctors conceptualise compassionate care and how they see their role in relation to others within the sociocultural context of their developing professional identity.

These storied texts illustrate the temporal nature of change, in relation to place and context and in response to different people and events. In analysing and interpreting these themed stories, I am interested in both what the junior doctors say, being the content of their story, as well as how they tell their story, being the language they use. This analysis is an iterative process providing opportunities for the stories and interpretations to be reviewed and re-interpreted as the novice doctors complete their intern year and as my study and interpretation evolves.

#### 6.1.1 HOW TO READ THE FOLLOWING NARRATIVES

These narratives and interpretive analysis may be read in two different ways. The italics, if read in isolation from the analysis, provide the intern's written and verbal transcripts unchanged from his/her original wording (except for the exclusion of obvious identifiers such as names of colleagues, or hospital locations). At the interns' request I have not included all their ums and ahs, but where I thought it added understanding I have included their hesitations and and their repeated words or phrases as I believe they capture the inherent

difficulty in articulating the emotional and at times unconscious thoughts and feelings which influenced their behaviours and ongoing practice. For similar reasons I have not changed the spelling or grammar of their direct quotes. Each intern provided me with over 20,000 words of text by the completion of this study. Like a diver diving to the ocean floor, you are confronted with a myriad of treasures from which to choose. In restorying each intern's story, I was diving for pearls, pearls of compassion. I like this analogy, as it is through agitation a pearl is created, and so too for 'my' interns, their dissonance and difficulties are shaping their developing professional identities. Within the text, I have chosen the lens of compassionate care in which to retell their stories, and locate their narrative. The plain text narrates both my story as a researcher and my interpretation of the learner's journey; they can be read in tandem or isolation.

In asking junior doctors to articulate how they have learned to express compassionate care, I am asking them to reflect on what, in many cases, has been unconscious behaviour. For them to articulate their thoughts feelings and actions is like asking them to 'unscramble eggs'. The use of metaphor is woven throughout their stories; allowing them to describe their experience, painting a visual picture, comparing the commonalities within different concepts, which allows them to explain and capture their experience for the reader or audience, in a way that other words may not.

I have written each intern's narrative as three distinct stories: his/her official account, which encompasses the expectations of the health service and registration board for his/her conditional year of training; his/her personal story, as to why s/he chose to study medicine and what s/he has brought to it; and his/her professional story, his/her first year of being a doctor. These three storylines highlight the separation of personal, professional, and official. In reality, these three storylines are blurred and in essence this study is about the integration of the three and the existing tensions between the personal and professional in the junior doctor's official role which impacts on the way in which they show they care for and about their patients.

## 6.1.2 THE “OFFICIAL” ACCOUNT

The eight participating doctors share the one official account. The official story is mandated by the Australian Health Professional Registration Authority (AHPRA) registration requirement. It is important that the reader understand this official account as the rotations the novice doctors undertake are crucial to their journey as a learner, to service delivery and to the intern passing the terms to receive unconditional registration. Significantly their supervisors may also be their assessors, which creates a potential power dynamic, not directly addressed in this study.

Each of the eight interns participating in this study is required to undertake 48 weeks of conditional employment in a hospital. During this time they have to complete three core terms of at least 10 weeks each, being surgery, emergency and medicine. They are also required to undertake two elective terms. In Queensland, Australia these electives may include mental health, obstetrics and gynaecology and paediatrics. These can be unusually demanding terms, some states in Australia do not accept interns into obstetrics and gynaecology or paediatrics because of the high risk nature of the clinical work. During each of these terms they are supervised and assessed and have to meet standards across clinical, communication and professional domains to ‘pass’ and be granted unconditional registration as a doctor in Australia. Failing a term requires the term to be repeated and delays their registration, which may impact on their future employability in what is a very competitive work environment with merit-based progression into future post graduate training. The learning objectives of their terms are drawn from the Australian Curriculum Framework for Junior Doctors, and the accreditation of these terms is overseen by a state-based accreditation body independent of the hospital/s.

As a study participant they initially wrote a short reflection for me as a final year (Year 4) student at UQ SOM, and once they transitioned to the intern space, have kept regular journal entries, recounted through the lens of compassionate care, as they completed their learner’s journey as an intern. I undertook in-depth interviews with them during term 1/2 (April/May), term 3/4 (Aug/Sept), at the completion of their intern year term 5 (Dec/Jan) when, once they have met the assessment requirements, they received and became a

junior house officer (Queensland) or a junior medical officer (other states in Australia).

### 6.1.2.1 Dr. Phoebe Brown – My Tiny Bubble of Panic

Phoebe is in her mid-twenties and was drawn to medicine from a very young age. She attended a small Christian school, and despite her initial interest in medicine, she didn't consider medical school a viable option when she completed high school. When I asked her why, she responded, 'I honestly didn't even think of medicine as a practical option for me. I just assumed it would be too hard I suppose.' She commenced a psychology degree and then realised halfway through 'that (she) really wanted to do medicine' and so once she finished the degree, she applied and was accepted.

#### PHOEBE'S STUDENT REFLECTION

Responding to the student question Phoebe wrote:

*There are some great examples of compassionate doctors around to learn from and some terrible ones. Most good examples of compassion have been simple acts like seeking out food for a hungry emergency patient or taking huge amounts of time to go through a treatment plan. I've tried to reflect on any contact I've had with medical professionals as a non-student to remember what it is like to be on the other side of the bed. As well, I've tried to observe what it is that allied health members of staff do that makes them so valuable.*

In Phoebe's student reflection she captures a number of key elements which she believed contributed to how, as a student, she has learned to express compassion. She described the simple act of a doctor seeking food for a hungry emergency patient, which recognises the needs of the patient beyond their immediate medical needs. The use of time, in both taking time to communicate a treatment plan and providing the patient with a time-line, contributed to the patient's sense of control. Her examples focus on patient-centred care. By drawing on her pre-medical student experiences, Phoebe tried hard to place herself in the patient's shoes or as she described it 'being on the other side of the bed', in order to develop an empathic

perspective towards the patient. Finally she commented on her close observation of the valued behaviours of the allied health staff. You get a sense, that through close observation of her colleagues in practice, Phoebe is trying to understand the tacit elements of care beyond the immediate biomedical issues.

## **PROFESSIONAL STORY – PHOEBE STARTS HER INTERNSHIP**

*During my first few days as a doctor I was excited to be helping people. I was keen to find out about my patients (sic) problems, medical, social and psychological so that I could be a wonderful caring doctor for them.*

In her initial journal entry as a new doctor Phoebe wrote about her excitement in starting out as a doctor and wanting to be ‘a wonderful caring doctor’. She wrote explicitly about ‘my’ patients and wanting to address their problems, ‘medical, social and psychological’. Her excitement in her new role was tangible.

Phoebe described how she quickly ‘swung the other way’, within weeks feeling cynical about the patient group.

*It didn't take me long to swing the other way.*

*I was working in a small country hospital ED, which functions partially as a GP service as there is limited access to GPs in town. Of course it is free and so unfortunately it attracts a rather demanding clientele who can't or won't pay for services.*

The shift, over a few weeks, in how she thinks and feels is dramatic and contrasts sharply with her original intentions. Her language shifted from writing about ‘my patients’ to her frustrations in dealing with a ‘demanding clientele’.

*I saw so many people in the first few days who came walking in with 10/10 pain and refusing to purchase their own scripts as well as an equal number of people with nothing more serious wrong with them than a minor cold. I became sick of investing energy into them that wasn't rewarded with a diagnosis or resolution and cynical about finding anything wrong with them.*

In her journal Phoebe described her patients as ‘demanding, frustrating people’. Her writing diminishes their claims to pain, as well as the seriousness

of their symptoms. The reward she anticipated as a new doctor was a diagnosis or resolution. She perceived the patient mix, their symptoms and level of acuity, and the free access to care which accepts patients with 'nothing more serious wrong with them than a minor cold' as denying her this, resulting in her quickly defaulting to cynicism, and to belittling the patients' health needs. Phoebe's reflections are interesting, as within the literature, a decline in empathy is reported in medical students after their third year of studies - a time when students engage more fully in clinical practice (Hojat et al., 2004). Hojat et al's research raises questions regarding the influence of colleagues, the culture of medicine and contact with patients on medical students' erosion of empathy. Phoebe's reflections suggest her inability to deal with the patients' need, and wants, and her perception of them as undeserving has a major influence on her diminishing ability to show compassionate care.

In our interview I asked her to tell me more about her journal entry and her experience as starting as a new doctor in an emergency department in a small town.

*To be honest I don't really think I'm a naturally compassionate person but I think it's something that I'm quite conscientious about and so I guess I strongly want to be a compassionate doctor as being a compassionate doctor is essential to being a good doctor. Isn't it?*

*All the doctors that I respect and want to be like, being a compassionate doctor is a very noticeable feature of all of them. But I guess the problem that I really see with myself is that I lack patience with people, even though I feel I that I want to be a compassionate doctor I have lost patience with patients very quickly and started to see the worst in people fairly quickly.*

While Phoebe suggests compassion does not come naturally to her, she emphasises her conscientiousness and how she is highly motivated to be compassionate, suggesting it a skill she hopes to learn through practice. Being conscientious is a theme Phoebe refers to several times in our interview and in her journals. Within medical education being conscientious has been used as a measure of professionalism, illustrated by behaviours such as being punctual, completing mandatory training and having the required vaccinations (McLachlan, 2010) (Papadakis et al., 2008). It appears that this reductionist

framing of conscientiousness is not the conscientiousness to which Phoebe refers. Her use of the word suggests more a conscious awareness of wanting to do the right thing and to be mindful of attempting to be compassionate in the way in which she provides care.

In our interview I asked Phoebe what she meant when she uses the word conscientious. There was a long pause ...

*Well I guess, at the moment being a conscientious doctor is better than being a feeling doctor just because um, I want to be a conscientious doctor cause that means I am good to my patients even when I am having a terrible day. Um, that I'm able to, and again I'm you know, we are talking about compassion and I am saying you express compassion through being conscientious. And so I guess what I am saying is, by that is that a conscientious doctor follows the same procedures and the same rules, um with every patient regardless of whether you like them or have compassion for them or not. OK? That's what I mean by it.*

So for Phoebe, on a bad day being conscientious may be more possible than being compassionate. Her definition describes providing every patient with the same level of care regardless of whether you like them or feel compassion for them. In this context, and for her, at this time, she suggests being a conscientious doctor is more important than being a 'feeling' doctor. She does however see compassion as an attribute which is essential to being a good doctor. Although she appears to seek my affirmation when she asks me 'isn't it?' The tension and dissonance Phoebe is feeling in wanting to be a compassionate doctor is palpable. She feels she is not naturally compassionate, strongly wants to be compassionate, perceiving compassion as essential to being a good doctor.

Through following her journey as a learner over time the temporal nature of narrative inquiry provides further insights into how Phoebe's more cynical response is tempered by the influence of her colleagues, whom she observed engaging with patients in ways which met the patients' emotional needs but with boundaries which protected their own emotional wellbeing.

*I'm happy to say that this process didn't last long either. I was fortunate to be surrounded by very caring and experienced doctors who*



*demonstrated how to sympathise with patients without necessarily becoming invested emotionally.*

When Phoebe completed her term in Emergency she commenced her surgical term. In our interview she talked about the impact of the style of practice as follows:

*It's probably not for me. I'm surrounded by great people um it's definitely the way to learn and work very fast but it's just not the style of practice that I really like. It's very high turnover and it is very superficial to the practice. We reschedule people for 2 min at a time and I really don't enjoy it. It's a very stressful sort of high paced environment as well.*

Patient throughput and turnover result in less patient contact, and a high stress environment which diminishes her enjoyment in her role.

A couple of weeks later, Phoebe, obviously influenced by the nature of the research she is participating in, made the following journal entry:

*I thought I should get a definition of compassion before I wrote anything more about it. I have been thinking a fair bit about compassion over the last rotation but haven't gotten around to putting pen to paper. I thought also that I would try to reflect separately on my surgical and ED rotations.*

*Compassion: 'a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering'.*

*(Dictionary.com, ) referred to by Phoebe*

After sharing her definition in her journal she wrote:

*I didn't much enjoy my surgical rotation and I really don't think I learnt very much about compassion at all during it. Surgical ward rounds are incredibly brief, the workload is huge and as an intern you actually have very little direct patient contact during the ward round. Because the workload is so large, it is very easy to view any opportunities for expressing compassion such as a discussion with a patient's family or a call to manage post-operative pain or request to consent a patient for*

*theatre as being an unwelcome distraction from that massive list of tasks you have to get through. To be honest, I think I spent the first two weeks of the rotation in a constant flap. Patients' requests were an annoyance. I was so highly strung that I found it very difficult to notice anything outside my tiny bubble of panic.*

Phoebe's reflection provided further insights into how the nature of the surgical rotation, and the pressure she felt in undertaking her role, influenced how she expressed compassion. Ward rounds are brief. The workload is huge. Patient contact is minimal. Phoebe lists three potential acts to express compassion: discussion with a patient family, management of post-operative care, and a request for consent. For her, due to the enormity of the workload, these 'annoying' patient requests have become an unwelcome distraction to her 'massive list of tasks'. Yet, family discussions, pain management and consent are core responsibilities for a doctor. It appears it is patient interaction and the demands it places on Phoebe, as an inexperienced doctor working in a complex role and system, which appear to create tension and dissonance for her, stressing her both physically and emotionally.

Metaphor is used liberally in Phoebe's reflections. She writes of 'being sick of people', 'swinging the other way', 'being in a constant flap', 'I was so highly strung'. Her emotive use of language captures her turmoil. Phoebe's conscientious striving to provide compassionate care is hindered by her self-described 'tiny bubble of panic'. Phoebe's use of a bubble as metaphor is thought provoking. Her use of the word 'tiny' may signify how insignificant she perceives her role as an intern; having little influence and significance in the larger hospital system. A bubble is fragile, floating adrift, its direction dependent on the way in which the wind blows. A bubble is a separate entity. Phoebe writes about her difficulty in noticing 'anything outside my bubble', there is a separation and distancing between her inner turmoil and the day-to-day responsibilities of her role. Phoebe's journals reflect a sense of aloneness in her learner's journey. Within this bubble she struggles with incompetence, low confidence, frustration and impatience, which all impact on her ability to be the compassionate doctor she desperately seeks to be.

Compassion is an attribute she clearly identifies in the 'good' doctors she wants to emulate.

Phoebe's journal entry below illustrates the anguish she feels in wanting to be compassionate but struggling in not knowing how to handle the myriad of emotional issues she is confronted regularly in undertaking her role. She has a clearly defined expectation of her role, what she expects of herself as a compassionate doctor and what she aspires too, but struggled with not being able to achieve.

*Honestly, I do feel that I am a compassionate doctor. I really do feel for my patients. However, I am easily frustrated with them. I suspect I become frustrated and express less compassion when I don't know how to deal with them. I avoid emotional issues because I don't think I have the skills to handle them. I am very aware that being a good doctor means being able to deal with these problems but at the moment I feel so incompetent in so many areas that it seems the least of my worries. I hope that being aware of my desire to become a holistic style doctor who does genuinely care for their patients will mean that I maintain my sympathy for patients and conscientiously become better at dealing with emotional issues.*

Phoebe's reflections suggest a diminished self-efficacy (Bandura, 1994) where she perceived she was performing poorly in her role, resulting in harsh self-criticism: 'I feel so incompetent in so many areas'. This results in her avoiding emotional issues. Yet she continues to anchor her journals with her ongoing aspirations to be a genuinely caring doctor modelling herself on her peers who she seeks to emulate as holistic doctors caring for their patients.

In her final term as an intern, Phoebe works in a medical ward, where she is confronted by a number of patients receiving palliative care. She reflects on the difficulties she has in dealing emotionally with these patients who are approaching death. In her journals she reflects on her emotional distress and the need to distance herself from the emotions the patient's situation elicits rather than from the patient themselves.

*To be honest, I haven't enjoyed dealing with palliative patients. I find Fridays and an approaching weekend uncomfortable when I know that*

*one of my patients will probably die over the weekend. I find that I ruminate over what they and their families are going through when I should be focussing on family and friends. I've shed tears for a few patients and have lost sleep over a few too. I doubt very much that my patients or their families would know that they such an impact. This degree of empathy is not productive. Obviously it causes me needless distress and at least on a couple of occasions, has meant that I have struggled to focus on the needs of other patients on these days. I feel a desire to distance myself from these negative emotions and my impulse is to distance myself from the person who elicits them. I don't think I've done this yet but I certainly recognise the risk of this happening particularly if I was working in this field for a protracted time.*

Phoebe is fully aware of how the negative impact of engaging too much emotionally with the patient leads to her own personal distress. She recognises how her inability to cope may impact on her own emotional wellbeing and her care for other patients. She struggles in developing safe boundaries in providing compassionate care. She differentiates between expressing compassion, which she sees as an action, as opposed to feeling the emotion of compassion. She wrote:

*Compassion needs to be expressed more than felt. Without an ability to distance one-self from the emotion compassion elicits, it can be counterproductive.*

Phoebe expects to be able to be compassionate to all patients at all times, regardless of how she feels.

*Regardless of how you feel towards the patient – you can still express compassionate care*

She tends to be self-critical when she fails to reach the high expectations she has of herself. Brown (2010), in her studies on shame and vulnerability extends the work of the Buddhist monk, Pema Chödrön, who suggests our natural tendency, when faced with pain and suffering, is to default to self-protection, blaming and judging – Phoebe judges herself harshly. Neff's (2011) work on self-compassion and compassion fatigue, suggests skills in

self-compassion are protective against becoming burnt-out. These issues are addressed more fully in the thematic analysis.

Phoebe emphasised the positive influence extremely compassionate senior doctors have had on her in developing a habit of compassion and stresses the need for compassion to be openly valued. Her reflection highlights the richness of learning embedded in practice, and how she has learned from observing her peers.

*The expression of compassion needs to be openly valued in medical teams. I've been very fortunate to be surrounded by extremely compassionate senior doctors this year who I feel have been of inestimable value in establishing a habit of compassion.*

A continuous thread throughout Phoebe's narrative is the need to feel confident and competent in undertaking her role which frees her to express compassion towards her patients. Her journal entries talked of control and having sufficient knowledge. She wrote:

*The practice of compassion is made much easier by feeling in control at work and by having sufficient knowledge to feel comfortable discussing care with patients. At times when I've felt overwhelmed at work, my expression of compassion has suffered.*

Communication has also been a significant factor in influencing the degree to which she engages with patients, when she feels more confident in her role she is more willing to engage which affords more opportunities to provide compassionate care.

*Similarly, when bosses have clearly communicated their understanding of a patient's situation and rationale for the treatment decisions made, my ability to communicate confidently with patients in turn has improved.*

Phoebe's identity as a doctor is carefully crafted, again confidence is an important factor. Her personal and professional identities are quite distinct – with use of voice and manner as described by her below:

*I definitely have a professional facade. I think that you need to have one. I mean, you need to come across as someone who's confident and*

*knows what they're doing. Yeah. And my personal facade... (laughing)... would not portray that at all (laughter).*

*I have a doctor voice... I definitely do have one, you know? I think it's a more modulated tone, it's a style of speaking that is very basic, more direct tones, short sentences and clear language.*

In explaining how she used her voice, Phoebe explained:

*In the workplace. I mean, if one of my friends was up there, I'd probably talk to her in a similar fashion but probably not exactly the same way... I'm using the voice right now, I'm sorry... it's just a very... it's a very low tone, very calm tone that emits the same pitch and the same rate. And even my body language becomes very... more direct and slow-moving... parts of it are definitely conscious and even with the way that I dress, I've thought a lot about it, you know? I do think about these sorts of things... you have to think about the type of doctor that you want to be and I want to be one of those doctors that when you walk in the room, you feel like they know what they're doing, they're not going to miss something, that things are going to happen and that you can talk to them...*

In her final journal entry for the year Phoebe wrote:

*Finally, compassion seems to be so much more about making a patient feel safe and understood than it is about doing anything for patients.*

As our interview comes to a close Phoebe summed up her year and her desire to express compassion as follows:

*An expression of compassion I have only really managed in the last rotation or so, when I finally developed enough confidence in my ability to do the job, that I can just make time to do the things that I want to do.*

Phoebe has developed new understandings over the course of the year. Her narrative provides insights into the range of influences which have either enabled or inhibited her as she has grown from being conscientious to being confident in being compassionate in the way in which she cares for her patients. The 'little things' which were so important to her in her first observations as a student are now within her reach as a

compassionate doctor, an affordance which has only come through learning embedded in the messiness of practice, in tandem with her increased belief in her ability to do the 'job'.

### 6.1.2.2 Dr. Trevor Smith – Maintaining my Moral Compass

Graduating in his thirties, Trevor is older than most of his cohort. He has substantive experience as a senior high school teacher and is passionate and knowledgeable about both education and medicine. This influences the way in which he responded to the questions I posed, and the way in which he narrates his story, as he thinks both as an educator who values and understands qualitative research, and as a novice doctor entering a complex community of clinical practice. A number of events and life experiences contributed to his decision to change careers from teaching to medicine.

*My grandfather was an orthopaedic surgeon and a yeah, if anything he ah kept me away from the profession because as a younger person he had such a dominating personality style that ah, he made medicine quite unattractive to me, but ah, it was actually ironic that it was only events much later in my life, that I, changed my whole approach to what medicine was and that lead me down the path to where I am today.*

His grandfather was a formative influence in his life typifying the dominating personality type which he identified with being a doctor, and which he consciously rejected.

The events to which Trevor refers to in his reflection were a traumatic formative experience during his early 30s, when, on a 4WD trip with his wife and friends, one of the cars had a head on collision with another 4WD. This experience fuelled his motivation to undertake medicine. Trevor wrote:

*Somebody died in the other car and our friends were quite seriously injured... we were both only first aiders, we did what we could, um. We did a good job of it. And um, it affected everyone forever... for myself and my wife we sort of had a motivational... um, well we used to say that well we didn't fall apart. And we were motivated to do better next time...*

## TREVOR'S STUDENT REFLECTION

Responding to the initial student question, Trevor wrote:

*Positive factors 1) Those attributes that I had prior to entering medicine*

*2) The positive reinforcement of good doctors*

*Negative Factors - The dominant culture inculcated within medical practice*

Trevor's initial student reflection emphasises issues which become dominant themes in his narrated intern journey. Trevor is acutely conscious of his motivations to become a doctor but is fearful of losing himself in the process. His narrative suggests a sense of foreboding in the tension between his autonomous self and the institutional forces embedded in the culture of medical practice which he consciously resists.

## PROFESSIONAL STORY – TREVOR STARTS HIS INTERNSHIP

The hospital which Trevor was allocated to was a regional hospital with around 300 beds. As part of his intern year he was seconded from this hospital to a number of smaller hospitals to undertake 10-12 week rotations. The size of the hospitals in which Trevor worked are important as they have implications for the relationships and boundaries which formed in undertaking his role in a setting where instead of constantly developing new relationships, as you would be required to do in a larger tertiary teaching hospital, Trevor built a strong base of supportive colleagues as he moved from one rotation to the next.

In his early internship, Trevor sent me regular audio journals of his learner's journey. As the year became increasingly hectic his journal entries became less regular. However, his interviews were a rich source of narrative, providing insights into how he constructed meaning from his professional experiences over the year. They captured the shift in his thoughts and feelings as he moved from being an outsider, on the periphery of practice, to an insider embedded within its culture. His first journal entry reads:

*Looking back on my first 6 weeks as a doctor, I had never done that before but how I treat people, how I engage with people and how I engage with new situations, um, these patterns have been formed by a*



*lifetime of choices and influences. So while there is undoubtedly an important role in my mentors and senior doctors and other more junior doctors that I see and work with, my initial conception is that, largely you bring your own, for want of a better word your own moral framework, to start off with. But having said that, you know I definitely see that it is the interplay and attention between your supervisors and their way of doing things and your, your wish to assert your personality and your style and your own moral compass.*

Trevor's reflective narrative is focused on events and influential relationships; however he foregrounds what he brought to medicine, his own moral framework as the dominant influence.

For our first interview we met in a coffee shop in Paddington. Sitting in the sunshine, amid the clatter of coffee cups, music and chatter, Trevor reflected on events over the last few months.

In his initial journal entries Trevor narrated two stories in which he described two encounters with two senior medical colleagues who had a divergent approach in the way in which they nurtured the learning of their students and managed their patients. These seminal experiences are important to Trevor as they have been influential in shaping both his expectations and aspirations as a future doctor.

I asked Trevor to tell me a little about those two influential figures.

One of these encounters took place in an orthopaedic term. For Trevor, the influences of his childhood experiences of his grandfather were compounded by this unsettling student placement. Trevor narrates a bedside teaching encounter facilitated by a surgeon by a patient's bedside:

*One particular patient had been referred to his clinic... He (the surgeon) goes into the room and barely acknowledges the patient, puts the x-rays up, we all of course have our back to the patient, while he is grilling us for about 10 mins and this guy was in his mid-30s, his wife was pregnant with their first kid and he is packing himself 'cause he wants to know if he is dying with cancer or not, and so this goes on for 10 minutes and I am just cringing cause I can just see the guy packing*

*himself and all this (name of doctor) wants to do is give us a hard time so we can learn and all the rest. In the end he says I don't think it is a problem but you need to have an MRI... we'll see you next week... And he, ah, was somewhat relieved by that, but I you know I just thought this guy has no consideration what-so-ever for the feelings or the impact of his actions. It obviously doesn't cross his mind though, it is just the way in which he has been acculturated into a biomedical practice. He is undoubtedly being competent you know, I have no reason to judge his clinical capacity but I am would never, ever refer to him or anyone like him, just because, yeah, his total ineptness in um understanding the social impact of the situation of his actions and I was just horrified.*

Trevor's narrated story provides the dual perspective of the learner and of the patient. The visual picture he paints of the students' backs to the patient, as the patient's xrays are discussed, emphasises the surgeon's total disregard for the patient's feeling. You sense Trevor's affront in the surgeon's behaviour. Trevor's narrative evokes a sense of powerless of both the students and the patient (and his wife) His words capture the discomfort the tension creates for him. He is empathetic, placing himself in the patient's situation. Trevor's language is emotive, his narrative emphasises both the patient's feelings, how the patient is 'packing it', and his own embodied feelings, as he describes physically cringing in response to the surgeon's behaviour, the horror he feels. He attributes the enculturation of the medical model for being responsible for the surgeon's behaviour. Yet the surgeon's behaviour does not diminish Trevor's perception of the surgeon's competence, which he frames in clinical terms by separating caring and competence. For Trevor, in narrating his experience, despite being a medical student, in the telling of this story his alliance is far more closely tied to the patient than the surgeon.

This student placement is an influential formative experience which endows Trevor's experience with meaning in knowing what he does not want to become. The surgeon's behaviour appears to personify for Trevor all the dislikes and fears about the influence of the dehumanising aspects of the medical model. This narrated story, told by Trevor, is a clear example of the lack of correlation (Wenger, 2007) between what the surgeon intended to teach, and what Trevor learned from observing the surgeon-patient interaction.

This experience is juxtaposed with an encounter with a medical consultant, which was affirming and reassuring, reminding Trevor to maintain his moral compass.

*The tension you have as a first year is that you want to help everyone. I think most people do. But you really can't do it in the way that you want to in the hospital system... there is no way to give everyone the detailed personal attention that your instincts crave to give... So, ah there has to be a compromise, you know you can't give 100% time that you would like to.*

Herein, Trevor's narrative highlights another stress a novice feels when confronted with the competing pressures of efficient service delivery, time constraints and meeting the individual needs of patients. Trevor's language suggests an emotional tug-of-war between innate instincts and institutional imperatives.

*I said to him (the consultant), this was in late third year quite often you have demented people on the ward and you know they cry out, doctor, doctor or nurse, nurse, all the time, it still makes me cringe as I go past. You know 'cause I know I have gotta ignore it but I find it hard to ignore. He said a very wise thing, he's very, very kind. Well you know, you don't have to ignore it, it's okay to pop your head in at least once that day and see if everything is okay. Give them a quick assessment, if it's not then you can do something about it. But um, ah, his words were important to remember, it's good to remember the reason why you came into medicine in the first place. Yes, your behaviour has to modify and you learn different ways of approaching (sic) but you can still, you don't totally lose your reason for coming in here and just following the way people want you to do it. Yeah, and I thought that was, ah, very wise. It was a good reminder for me.*

In acknowledging 'he knows he has to ignore it' Trevor explains to me the patients 'belong' to another doctor. In narrating this story he is illustrating one of the many boundaries which define the community of practice he is entering and the complexity of the system he must navigate his way through as a novice.

The biographical details of Trevor's student experiences provide a narrative basis on which to build his learner's journey as he constructs his professional self. His narrative is initially embedded in the patient experience with his relationship with the consultant being transformative in the way in which his words reaffirm for Trevor his motivation for his vocation. The influence of both the surgeon and the consultant highlight the relational and social dimensions of learning embedded in their roles and responsibilities within their shared community of practice.

Ironically for Trevor, his first term as an intern is also in orthopaedics.

*When I started this rotation I had a lot of foreboding into what it would actually be like and um, whether I could handle or how I would survive as an entity in a field of strong personalities.*

Trevor's use of the word entity highlights his disconnect from others in the team; with his focus on survival highlighting his vulnerability as he commences his rotation.

However, to Trevor's surprise the rotation is an overwhelmingly positive learning experience, predominantly due to the supportive nature of the supervising surgeons their relationship with their registrars and the flow-on effect with the more junior staff.

A few months later, when Trevor reflects on a patient who is improperly diagnosed for terminal cancer, he comments:

*the thing I've learnt early this year as an intern... is to be kind on your colleagues. Because you get caught in situations where you have to take short-cuts. You have to compromise somewhere. You can't do it all professionally.*

This response from Trevor is evidence of a small shift in his alliance from patient to colleague. This is manifested in a number of ways; his emphasis on being kind to colleagues, his acknowledgement of the need for short-cuts and compromise. Interesting too, is the way in which he framed these outcomes as an acceptable departure from professional behaviour and actions.

During our second interview, Trevor talked about a difficult relationship with his supervisor and about learning to 'play the game'. While I assume I know what he means I asked him to be more explicit, I asked 'tell me when you say 'play the game' what do you mean?' Trevor responds 'Play the game is in the most literal sense, is that you need to follow the direction of your supervisor or your boss. Even when it's not in the best interest of the patient.'

This comment from Trevor captures the contradictions inherent in working in a hierarchical culture where your supervising consultant also undertakes your assessment which ultimately influences whether you receive your unconditional registration when completing your conditional intern year. For Trevor he felt compromised; he needed to follow his supervisor's guidance despite not feeling it was for the benefit of the patient. Wenger (2007, p. 175) refers to this as the 'tradeoffs of engagement'.

The relationship which Trevor had with his supervisor was central to how he performed his role; including his ability to express compassion.

*You know, I could really see that their trust in me had grown a lot and I wasn't needing to be interrogated so much as I had at the beginning of that particular rotation... Early on, now I don't know if I told this last time, but... Very early on, it's almost no matter what you said, they would be able to just find a hole.*

*It's the pressure that you get that diminishes your ability to act with compassion.*

*You need autonomy to be able to act with compassion. If you're in a totally prescriptive situation and you don't have a degree of freedom to deal with, you're not able to... you don't... you're not able even to extend compassion to your patients*

*And yes, the more experience you have and the more of a relationship you have with the supervisors, the easier it is.*

For Trevor, both his increasing experience and his supervisors developing trust in him, gave him greater freedom to be compassionate towards his patients. Elsewhere, he talked about being given 'permission to grow' and the 'shelter of practice'. His reflections are suggestive of a softening of the

boundaries between the roles and responsibilities of his supervisors and his own role as an intern, a building of mutual respect and trust.

*Here's another analogy. Particularly in our thinking, we were talking about empathy and compassion towards patients and stuff. At the beginning, it was quite idealistic. Hmm. And I tried. In terms of a relationship, it's a bit like... you know, falling in love. Yeah. You have all those expectations, but then as the relationship matures, you knock a lot of the edges off. Yeah. But it may not be as idealistic as once, but there's a type of realism that then replaces that. And a substance. Yes. Hmm. And so, rather than just aspirational thinking ahead, you know, you have reality from within which to practice. And the good and the bad experiences that I've had this year, some of which we've shared, you know, just help me to build my identity and I'm quite comfortable with it ...*

Trevor's narrative emphasises the lived experience, differentiating between aspirational thinking and the day to day reality of practice, and the influence of experience embedded in practice influencing his developing identity as a doctor.

The temporal nature of Trevor's story, continues to illustrate a slow shift in his positioning within the culture of medicine, as further evidenced by his acceptance of black humour, a well recognised tool used to cope with difficult situations within in-groups, historically providing an entrée into medical practice (Bleakley, Bligh and Browne, 2011, p. 39).

*Oh yes, I think now, further into... you know, towards the end of my first year, nearly at the end of my first year, I am much more comfortable operating with black humour, particularly as I did with... joking with colleagues. Yeah! But I feel strong enough here to do that. Have a joke privately in (at) the expense of a situation or person, but still have empathy and compassion towards them.*

For Trevor, the above quote illustrates how he has found another compromise, a way in which to be part of his community of colleagues but not at the cost of losing himself or his concern for others, finding a middle ground, between being himself and being a caring doctor.

I asked Trevor about the role models who so impressed him when he first started out, he responded accordingly:

*The closer you get to anyone you know, they become more human. Just more real? Yeah, having hissy-fits over people that frustrate them, particularly with the administration things. And it's from a good place that they have a hissy-fit. I have hissy-fits, so I'm glad that he does 'coz I certainly do... you know they've become more human ... and more likeable, probably, for that. (laughs)*

Trevor's relief is plain, the doctor who as a student he idealised as a role model, placing him high on a pedestal, is now much more accessible, as he perceives that they share the same human foibles - a frustration with the system - a common ground. Yet boundaries continue to exist, for his mentor, the bad days do not extend to getting frustrated with patients.

In our interview, my role as researcher, potentially influencing Trevor's responses, is evident in the way in which he carefully crafts his words.

*And this might be a bit of a shock to you, but the patients are just little buoys going past you in a very fast river...It just is, they change so often. So the patterns that you have and the way that you deal with them and your default intention towards them become more and more formed by other people around you, not by them.*

Trevor's use of a fast flowing river as a metaphor in depicting the patient flow is illustrative of a growing shift in his approach. As Trevor's role and responsibilities increase and he becomes more accepted as a member of the practice, the patients, while still central to the role of the practice, have become more peripheral to Trevor's everyday practice and his developing identity as a doctor.

Trevor's initial focus was very patient centred (wanting to respond to the demented patient calling out) not only in the delivery of care but in shaping his learning and in forming attachments, it was as though he was one of 'them'. His behaviour and actions 12 months later are anchored in his colleagues and team around him; he looks to his colleagues for affirmation and reassurance.

In our final interview I asked Trevor about his original concerns, he responded:

*The negative factors in what I wrote... in that, it's speaking a lot of my hidden fears of the medical profession. Hmm. Particularly from a student perspective. And they're still there but now I'm part of it, it's a less acute... Oh... you'd have to realise that's part of me becoming part of the profession.*

Trevor's emphasis on 'being part of it' demonstrates his increased identification with the role he undertakes and the culture that is an extension of that role, it is as though he has taken it on and conquered his fears. In our interview I asked Trevor to reflect back on his earlier concerns regarding losing himself to the culture of medical. He responds:

*'I was looking as an insider outside to some of the most negative aspects of the medical profession... and from an outsider, it was a very fearful thing to move within it. So I don't have that fear anymore... The compassion and empathy – I feel confident enough to be able to express that, in spite of those fears now.*

Trevor's reflections suggest that his fears of the culture of medicine had been an inhibiting factor in his ability to express compassion and empathy.

As our final interview came to a close, he reflected on the last year.

*So now, a year down the track, I'm much more comfortable within that profession, though still being quite critical of it, but I've been able to occupy space and learn and work within it. So... the fear behind that negative statement is no longer there. Does that mean I'm not compassionate anymore? No. Am I still exposed to pressures from within the culture of the profession? Yes, but I feel much stronger within that now because I found my own feet and I'm still recognising there's a long way to go, but it's like I found... metaphorically, I found my voice so I'm comfortable with that...*

It is through engagement and participating in practice that a novice aligns themselves within a community of practice, creating their own place amongst its members (Egan and Jaye, 2009) (Wenger, 2007). Trevor's use of metaphor is suggestive of this belonging or connectedness. For Trevor, perhaps, in finding his feet, he has found the place he belongs in the profession, his fit. In using



the expression 'I found my voice'; he uses a metaphor which emphasises the relational connection to others, sharing meaning and experience, being heard by others, others with whom he has a mutual respect and shared understanding.

So a year down the track Trevor is less of an idealist, perhaps a little more cynical 'having to play the game' to pass the term. While still wary of the culture of medicine, he appears reconciled with the blurring of his personal and professional selves and his identity.

In completing the narrative arc, Trevor has modified his way, compromised and at times conformed. He has navigated a complex myriad of clinical practice to the year's end. No longer on the periphery, he has gained legitimate entry into the community of practice (Wenger, 2007). While Trevor's metaphorical moral compass has wavered at times; his emergent identity continues to extend his compassionate care, perhaps more pragmatic and more practical, but not lost to the demands of the complex system or medical culture in which he works and by which he is now defined.

Trevor's narrative does however shed light on how the day to day demands of patient care delivered in a complex community of practice, with high stakes, may lead to a shift in the way in which care is provided. His learner's journey illustrates the potential for an erosion of the humanistic elements of care, when the practical realities trump the aspirational ideals of the novice. For Trevor being conscious of his personal values and actively seeking positive role models, who acted in consonance with him, provided him with a protective mechanism, when a less experienced and more easily influenced novice may have succumbed more easily to the pressures inherent in working in such a demanding environment and complex community of practice.

### 6.1.2.3 Dr. Bill Roberts – Making Sure that the Patient is Happy

I only know Bill through his regular journal entries which populate my inbox, and his voice over Skype; we have never met in person.

Bill shared little of his personal story. During my analysis of his narrative, a complex web of issues unfolded; his patients' stories and his response to them, are, at times, confronting. Without understanding the complexity of Bill's journey as a learner, his patients' stories, the context in which they live and he works, it would as reader, researcher and observer, have been easy to pass judgement on his thinking and his actions. His candid reflections, however, provide a depth of insight into the moral and emotional dissonance that exists for doctors in responding to their patients' needs. His reflective journals provide a platform on which to explore the tensions which shape the way in which he learned to provide care as a novice doctor entering a complex community of practice.

Bill's path to medicine was not one typical of his cohort. When I asked Bill why he chose medicine? He responded:

*Actually I did engineering to start with, a friend of mine was doing science and wanted to head into medicine and so I switched into it as I had nothing else to do...*

#### **BILL'S STUDENT REFLECTION**

*Teaching in clinical communication skills in 1st and 2nd year was a major influence. Also occasionally being present when a consultant or registrar are (sic) showing compassion for their patients. Sometimes when I have seen a doctor NOT being compassionate to their patients, I can see that situations escalate and patients become unhappy with their care. So I model my behaviour in trying to do things differently so that that situation will never happen to me.*

In responding to the initial study question as a medical student Bill acknowledges the influence of the formal curriculum, but it is the informal curriculum, the more tacit elements in what he observed, which is the major influence in shaping how he has learned to express compassion. Observing the consequences of the clinicians' behaviour, as directly related to the

escalation of the patients' unhappiness, appeared to act as a catalyst for his future behaviour. He consciously rejected the negative role modelling as the way in which he should act.

## **PROFESSIONAL STORY - BILL STARTS HIS INTERNSHIP**

Bill wrote his first journal entry in early March, approximately 6 weeks into his intern year. He commenced his term in a surgical unit in a small rural hospital. Bill's journal entries were written as medical cases, he related the patient's story to fit the medical framework of history, diagnosis and prognosis. While this case presentation technique assists a doctor in formulating their clinical reasoning and is the gold standard taught in medical school, it also risks dehumanising the person, reframing the person as a patient with a medical condition for intervention. Bill followed each 'case' with his own personal reflection.

He started his journal by writing:

*I am choosing to reflect on any patient that (sic) has left a memorable impression on me, good or bad.*

This comment suggests an immediate shift from observing and responding to colleagues as influential role models to reframing his learner's journey in responding to patient behaviour and situations, which resonates with his transitioning role; no longer an observer but a doer.

One of Bill's first patients was a 68 year old male who had incurable metastatic bowel cancer. The patient's family rejected palliative care and threatened legal action.

Bill wrote:

*This case occurred during my first few weeks as an intern, and I will never forget it. I felt out of my depth, as the patient's condition was complicated and his family were uncooperative. Although I can understand the shock that occurs with hearing your loved one has incurable cancer, it was difficult for me to feel compassion for them since they fought against everything we offered them. After the son*

*threatened legal action, I actually felt scared, and wanted to avoid his room altogether. Obviously I didn't do this, but I felt like it.*

*I learned for the future that when breaking bad news to patients, it has to be done in no uncertain terms. In this case, I think it would have been better to sit down with the patient and his family during a quiet moment, and explain exactly the nature of the disease and our treatment plan, and make sure that they understood there was no hope for a cure. In the long run it is more compassionate than letting them think more could be done, and then being completely shocked after the patient has an undignified death on the ward.*

Bill describes a confluence of events and variables which influence his response to both the patient and the situation. His response to his feelings of loss of control, and being out of his depth, is to try and create certainty from uncertainty: this is your disease, there is no cure, this is what we are going to do. This reframing of the situation allows medicine to take back the control and create order from disorder. Bill's narrative explores one of the inherent contradictions within the practice of medicine as a science; an imperfect science which when set within the messy parameters of human interaction is highly interpretive in practice. He framed compassion as the need to break bad news in no uncertain terms – to make the family understand 'there is no hope'. Bill's inexperience and desire for certainty, compounded by being time poor, and poorly supervised, has morphed into a reframing of the patient's (and their families) experience where in the 'best interests' of the patient and their family – all hope for a cure is removed. It is these tensions that create dissonance for Bill, who as a novice craved certainty and struggled with the complexity of the multifaceted nature of patient care embedded in a bewildering health system and demanding social context.

In discussing how difficult this situation was for him, Bill commented:

*I guess it was still while I was learning the ropes with what exactly to do clinically and so this patient kept having turns and kept having arrhythmias and yeah, and a possible heart attack at one point. It was hard enough for me being on the ward while my consultant and registrar work in theatre all day.*

The timing of this difficult situation had a major impact on Bill, occurring in the first few weeks of his internship, with Bill writing 'and I will never forget it'. His learning is shaped by a systemic problem where as a student transitioning to novice doctor he is provided with little supervision or mentoring in dealing with highly complex interactions in a high stress environment.

Another patient memorable to Bill is an elderly male patient with ischaemic bowel disease. This patient, also required palliative care, and spent an extensive time on the ward due to difficulty in cannulae insertion. This resulted in Bill spending extended periods of time with him looking for veins.

Bill wrote:

*So I spoke to him a lot, and got to know him. He eventually had to go to palliative care after 2 weeks. I learned that getting to be friendly with patients makes it almost sad when they leave the ward. In future, I'll always be nice to patients, but keep most of the conversation professional, for my own sake.*

Bill's relationship with his patient was influenced by liking him. Spending extended periods of time with him afforded him time to engage with the patient. However, Bill's take home message from this interaction was 'be nice but keep it professional', a key message in emotional distancing, and the creation of professional boundaries, partly a protective mechanism 'for his own sake'. Bill's narrative highlights the difficulty the novice doctor confronts in learning the appropriate level of engagement, a central issue within this study, the balance of meeting the patient's need for engagement while protecting your own emotional and professional wellbeing. In this context compassion can be perceived as sitting on a continuum, with too little at one end and too much at the other. For Bill knowing where to sit safely on that continuum is fraught with tension. His narrative provides insights into the nuanced learning which takes place in the affective domain of attitudes, values and emotions, the soft underbelly of care, often tucked away from sight.

Bill openly wrote and talked about liking or disliking a patient (or their family) and how that influences the way in which he provided care. This is most evident in the next case which Bill wrote about in his journal, a narrative which contrasts sharply with the previous patient story.

Once again the patient is an elderly male with a range of medical issues and possible dementia, who was admitted to hospital for what Bill described as 'social reasons'; he described the patient's wife crying, as she was unable to cope with her husband at home, and required respite care for him.

Upon reflection, Bill wrote:

*I really just had to pretend to care about this patient and his wife in this case. I can understand the stress they must be under with his medical problems and the fact that his wife can't take any more time off work. However, a hospital is not a hostel for patients to stay without a reason, and I was actually resentful to them for treating it as such. I can recognise now that because I didn't particularly like the patient and his wife, I probably would have offered sub-standard care to them had he actually needed medical care.*

Bill's emotional response to the patient and his wife were in direct contrast to how he perceived he should act. This created a conflict for him, a clash of personal and professional identities. He created a facade of caring. His understanding of their social predicament did not lend itself to acceptance and authentic compassion. His resentment of their use of the hospital for social rather than medical needs was a constant thread woven through his narrative. For Bill, medical care is narrowly defined; the patient's social context disrupts his notion of what being a doctor is, he seems ill-prepared to deal with the broader consequences of patient care embedded in their complicated lives.

In Bill's next term he was seconded to an emergency department in a small regional hospital, and wrote about having to 'approach care very differently'.

*This has given me an entirely different population of patients with entirely different diseases and social problems to deal with. In particular, around 50% of patients in the ED are indigenous, and despite the fact that I myself am indigenous, it has been a little confronting, and I have had to approach patient care very differently. I'll talk about a few points that have helped shaped how I show compassion.*

Bill's demographic profile of the regional population of the hospital in which he was working set the tone for his reflections, establishing the social context for his patient encounters and the influence of identity, time, place and culture on the way in which care was delivered in his new community of practice (Wenger, 2007).

While Bill referred to his own indigenous identity in his story, it is not central to how he framed his story as a novice doctor undertaking his intern year. When I hesitantly explored the issue, our discussion became awkward. Bill said, *'there's a lot of people who would feel intimidated..., treating aboriginal (sic) patients... yeah'*. I asked, 'And do the aboriginal patients – do they recognise you as indigenous or is that not something that's obvious?' 'Oh, probably not. No-one knows, (laughs) Oh, okay. Yeah. No, no... It doesn't really bother me, though. Pardon? It doesn't really bother me that much. It doesn't really bother me. I'm not... you know. Yeah, sure, sure. Um... Er' there is hesitation and discomfort in both our voices and comments. My questions quickly slipped into safer territory.

I am aware that I have become more cautious and protective in my questioning, not wishing to intrude on such tough emotional terrain, which may (or may not) be outside the remit of this study. I know many young indigenous people find it hard to identify as indigenous because of the burden of responsibility it can create for them within their community and the broader community in general. I am conscious of not framing Bill's identity in this way, but grateful to him for providing this insight as it sheds some light on how confronting it must be to deal with the social issues within the community in which he is working during this period. These insights also provide some understanding as to why later in his reflections Bill may struggle to care for patients he perceives as bringing their own health problems upon themselves.

During this rotation, Bill didn't talk about 'his patients'; he talks about the population of patients, with entirely different diseases. He was critical of their social situation, struggling with the nature of their health issues and the influence of alcohol on their health.

*Occasionally there are social crises involving indigenous children, such as neglect or substance abuse. In order to give these children the best*

*shot at a decent adulthood, then I don't hesitate to get the department of child services involved. I have even had to involve the police on one occasion. I think it can be traumatic for the children to have to see these services, but it's far more compassionate than allowing them to continue to live in their home environment without intervention.*

Bill wrote and talked about having to involve the Department of Child Services (DOCS) and also the police, weighing up the consequences of his actions, and framing the interventionist approach as the 'far more compassionate' option. Bill's definition of compassion is broad. During our interview I asked Bill how he defined compassion, he responded:

*I guess I'd think compassion is just providing the best medical care you or the unit can provide and making sure that the patient is happy about it or on side about it.*

Again for Bill, the emphasis is on the provision of medical care. As a young, inexperienced doctor he struggles with extending compassion towards some of his patients yet he continues to seek to place the patient at the centre of the care he provides.

Woven throughout Bill's reflective journals and interviews is his desire to have more control over the situation, to cure the patient, and in doing so to ensure a happy ending. His distress is evident when this is out of his control. He describes people as patients; his patient stories are anchored in their medical and social conditions.

In his journals these 'indigenous cases' are juxtaposed with 'another one of those cases' as follows:

**Background** - *an extremely obese 46 yo (year old) lady has been under the care of my gen med (general medicine) team for almost a year. She currently has no medical issues, but previously had a below knee amputation of her right leg as a complication of her diabetes and is now in a wheelchair. The reason she can't go home is that she can no longer fit through the door to her flat with her wheelchair, and has nowhere else to go... So she's stuck in this hospital until then. The only treatment she's receiving is regular physiotherapy and dietician input for*



*weight loss. The patient is depressed at being stuck in hospital, and our team is annoyed that we have had a patient under our care for so long. This is another one of those cases where I have to keep my own frustrations in check to provide appropriate patient care. I'm of the mind that it was kind of the patient's own fault for getting so fat that she can't fit through her doorway anymore, so why should we have to spend our time sorting out her living arrangements. But that's not the way the hospital system works I suppose. I've really just had to grin and bear it with this situation, and that's as compassionate as I'll get.*

Bill's frustrations in 'dealing' (a word used liberally throughout his journals) with this case was palpable and complex. He has a reductionist definition of medical care which is directly linked to his medical role and responsibilities. Without knowing the patient's full 'story' he judged her situation and her use of the hospital system. For Bill, the messiness of the patient's social situation appear to once again complicate a straightforward resolution or happy ending. Bill wrote about 'our team being annoyed', asking why should 'we have to sort out her living arrangements', he clearly identified closely with the team in which he was embedded.

During our interview, there was a lot of background noise. I commented to Bill 'It sounds like you're washing the dishes or something?' He laughingly responded, 'No, no. It's alright', he replied 'I'm just cooking and talking at the same time'. It reminded me how crowded these young doctors' lives are, given that I was asking intensely probing personal and emotional questions while he was cooking himself dinner...

In the midst of this domesticity, Bill responded to my questions as follows:

*I guess the social issues, Um...they're not really medicine. I mean, all you're doing is, you know, you've got patients waiting for nursing home or patients who can't go home because they can't walk up the stairs or something like that.*

Over time, and in response to specific difficult patient situations, I detected a shift in Bill's response. He moved from a focus on the best outcomes for the patient to a high level of frustration with the difficult patients and situations,

wanting to distance himself from his patients. The erosion in his empathy and compassion is in direct response to the patient behaviour, anchored in social problems rather than specific medical conditions. What emerges is a form of triage of care, where compassion, as a finite resource, consciously or unconsciously, is rationed to the more deserving cases. The deserving cases are those where the patient (and family) is nice and liked, are not perceived to have brought their ill health upon themselves (eg unlike obesity) and have a curable or treatable medical problem rather than compounding the difficulty of the case with a messy social problem or situation. Bill's narrative illustrates how through such influences, the slow erosion of empathy contributes to a rationing of compassionate care, where black and white is preferable to multiple shades of grey, and where the expression of compassion becomes conditional.

There is a noticeable shift in Bill's reflections. Initially his emphasis is centred on the influence of observing senior colleagues' interactions with patients, in what, not to do, as well as, what to do. As his role evolves there is a reflective repositioning where it is the patients and their use and perceived abuse of the system, which appear to have the greatest influence on the way in which he provides care.

I sensed Bill's growing conflict as a doctor engaged with the day to day complexities of providing effective patient care and his developing professional identity. He transitioned from feeling sad when too close to a patient, to needing to manufacture a compassionate facade as he pretended to care, to later struggling to show he cared by 'grinning and bearing it', to this final 'case' below where he acknowledged his total absence of care for the '64 year old alcoholic male'.

**Background** – *64 yo alcoholic male has presented to hospital after being kicked out of his hostel for being a nuisance. He also unfortunately broke his arm after being thrown down stairs by someone. He is completely unreasonable, doesn't need admission, but will be homeless if we don't admit him. He's therefore stuck with our team until he finds another hostel that he can go and drink at... I've had to put a new plaster on his arm TWICE, and there is nothing wrong with him other than that.*

*I'm pushing to get this patient out of hospital as soon as possible. He is an absolute drain on our resources and my time. I actually don't really care where he goes, just so long as it's out of hospital. This makes me uncompassionate, but it doesn't really bother me. He'll be back as soon as there is something else wrong with him.*

Bill's language is forceful, using metaphor – 'pushing to get this patient out' – to illustrate his strong emotional response. He is his own judge and jury, conceding that his desire to rid the hospital of the patient is uncompassionate. There is no pretence of caring. There is a shift from caring, to pretending to care, to not caring that he doesn't care.

The dominant discourse throughout Bill's reflections uncover a little told narrative of not liking your patient or the dissonance encountered when you feel your patient is undeserving of care or, that their irresponsible behaviour has led to their diminished health and social issues.

While I asked the question, how do you learn to express compassion in the clinical context, Bill's narrative builds an understanding into why and how a junior doctor may lose their sense of compassion. His narrative illustrates why and how the erosion of empathy may occur over time.

Bill brings closure to his year of written reflections by providing a summary of what he considered the key issues for him.

*Working ED at (regional) hospital – I'm seeing more new patients every day than I have been throughout the whole year, and have really started to streamline my process of dealing with them. In terms of compassion, I've really just been doing what has worked for me and others I've observed since the beginning of my intern year.*

*My first general rule is to keep the patient and their family in the loop with what medical treatment or investigations we are doing, and the reason why. I've found that as long as patients know what's happening, they are generally happy with my care (as long as they've consented to it of course).*

Within Bill's reflections there is a growing competence and confidence in his skills base, both cognitive and affective, embedded in clinical practice and a

now more familiar system and flow of patients. Bill identified the importance of communication as his 'first general rule'. His narrative clearly demonstrates how this rule is embedded in practice which imbues it with meaning.

*It's also good to find out what the patient's agenda is. If they come into the ED with what would seem to most people to be a trivial complaint (e.g. common cold), I always ask them what they wanted to get out of their visit. It is often useful because all patients have their own back-story, and sometimes some reassurance from a medical professional is all they need. This is particularly important when young parents come in with their children.*

Bill identified patient centred care, as a key issue, again giving it meaning from his experience. The patient's back-story, the patient's agenda and the provision of assurance are central to his message.

He emphasised the need for speed, especially in the Emergency Department where the aim is to try to get things done for patients as quickly as possible, and explain any reasons there might be delays in their treatment.

*We as an emergency department also have strict rules which are enforced to try to get patients seen and sorted within 4 hours. This actually makes me work faster, and helps me deliver better care to patients.*

Time is a constant theme throughout his reflections. He equates working faster with better patient care. It is an interesting juxtaposition, as working faster would afford less time to engage with the patient.

Bill's final point focused on not 'pretending' to know.

*Finally, one thing I've learnt from a few consultants I've had throughout the year is that if you don't know something, don't pretend to. A patient is always happier to get the correct answer than to hear a doctor waffling and/or bullshit on about something. I actually like to go and look something up, or ask senior colleagues and then relay the information back to the patient.*

Bill's closing reflection completes the narrative arc, in many respects returning us to where he started in his student reflection - a year later - still predominantly learning what NOT to do, from observing senior colleagues.

*The way I show compassion to patients this year has been mostly intuitive...I think I've honed my compassion mostly from trial and error by my own dealings with patients every day. I also learned a bit from watching how senior colleagues deal with patients – this has probably taught me more how NOT to deal with patients than how to deal with them though.*

*That's about all I have to reflect on being compassionate as an intern.*

As our interview drew to a close, I asked Bill, if he was to have one message for the new graduating students who start this year as interns, what would it be? He says 'I guess they should just make sure that they learn something from every patient – yeah, clinically and sort of personal'.

This final comment captures his learner's journal, the morphing of the clinical and personal, the blurring of boundaries, the acceptance of the messiness of medicine within a social and emotional context, both his as the learner, and his patients' reflecting a growing maturity for Bill in his role.

Bill's insights into his struggle for compassion provide a small window of understanding into the pressures a novice doctor confronts when entering the hospital clinical environment on the periphery of this particular community of practice. His journal entries act as a scaffold on which he lays bare his emotional responses to the patients for whom he cares. Keeping the patient happy is a consistent theme through Bill's reflections. Bill's narrated journey has captured the tensions that exist for him in trying to do the right thing by his patients. His nuanced and candid accounts provide insights into how and why he has acted as he has, and the compromises which he has had to make along the way.

His formal university training has only partially equipped him for the multi-faceted nature of clinical care. Clinical reasoning, as a medical construct, attempts to make sense of what is going on for the patient; it is based on an orderly progression of thoughts. As Bill's narrative illustrates, messy social

issues, which defy easy resolution, complicate the patient trajectory and in doing so make for a difficult learning environment for the fledgling doctor. For Bill, inexperience, stress, and uncertainty result in a rigid framing of the medical role. Both conscious and unconscious compromises are made, thwarting his attempts to create a happy ending.

Bill's journey provides a nuanced exploration of the enabling and inhibiting factors which influence patient-centred care as a commodity embedded in practice. A picture unfolds of a culture where compassion is conditional. This study asked the question, how is compassion learned? Bill's story, however, provides nuanced insight into how compassion is at risk of being 'lost'. Fortunately for Bill, and his patients, it is his determination to do the 'right thing by his patients' which provides him some protection against this loss.

#### **6.1.2.4 Dr. Mary Gray - I Just Didn't Care, Till Now...**

Mary is a twenty-five year old doctor who spent her intern year at a large teaching hospital in Brisbane. She chose to record her intern journey through a Tumblr blog, which she titled 'never horses, always zebras', a play on a phrase used by more experienced staff 'always horses, never zebras', suggesting, if you hear hoof beats, think horses – not zebras. In other words look for more common rather than rare conditions. As Mary's blog title alludes, her experience was at odds with this expectation.

Mary emigrated to Australia from Southeast Asia with her family when she was nine; she considers English her first language. Her medical internship is her first job, which is a significant factor in her developing identity as a doctor, as a young person, transitioning into a complex work environment. She is exposed to a myriad of experiences which shape her perceptions both personally and professionally. Her parents supported her medical studies. She laughingly says 'according to my mother, I owe them the rest of their lives for that, I probably do.'

When I ask Mary why she chose medicine, she responded 'it was the only option left'. I asked her for clarification.

*My mother and I, when in grade 12, we were filling out all those stuff for the QCS (Queensland Core Skills) and stuff like that... we sat down with that book of all the degrees and... we went through that from cover to cover and crossed out... we discussed pretty much every single one and then basically what was left was medicine, law or teaching. Yeah. And out of the choices, I went with medicine.*

So for Mary there was no vocational calling to work specifically as a doctor more a pragmatic decision which was further consolidated when she realised she 'really liked medical sciences, anatomy and physiology'.

### **MARY'S STUDENT REFLECTION**

In responding to the student question, Mary wrote:

*The biggest influences have definitely been the interns and residents. They interact with the patient most and are responsible for patient education, as well as being the doctors I spent the majority of my time with. Many of them have provided good examples of being compassionate, but the ones that haven't definitely stood out. Registrars are much the same in this regard. Other influences have been Consultants, who perhaps have more freedom with regards to how they interact with patients. Some have been brusque and impatient, while others take the time to talk to the patients and develop a rapport. But all of them bar a very rare few are courteous to their patients and welcoming of their input. Minor, but still memorable, are the allied health professionals - the nurses, the pharmacists, physiotherapists, etc.*

Mary's reflection on how she learned to express compassion as a student emphasises the formative influence of her colleagues. The level of status her colleagues have appears to shape the influence they have on her. She highlights her immediate peers, the residents and junior doctors, the registrars and then the consultants who she considers having more 'freedom' in how they react with the patients. This freedom is assumed by Mary because of their seniority and expertise which affords them more flexibility within their role. Finally she refers to the influence of the allied health professionals, as 'minor but memorable'.

Time is also a major influence, the time she spends with her colleagues; the time her colleagues spend in interacting and talking with the patients, which appears to be defined by their role in this medical hierarchy. In looking for examples of compassionate care, Mary highlights the doctors who 'stand out' as the ones where compassion has been absent.

Mary attributes the seniority of her senior colleagues, their status and expertise as giving them more freedom in how they spend their time, this is evident throughout her narrative as both a student and an intern.

### **PROFESSIONAL STORY – MARY STARTS HER INTERNSHIP.**

As a way of capturing her journey, Mary recorded regular short video clips, where she spoke directly to the camera reflecting on her working days. As the year progressed she also reflected through a written blog. Her video blogs are punctuated with ums and ahs, the hesitation in her voice capturing her difficulty in trying to articulate the depth of her experience and her uncertainty in how she responds to a range of events which shape her learning.

Mary's first term was a half term (5 weeks) in Mental Health. After the first night on a mental health ward she talks about an incident with a patient who tried to strangle her.

*A patient tried to strangle me... Oh I was freaking out... I was like holy crap. I don't know what I am supposed to do... I called my Reg (registrar)... He wasn't worried as I was. I assume that he is more used to it than I am.*

One of the key aspects of learning within a new community of practice is the intended gradual movement of the newcomer shifting from the periphery of practice to assuming fuller responsibility (Wenger, 2007). For Mary, a novice entering a new community of practice, support from more experienced supervisors is essential and yet Mary's narrative suggests this is lacking; her registrar is less than effusive in his support, which she attributes to his experience, gender may also be a contributing factor.

Five weeks later, Mary still continues to struggle with the chaotic nature of the rotation.



*Yay. Today was my last shift and I am soooo glad it is my last shift... Am, it was just, it went nuts. I arrived there about 8.20 and it was really okay until about 9 o'clock when everything went to crap...*

*With a patient the phlebotomist couldn't take bloods from, I couldn't take bloods from, I had to call the anaesthetist who couldn't come down. Then we had to talk to the DEM reg, (Department of Emergency registrar) who said speak with the med reg (medical registrar) as it was really their field. Called the med reg, who told me it wasn't his job and he had no interest in it, and so then I said fine.*

Her journal entry highlights the fragmented nature of the way in which care is provided and the dependence on colleagues to assist in undertaking specific tasks, and for Mary a perceived lack of support from her colleagues. For a novice to function well in a community of practice requires supervision and support from those with expertise, for Mary the fragmented nature of the process of receiving support for herself and the patient diminishes this sense of belonging and hinders her learning. This struggle detracts from her ability to engage with patients at a more compassionate level.

After completing her first five week term as a doctor Mary acknowledged how cynical she had become, influenced by her colleagues and the 'system'.

*I am so cynical now. I have only been working 5 weeks and I am so cynical about the hospital system in particular.*

Mary blamed the amorphous system for her growing cynicism, as though it is an entity in itself. This growing sense of cynicism begins to shape the way in which she provided care. While she initially struggled with the system her focus slowly shifts with the demographics of the patient population and their behaviour influencing how she responded.

For our first interview, I met Mary in a cafe. She turned up, her face looking familiar but less stressed than in her blogs; appearing more animated, with a warm smile, she consented to the recording. I began by saying I wanted her story and not a question and answer session. I used aspects of her blog to nudge her along. She told me of her difficulties with mental health and her then current term being orthopaedics. How hard it has been.

*I am finding in orthopaedics a lot of the families just want someone to explain to them what is going on. They don't even expect me to do anything, really at the end of the day they just need someone to talk to and everyone is just so busy that I think that they are just really grateful.*

Mary emphasised the busy nature of the clinical environment. She wrote how grateful the patients were when they were given a chance to talk. Listening and engagement are central themes to which she returned to throughout her journals and interviews. She did not consider herself a people person yet she emphasised how giving time to listen is important.

Despite this she diminished the role of listening when she wrote, 'just listening', an act which she referred to as 'not doing anything', suggesting that she perceived real care and her role as 'doing something' – a procedure, a diagnosis or a test – the artefacts - which underpin her identity as a doctor. Mary was very task-oriented in her focus. In reframing listening in this way, she dehumanises the act, this reification (de Zulueta, 2013) of listening, turns the practice into an instrument for utilisation rather than a potentially caring compassionate act.

*You have days with clinic on, and surgery... some days I barely see my patients. Some of my patients I only see once a day... I try to do a morning ward round with my regs ... and then before I try to go home I try to see them one last time.*

Mary used the prefix 'my' when she referred to her patients and to her registrar, highlighting the sense of ownership she had in her role with her patients and colleagues at the centre of her community of practice.

In her next blog, Mary has finished a term in orthopaedics and was working in the Department of Emergency. She lamented no longer working in orthopaedics. There was a shift in her emphasis from her colleagues and the system to the 'people' who she perceived as using it inappropriately. So while the patients are at the centre of her community of practice, they had become an amorphous group of people rather than patients requiring individual care.

*I honestly thought I'd never say it, but I do. I miss ortho. I miss the fractures and the x-rays and the patients who have something wrong*

*with them. The worst thing about DEM is how many patients don't need actual emergent management. How many people come in to DEM just wanting a bed for the night or food? The people who waste time and money and bed space because they want a day off from work. Who come in with a problem they've had for ages because they're unhappy with how they've been looked after by a GP.*

For Mary, it is these types of 'problem' people who came into emergency which shaped her continuing disillusionment with the system. She contrasts the 'patients' who she cared for in orthopaedics and the 'people' who attended Emergency who had 'spurious complaints' as opposed to the 'patients who have something wrong with them'. Mary's narrative reflects her identity as a doctor, her perception of the role being very task and procedure oriented, she misses 'the fractures and the xrays' the tangible aspects of patient management, which encapsulate concrete roles and responsibilities. She laments people exploiting the system for social care such as food or a bed, trivialising the social aspects of a patient's wellbeing. For Mary a patient's needs are defined by medical, and not, social needs. These factors influenced her ability to express compassion towards her patients, perceiving them as exploitative and undeserving she is frustrated and disillusioned, this creates dissonance for her in her developing identity as a caring, sympathetic doctor, as expressed below:

*I want to say I'm sympathetic to anyone and everyone, but all I can think of is how many people are out there who can't get a bed or be looked at as urgent as they need because someone else is taking up their spot with spurious complaints. I think we can talk about patient-centric care and being compassionate doctors all we want, but when you're faced with patients who'll get angry at you because they've had to wait to be seen for their left arm tingling that's been there for a year, it's hard. Especially when you've just come from seeing a patient who's got an aortic rupture. It puts everything in perspective and I wish people could understand that.*

Feeling out of her comfort zone; the system, as described by Mary, created a sense of bewilderment which detracted from her ability to be patient-centred.

Her sense of powerlessness is captured by her drawing a comparison to being in a horrible game show, a reality show:

*paggers going off... it's like a horrible game show – you don't know what's on the other end, only that there's someone who wants to talk to you and you've got to have to take care of it and it could be anywhere... it's kinda like a reality show...*

At times she appears totally overwhelmed, her storytelling is tangential; she diverges off in all directions as she attempts to come to terms with the wide range of clinical experiences she confronted and her exposure to life and big issues in general.

*The American health system is infuriating! Aside from the moral high-handedness that abounds when the topic of contraception or abortion comes up because God forbid a woman has the RIGHT to choose what to do with her body. No, she needs crusty old white rich men to decide that for her; apparently we still live in an age where females just can't make responsible decisions? I don't know. But that's only the tip of the iceberg.*

*Today, an American friend told me that her health insurance doesn't cover asthma medications because, to quote, 'they aren't necessary'. Wow, pretty sure all those people dying from Asthma disagree...*

*Thinking about it is making my blood boil.*

Her choice of topics range from women's rights such as abortion to the availability of asthma medication. Anger and frustration are evident in her narrative, she wrote how 'thinking about it makes her blood boil'. She referred to 'crusty old white rich men' making decisions about women's bodies. Her reflections are those of someone inexperienced in dealing with the issues and concerns of her patients, she appears ill-prepared as both a doctor and a young person exposed to the harsh realities of life.

When Mary commenced her term in emergency she wrote about the range of patients with whom she dealt with and those that were most memorable as follows:

*Young girl coming in with direct self-harm...*

*Another patient with direct self-harm, this time an absolutely charming man who put two cuts on his forearm... And then he threatens to go after the psychiatrist with the razor he used to cut (after complaining about how much it cost...) charming, absolutely charming.*

*Miscarriage. She was 23, second pregnancy. First one was an ectopic. And giving the news that this one was a miscarriage was one of the hardest things. She was absolutely shattered, and her husband was too. Which was such a sharp contrast to another lady having a miscarriage later that night, who shrugged and said, 'Yeah, I thought so.'*

*There're a lot more, but yeah. Emergency is an experience, and it's fun. You roll with the punches as they come and just try to keep your head above the water. Worst patient I've had is probably this drunk who threatened to rape the female staff and swore and threw punches and refused treatment... I handed him over to another intern, a male one because like hell I was going to stay around to be abused like that.*

*I've got a few thoughts on my mind so it's all over the shop this post.*

*Just finished DEM and I'm actually upset about it. It and Orthopaedics were one of my favourite terms. Ups and downs, and some days I felt like the most useless intern in the entire world, but it was fun. Whereas, I'm only two days into O&G and I'm ready to throw in the towel. I was meant to finish at 4.30 today, I finished at 8pm. I'm hoping it's not a recurring event, it shouldn't be...*

For Mary it appeared that each time she entered a new rotation she is overwhelmed but once she becomes familiar with the way in which care is delivered specific to that unit she learns to enjoy the experience. Central to her behaviour is the support of her registrar, impacting on her everyday practice. She writes about wanting to emulate the 'nice' ones. These events and experiences shape her experience and craft her future identity as a doctor and colleague. Her self-criticism, where she described herself with the 'most useless intern in the world' equates with a lack of self-understanding and self-compassion, in tandem with the lack of compassion shown towards her at times by colleagues, or conversely her colleagues care for her, can make the expression of compassion for others more difficult or more easy.

*Luckily, I've got a fairly nice registrar who's good about my utter failure as an intern.*

*And I've decided I want to be like those registrars. Because there is nothing like having someone just ask you if you're okay. And the midwives on the wards were just...they asked me if they could get me tea or yoghurt. They'd seen me running around like a headless chicken the whole day.*

Her reflections are full of contradictions, earlier in her journals she is angry at the lack of control women have over their fertility. Now having worked in obstetrics she writes about the need for strong paternalism and having Implanon inserted... She is quick to judge and disappointed by patient behaviour.

*In obstetrics, I can't help but think some people shouldn't have children. Ever. Some women desperately need some strong paternalism and just get an implanon (brand of hormonal implant) inserted while they're in hospital. So many women who're too self-involved to care about anyone other than themselves. Women who are drug addicts. Psychotic. Acopic. It's genuinely not safe for babies to go home with these ladies.*

*I wish I could be sad about leaving obs (obstetrics) and gyn (gynaecology). But to be honest it was the worst 10 weeks. Especially the last 5. There were few regs (registrars) who were amazing. Few midwives who knew what they were doing. And few consultants I felt I learned from.*

*Most days I was just trying to keep my head above the waterline and survive. I liked the medicine but the work environment was unbearable.*

This metaphorical notion of 'keeping ones head above water to survive' is crucial in shedding light on our understanding on the ability to be compassionate during time of multiple stressors and pressures on the novice doctor.

According to de Zulueta (2013, p. 88), at times of 'self-orientated survival mode, our attentiveness is narrowed and our capacity to be kind and caring towards others is reduced or extinguished'. For new interns like Mary, this

survival mechanism, trying to protect their self-image and their newly evolving doctor identity may compromise the opportunity to be compassionate.

Mary's perception of the patients changes, their anger and abuse of the system challenged her notion of patient centred care and her ability to express compassion. In her December blog she wrote:

*I've found myself saying more and more often, 'I don't like Mr [insert name]' And I almost never mean the person. It's kind of shameful to admit it, but most of the time I don't care about the person. Well, I do in as they're sick and I need to care for them kind of way, but it's a distant manner of caring. Most of the time, I listen to their social circumstances and feel momentarily bad for them and move on. I'm not sure if it's because we see so many people that we're desensitised to it all. Caring is tiring. Being compassionate can be exhausting.*

This belief held by Mary, that caring is tiring and being compassionate can be exhausting are crucial in our understanding of what constricts clinicians in their caring role. There is a long held belief in medicine, that getting too close to your patient or engaging emotionally is like 'opening a can of worms' (de Zulueta, 2013, p. 87) which is detrimental to both patient management and clinician wellbeing. There is a growing body of literature which refutes these beliefs, suggesting being emotionally engaged with your patients and having self-understanding improves patient outcomes and reduces clinician burnout (de Zulueta, 2013).

*Anyway, so yeah, I've been saying that a lot. And I pretty much mean they're a very sick, very complicated patient and I don't like them under my care because when they crash it's not going to be pretty. But I heard myself saying that one day and realised how it must sound to outsiders. So I am resolved not to say things like that anymore. Let's see how that goes...*

Mary's dislike of her patients is a constant theme reflected throughout her journals and interviews. She talked of a doctor telling her 'you are not going to like every patient' and how she remembered thinking 'no I will try' and then commenting:

*It's a little bit crushing to realise you can't quite keep that promise, you sort of realise you are seeing people at their worst times and some are bad and some are really horrible...*

Mary's frankness in expressing her dislike for the patients with complicated needs provides insight into how as a novice she struggles with the responsibility and possible consequences of providing care. Her fear of unintended consequences or the risk of an adverse event and her lack of confidence and competence compound her discomfort and increase her emotional distancing in the way she delivers care to her patients, curbing her ability to express compassion.

Mary's final term is in Medicine, where she works predominantly with elderly patients with multiple comorbidities. She continues to struggle with seeing beyond the medical needs of her patients. While frantically trying to complete a multitude of tasks she observed a consultant's behaviour and commented about the way in which he relates to his patient:

*My consultant... sometimes he'll just sit and chat to them about the cricket, about how things are going and then that's the end of the ward round for the patient. And so they won't have talked to them medically at all.*

Having the time to sit and chat about the cricket is something not afforded to her as a novice struggling to perform her role with limited time and expertise.

As the year progresses Mary reflected back on her horrible game show comment saying 'it can be fun, it keeps you on the ball' she is more at ease with her responsibilities and her role in the team. Yet tasks, procedures, and the completion of forms continue to be prioritised over patient engagement.

She grappled with trying to negotiate her role, which while legitimised by her title and related responsibilities is restricted by her limited experience and know-how. Consequently, she hovers on the periphery of the community of practice, within a system which is dependent upon the co-operation of her colleagues, colleagues who, from Mary's perspective, at times appeared reluctant and at times, obstructive in contributing to the shared care of the



patient. These factors combine to restrict her ability to express compassion when caring for her patients.

Mary's narrative, reflects the title of her blog, 'always zebras, never horses', as discussed earlier. Her role is influenced by being based in a large teaching hospital which admits patients with complex conditions and a high patient acuity, where she struggled in an unfamiliar environment where she felt out of her depth and personally and professionally overwhelmed which resulted in her expecting what she should least expect.

Her last reflection is framed around an emotionally demanding day which she described as 'weird', an interesting choice of adjective.

*Today has been a weird day.*

*Came into work and one of my patients had perforated his bowels. He's 92. He has severe COPD. He is NEVER going to get surgery. He is also not getting IV fluids or antibiotics. He is now on a care of the dying pathway. And I haven't had a chance to really take in what it means until now.*

*Another one of my patients had a right MCA stroke. He's probably now bleeding from an ulcer, has a Hb of 70. He's also not a candidate for intervention. Or even investigation. He's probably going to be palliated tomorrow.*

*A third patient has had a cerebellar stroke. There's no way he can go back home when he can't even stand or lean forward without falling side ways (sic). He's profoundly deaf and just wants to go home to his wife.*

*They're all sad stories but it's only now that I can find the time or energy to care. Compassion tends to be the first emotion ditched when I'm busy. Intellectually, I know I should care about what the patients and their families are going through but it's just easier not to because there's no time. Got to get that cannula in. Get those bloods sent off. Get the referral done. Get imaging forms in. I was filling out the care of the dying pathway form and I realised I hadn't even SPOKEN to the patient or his family. But I just didn't care. Until now.*

This final blog entry has a poignancy to it. Mary is still overwhelmed by system demands and shortage of time, as the artefacts of care - forms, procedures and referrals - become artifice creating a barrier to her expression of compassionate care. However, as her intern year comes to a close it is as though the enormity of the patient's situation has finally hit home to her. While she initially framed her response in terms of ditching the emotion and ignoring the intellectual. For Mary, the day appears to have penetrated through her everyday routine to interrupt her thoughts. There appears an awakening of the emotional context of the care she provides. It is as though she has developed an awareness of the enormity of her role and the patient experience, a realisation that her actions have consequences. Her final journal entry reading, 'but I just didn't care. Until now', suggesting the gravity of her patients' experiences created a chink in her armour of detached concern, she finally has been afforded the time to care.

#### **6.1.2.5 Dr. Neel Das - My ID tag Reads 'Dr. So-and-So'.**

Neel grew up in South East Asia, his parents are Indian. He comes from a large extended family where 'nobody has an interest in medicine. And there's no doctor in the family'. His father, a successful business man, completed high school but did not undertake a degree. This is important and central to Neel's identity as not only did he complete a degree he has also become the first doctor in his family. His Christian beliefs were a major influence in his choice of career in medicine. English is his first language, and he worked in various roles for a couple of years prior to travelling to Queensland to undertake his medical studies.

Neel and I initially met when he consented to participate in the study. He was quiet and unassuming; having an earnest approach to his work as he nervously anticipated commencing his internship. In undertaking his journal entries Neel kept the question of what influenced his expression of compassionate care as a central tenant of his writing, relating his experiences directly back to how he provided care, providing rich insights and understandings of this complex dynamic. The issues of identity, personal and professional, are core to his journey as a novice doctor as he negotiates meaning across time, place and events. A dominant discourse which emerges

throughout his reflections is the relational nature of his role while engaging with his peers and patients in this complex and complicated community of clinical practice.

### **NEEL'S STUDENT REFLECTION –**

In responding to my original question asking the final year student cohort how they have learned to express compassion in the clinical context, Neel wrote:

***Positive** - Being in a fun team which allows medical students to become involved in activities/clinic/ward work etc - My religion as a Christian - Formal UQ education and classes regarding psychological/psychiatric issues, emphasising how much difference the doctor-patient alliance makes towards their improvement. Seeing patients who are appreciative towards doctors and medical students - seeing patients look hopeful in regards to their prognosis/after receiving positive news*

***Negative** - Interacting with healthcare staff members who speak with pessimism regarding their patients -interacting with patients who are angry -Interacting with patients who show disdain towards doctors and medical students -Being turned down rudely by patients when a history/examination is requested*

Neel's reflection straddles the complex divide between his personal identity and his fledgling professional identity. Engagement with his colleagues permeates his narrative. His Christian beliefs anchor his cognitive and affective thoughts, feelings and subsequent actions. Feeling appreciated, and the patient's positive demeanour, are both important in shaping how he engages with his patients and his self-perception and subsequent mood as a medical student. Contrasting with this, is when his expectations of patients and peers alike are unmet or awry. He experiences difficulty when confronted with peers who are pessimistic and patients who are angry or rude or those who show disdain. These factors converge to form an expression of compassion, which for Neel is conditional; dependent on both how his patients and peers treat him.

## PROFESSIONAL STORY – NEEL STARTS HIS INTERNSHIP

Neel's journey as a learner is paradoxical; it is framed around his developing individual identity as a doctor, an identity which envelopes his narrative, shaping his sense of self. Yet he constructs meaning from his experience, experience which is heavily dependent on, and influenced by his relationship and engagement with others, his colleagues, peers, extended team members and his patients. Neel's developing professional self-identity acts as a conceptual frame of reference linking his role, responsibilities and behaviours both professionally within his community of practice and personally with family and friends. The patient's diagnosis positive or negative, influences how he expresses compassion. This is in tandem with his engagement with his peers and patients which influences his own emotional wellbeing and in turn shapes how he responds to his patients.

In his first journal entry, Neel wrote:

*Orientation lasted 4 days, during which we had the luxury of having the outgoing interns teach us the ins and outs of surviving internship. Then day 5 came, and I was all alone, just me and the registrar, and we were on take too! (Accepting patients for admission to a hospital bed)*

Neel's immediate focus is on survival, not his physical survival but his psychological survival, this is noteworthy as in this context it encompasses his ability to deal with the difficulties a novice doctor confronts when entering a community of practice. He writes of being alone, despite the close supervision of his registrar, this aloneness is determined by his status as an intern - being an intern on his own, he compartmentalises his role using it to separate himself from others – both peers and patients.

*Fortunately my registrar... smiles almost all the time, so her appearance calmed me down to start with. It turns out she is a great teacher too. She patiently showed me how to do a proper discharge summary instead of growling at me or threatening to report me to my consultant.*

For Neel, how others relate to him has a significant impact on how he feels and acts. His registrar, who is his immediate supervisor, is perceived by Neel

as supportive and smiling, her patient manner calms him contributing to his ability to express compassion.

*My positive attitude is somewhat linked to the question posed in this study. Because I am happy and look forward to going to work, I do not take in negative 'baggage' with me when I see patients so my attitude towards them is more compassionate to start with.*

Neel is explicit in relaying how his emotional frame-of-mind directly influences the way in which he provides care to patients, his happy temperament frames his compassionate disposition. In his journal he writes about the constant demands of both nursing colleagues and anxious families:

*In all cases, I have found that a polite demeanour and clear language on my part makes life so much simpler and more enjoyable for everyone. This has been my experience so far, and it certainly has made me feel compassion towards patients. The times when I find it hard to express consideration towards patients are times when I am so busy running around doing tasks, and times when I am preoccupied with negative thoughts or emotions. In these instances compassion often becomes secondary.*

So for Neel feeling stressed, time-poor and emotionally vulnerable results in him becoming task orientated rendering compassionate care a lesser role. This is an important observation as he is conscious that these factors eclipse his role as a compassionate doctor. His daily clinical practice is full of contradictions. His reflections suggest kindness and compassion require time, space, confidence and competence, yet he works in a system where, especially as a novice, he confronts uncertainty, and system demands that highlight his own sense of emotional insecurity.

*There is no doubt that I also learn to show kindness to patients by seeing and learning from senior colleagues, i.e. my registrar and my consultant. Thus far, they have been assertive and confident in the way they examine and discuss clinical issues with patients. This seems to give them confidence that their doctors are in control and that we are indeed making a positive effort to provide them with relief for their ailment. When they (the doctors) have gained their trust and*

*confidence, then there is an impetus to actually show compassion to patients because they have an expectation that their good intentions (whether verbal or physical) will most likely be met with gratitude from the patient or those in their company. Conversely, the situations in which acts or words of kindness by doctors (myself included) are simply met with apathy or negative sentiment, are the occasions where I sometimes feel that patients simply do not deserve any 'extra' care beyond the minimum of taking a medical history, examining them, admitting them as inpatients, prescribing drugs etc.*

Throughout Neel's journal entries the nature of the engagement between doctors, and the patients for which they provide care, directly influences how they care for them. He perceives being kind as an added 'extra' for those patients who are deserving of care 'beyond the minimum' the minimum being determined by concrete tasks and clinical and system functions and requirements. His compassion continues to be conditional, dependent on the disposition of the patient and how appreciative they are of the doctors' care. He perceives his senior colleagues as assertive and confident, traits which he reifies as strategies used to gain control and then if a patient responds appropriately to bestow compassionate care upon them

*Last year I walked around the wards with my ID tag saying 'medical student'. When I compare those times to the present day, where my ID tag reads 'Dr. so-and-so', the difference in patient reaction is stark (patients give a great deal more attention when they see Dr. on the name tag). I have more motivation to share a kind word with them because I already have the expectation that I will not be ignored or treated with disdain. This is not simply a conjecture; rather it is something that I have experienced first-hand.*

Neel's identity as a doctor is core to his being, which he explicitly states influences the extent to which he expresses compassionate care. Again his response is framed in direct response to how he perceives the patient responds to him. When we explore this further in an interview his narrative unfolds as follows:

*I mean, but, what I think is most obvious is that, um, well, the whole of competence is higher in how I, in how I conduct myself, that is also*

*because, um um, perhaps this wasn't how I felt in the first couple of weeks, um, so, when I was midway between being a student and an intern. Yeah. Initially it was like being in no man's land, as time went by I felt more confident and more sure of my identity as a doctor. Yeah. And ah, i found that patients when you wear that name tag and walk around, with the prefix doctor there, it gives the patients a lot more confidence, like when I say something with authority, they trust me, like they, um, as a, like if, I give them, um, a little bit of advice like they should go and see their gp (General Practitioner) for high blood pressure they listen, like, I felt as a med student when I went to give advice people would just, ah, um, (shuffling) can't think of the word, um, like, mm, they might agree with what I am saying but I get the feeling that they don't actually really trust me (voice is quieter) so, they don't actually trust me.*

Neel explains in more detail his perceptions of the influence of his title and role as a doctor, in building trust, confidence and authority, which then places him in a position to have a more compassionate demeanour towards his patients.

Eight weeks into his intern year and three weeks into his second term, in medicine, Neel writes:

*I feel very comfortable with hospital staff and the way things are done in the department of medicine. The best moments I have discovered at work so far are (in no particular order) -*

- The fun discussions and gossip sessions interns have amongst themselves and the registrars.*
- The excellent learning opportunities that I get when we do consultant ward rounds.*
- The speed at which the ward round gets done and decisions are made when we do consultant ward rounds (leaving everyone in the team with time to spare and have a coffee break).*
- When family members of patients come in feeling anxious and sceptical, but appear noticeably much more contented and relaxed after chatting with me (and/or the registrar). Some have*

*complimented me directly after our discussions and these moments make it all seem worthwhile, amidst all the mayhem of the usual intern's day.*

For Neel engagement with colleagues, patients and their families continues to be a major enabler in how he feels about himself and his role which then extends to how he expresses compassion.

*It is my position that the compassion expressed by a doctor is a reflection of the sum of all good things and all bad things happening in the life of that doctor. This includes factors at work, and also personal and social factors outside of work. In my case religion also plays a role in this dynamic pot of circumstances. Christianity as I see it states that compassion should be expressed towards patients, however obnoxious they can be. In theory, that is. In reality... I try hard.*

Neel captures the difficulties he confronts in wanting to be a compassionate doctor, as prescribed by his Christian values while dealing with the reality of patients he finds 'obnoxious'. His reflection encapsulates the range of influences good and bad, suggesting it is the sum of the parts, the interface of personal, professional and social which for him as the doctor co-exist; competing and complementing the way in which he provides care.

*As a Christian, I believe in bible verses such as -*

*1) Mark 12:31*

*The second is this: Love your neighbour as yourself. There is no commandment greater than these.*

*To me this means putting in my best effort wherever possible, as I would want the best efforts from my doctors if I were the patient.*

*3) Luke 6:27-30: But I tell you who hear me: Love your enemies, do good to those who hate you, bless those who curse you, pray for those who mistreat you. If someone strikes you on one cheek, turn to him the other also. If someone takes your cloak, do not stop him from taking your tunic. Give to everyone who asks you, and if anyone takes what belongs to you, do not demand it back.*



*I have no doubt that these biblical principles subconsciously affect me in my daily dealings with patients.*

His Christian values are a defining factor permeating his day-to-day practice.

On completing his surgical term (Term 2) Neel writes:

*Our surgical team comprised two consultants, one fellow, three registrars and two interns. It was a really fun and enjoyable term with many great learning opportunities. I felt that I got along very well with the team, especially the other intern in my unit, which I feel was a significant motivating factor in my day-to-day duties. My supervisor for surgery was happy with my performance and he gave me good reports for the mid-term as well as the end-of-term intern assessment. I feel that these factors have all contributed to my motivation and confidence levels being high throughout the surgical term and even up until now. This has certainly influenced my attitudes towards patients positively, including being compassionate and understanding towards their circumstances.*

In completing his reflection, Neel's primary focus and starting point is fun, enjoyment and getting on with his team. Fun is a descriptor which he uses liberally throughout his narrative suggesting a light-heartedness when he finds his work pleasing and agreeable. This contrasts starkly with the function of his role and responsibilities especially in the context of patients and families who are suffering. He finds his student rotation fun, his surgical term fun, his GP term fun and his emergency term fun.

Two weeks into a GP term Neel writes:

*It's been very fun so far ... I find that patients attending the GP clinic usually (but not always) have less severe medical conditions than those attending the hospital, so they are generally happier to start with and they usually leave very happy as well because their desires are fulfilled within 20 mins or so (eg someone wishing to receive a sick certificate can get his/her wishes met on the spot, someone wishing to have a strange skin mole removed can have it done within minutes, a mum can feel much better once her child is seen and she receives the relevant*

*advice/instructions, etc). It is also a very rewarding and privileged experience to deal with patients who have anxiety/depression - for them it is usually a long-term ongoing issue. I think it is easier & more natural for GPs to be compassionate to patients than doctors working in the hospital setting, just because of the nature of the patients being seen.*

Neel's ability to express compassion is also enhanced by the acuity of the patients for whom he cares. During his GP rotation he perceives the patients to be happier and easier to meet their needs, ultimately leading to a happier and more compassionate encounter with him as their doctor. From this experience he construes this to mean that it is 'easier and more natural for GPs to be compassionate', suggesting the hospital setting and the acuity of hospital patients hinders the expression of compassion.

In the December of his final term Neel took leave, and wrote an entry in his journal from overseas.

*Just felt a sudden urge to get away from medicine and go far away (although a doctor can never really get away from medicine). Most of my colleagues/seniors know that I will be leaving the world of high-flying, A-type personality medicine to go into psychiatry from next year onwards, so they (quite happily) let me take lots of the psych cases coming into the ED as these usually take a very long time to sort out and get a history from. I am also seeing a lot of general medical/surgical/pregnancy cases in the ED so it is a good mix all-round and I'm really having a lot of fun. Shift work is OK, but i would rather not do it if i had the choice.*

Neel writes of his inability to escape the identity of being a doctor and of his outbound trajectory of his current community of practice in the hospital to his preferred vocational path of psychiatry.

*With regards to the main question of doctors learning to express compassion, I suppose this process is dynamic and changes according to encounters with patients. In general I think a good way to sum it up would be to look at things from a bio-psycho-social point of view. ... the part where you look into their understanding, their psychological*

*wellbeing, like, how well their family member or their carer understands what's going on.*

Neel explains his understanding of compassionate care as being related to engagement with patients, extending beyond the medical aspects to embrace the psychosocial aspects of care too.

In Neel's final journal entry he wrote:

*By the way, I have been making physical contact with patients (patting on the shoulder) - to elderly patients especially, but in the ED, this has now been extended to pregnant women who get a diagnosis of miscarriage/threatened miscarriage (to cheer them up), as well as male teenagers/young male adult patients (makes me feel momentarily like a big brother to them!)*

This had been in response to a question I asked him about touch, and whether he used non-clinical touch as a way of expressing compassion. His journal entry makes explicit where he thinks the boundaries exist, in who, when, where and how he can use touch in this way, the touch of comfort. While Neel's comments above could be construed as paternalistic, I interpret them as a genuine effort on his part to engage with patients in a caring and kind way blending his cultural identity with that of being a good doctor.

Neel's experience highlights the centrality of engagement in practice and learning as being inseparable from his day-to-day role and responsibilities. It is his shared connection with others from which he derives his sense of professional self. Inherent in this, is the tension which exists between his cognitive reasoning and how he negotiates meaning from his experience, and his relationship and connection to his peers and patients which directly affects his emotions and feelings. While he is conscious of his novice status, and his need for supervision, it is the system and patient requirements which drive and underpin his learning. He strives to survive, but also to become; the idealised notion of the good doctor, a constant construct overtly displayed in his name-tag and the stethoscope as the artefacts he uses to differentiate himself from the student and the newcomer.

### 6.1.2.6 Dr. Grace Theil – I realised it was possible to practice this way

Dr. Grace Theil is in her mid-twenties, and has a lot of 'medical' people in her family. Her father is a medical scientist, and her mother, aunt and grandmother were all nurses. Grace too, was 'attracted to medicine; finding it interesting'. After graduating from high school, Grace enrolled in university, initially studying Arts/Law before she changed to medicine. Grace undertook her intern year in a relatively large urban teaching hospital in Brisbane.

#### GRACE'S STUDENT REFLECTION:

*Personal experience shows me how I'd like to be treated. Good mentors show me the value of compassion. Bad mentors show me the importance of being better.*

Grace's brief student reflection captures the essence of her journey as a learner; evident throughout her reflections and stories is her emphasis on observing and accepting or rejecting the behaviour of her colleagues, which is central to the way in which she constructs both her medical identity and meaning from her intern experience. She is also mindful of her own personal experiences, emphasising how she would like to be treated as a patient, rather than being totally focussed on what she aspires to be as a doctor.

#### PROFESSIONAL STORY - GRACE STARTS HER INTERNSHIP

Grace sent regular written reflections to my in-box. Her first reflection, written a couple of weeks into starting her intern year, read:

*I've started my internship in Emergency. The first two weeks were so overwhelming; it was like being a medical student with too much responsibility. Nurses rolled their eyes and demanded immediate analgesia written up and I thought: how do I do this safely but still save face. I wanted to cry at some point during every one of these shifts and was adamant it was unfair to throw us in the deep end like this.*

Grace's reflection captures the traumatic transition for her, from student to doctor; a newcomer entering her community of practice (Lave and Wenger, 1991) (Wenger, 2007). A number of variables create a tense overwhelming

situation for her, including: increased responsibility, unsupportive colleagues, the immediacy of needing to act, patient safety, saving face, emotional distress and the perceived unfairness of being 'thrown in the deep end'. Her use of this descriptive metaphor paints a dramatic picture of her lack of preparedness for her new role. Unlike her student role, where on the fringes of clinical practice she could observe and listen, she is now expected to act. Service delivery requirements and responding to the immediate needs of the patients structure both her role and her learning within it.

*At this time the most important thing was the relationship with the registrars and consultants, and learning from how they interacted with the patients.*

The prevailing influence on Grace's learning, at this time, is distinguished by the relational nature of her connection to her colleagues; while she is conscious of patient care, it is her colleagues, both medical and nursing, who are the focus of her attentive observation.

*Each and every one had their own style, own level of tolerance and empathy, and own pedantic nuances. One consultant taught us that communication was key and that sitting down to listen and taking the time to print out information and explain all that was going on was one of the most important factors in patient care. Another consultant was just downright lovely to all patients, even the ones you roll your eyes at. And I admired her for that. The consultants that were there because they had to be, who were rude and condescending to patients, I lost a lot of respect for.*

Billet (2001), argues that the distinction between formal and informal learning in the workplace is a nebulous one, as the very act of practice is learning, and the activities undertaken to provide a continuity of practice, within a defined community of practice, provide the formal learning structure. This is evident for Grace, observation and reflection are her greatest teacher. The influence of her colleagues as role models is dominant throughout her journals. This early journal entry highlights how some patients' needs are seen as less than others and deserving of an 'eye roll'.

*I quickly took elements of their style and made my own. A positive disposition and a keen ability to listen put me in good stead. I've loved this rotation overall (Emergency) and am amazed at all I've learned in such a short amount of time. I no longer feel like crying but I'll often go home and wonder if I've done the right thing and perseverate over little mistakes I've made.*

Grace consciously and 'quickly' filters her colleagues' acceptable behaviours and actions into her own repertoire. Her journal reflections emphasise the haste in which she has to learn to act like a doctor and undertake the responsibilities of a doctor. There is no slow unfolding of increased responsibility as she shifts from the periphery of practice to fuller responsibility.

*It is a slow but steep learning curve and every time I worry, I remember that that is what makes a good doctor.*

Grace aspires to be a good doctor; she enters the profession with a pre-conceived ideal of the good doctor. For her, this ideal includes the constant reflection on what she did during each shift and whether she had 'done the right thing'.

*I lost a patient in my first few weeks and didn't cope well at all, but I know it was not (my) fault and the best thing to do in that situation was to be caring and empathetic with her family.*

The patients become more central to Grace's journals, as her emphasis shifts to focus more on the patient and as illustrated by the more inclusive way in which she manages their care.

*I have had a couple of emails with positive feedback from patients and it absolutely makes my day! In these two instances I had done very little as there had been very little wrong with them. I didn't find a strange sign and order a cool test or diagnose a weird or wonderful syndrome; I listened. Plain and simple. I'm in this profession because it's interesting and rewarding. The patient is here because they have a problem, however trivial, and they want someone to listen to them and take them seriously.*

The importance of positive feedback is crucial to how Grace feels. However it is feedback from her patients, not colleagues, which is now emphasised. Grace's emphasis on doing very little is something which she refers to continually throughout her journals. This is evident in her emphasis on listening which is a dominant theme within Grace's journals and narrative across the year. However, she initially perceives the role of listening as doing very little, in comparison to more task orientated aspects of the role such as diagnosis, or pathology.

*I still struggle at times to put aside preconceptions e.g. in chronic pain. We all joke about psych issues or trivial complaints, but we are just doing what anyone needs to do to get through the shift and the shit.*

Grace dismissed some groups of patients' medical complaints, trivialising their concerns and justifying the humour as a coping strategy. In doing this she is also adopting practices of the group as a way of belonging, despite this behaviour being at odds with the way in which she wishes to practice.

Three months into her intern year, having completed her first rotation, Grace and I met to put some flesh on the bones of her journal entries.

We reflected on her earlier comments about 'being thrown in the deep end'. Three months down the track, she is able to look back and laugh, commenting how 'you finish uni, go on holidays for three months, and then despite plenty of drinking in between, you are expected to start with doctor knowledge instead of student knowledge'. She qualifies this however, by stating:

*I think it's important to throw us in the deep end. There's no other way to do it but I feel like as I get more and more knowledge, like it's safer and safer ... I realise how much more dangerous I was ...*

Her term in paediatrics provides her with a demanding but affirming experience. She wrote:

*Paeds had an entirely different feel about it. I knew it was what I wanted to do and because it is fairly specialised it is full of people whose interests are in the right place.*

*It had such a pleasant environment and I found that working with parents was very rewarding. I also worked in kids' rehab which included*

*spinal cord and acquired brain injuries which was devastating. I had a great allied health team to work with and we often had a debrief on how horrible life can be over a piece of cake. I had nightmares about those kids and would come home feeling so drained. I found compassion easy but exhausting and much harder to remove myself from. One child was a sole survivor in a motor vehicle accident. One was a brain injury because the mother was so tired she forgot the baby was on her bed not in the cot. I think they just appreciated having people to listen so in paediatrics a lot of time was invested in the parents as the kids were incredibly resilient (or too young to understand). I didn't just work in the most depressing unit- I did a lot of interesting work too and loved working with like-minded people.*

Grace's comment regarding the nature of providing compassionate care is important as she associates compassion with exhaustion and being difficult to disengage, yet these concerns are juxtaposed with finding compassion 'easy'. So for Grace, the expression of compassion is easy, as the patients' needs were significant unlike some more trivial patient needs she had encountered. However, the emotional consequences were difficult, in that she found it difficult to then disengage from the situation, having nightmares once home.

Engaging with others continues to be an important theme intertwined throughout Grace's reflections. Her emotional response to her patients is a major influence on her day-to-day role, anchored by the patient's condition and related needs having enormous impact on how she copes and her ability to be compassionate.

*Now in general medicine. This is the opposite of paed. I hate it and I'm counting down the days. This is also mainly about working with families but it is within a geriatric population. They all remind me of my own grandparents and it pulls on my heart strings. I do a lot of 'Not for resuscitation' orders, death certificates and family meetings. I almost find it bizarre how removed I am from it, I don't know if it is a lack of interest in the area or just a protective mechanism. I find it difficult when I don't share my consultant's way of practicing medicine: she investigates and treats everything whereas I think there is a dignity to withdrawing treatment at the appropriate stage in someone's life. There*



*is also a particular nurse who seems to push people through as if the job is about how many people we can get in and out of the ward- obviously they have lost sight of why we have this service in place. I feel like there is such a patient load that compassion can be a luxury and I often go to work ready to be attacked from every angle: whether it is strong personalities in the workplace or just quantity of work. I'm still learning a lot about myself from the experiences and my colleagues and some days are harder than others.*

Again, for Grace, the demands from the patient load, and lack of system and staff support, diminish her ability to show compassion, which she refers to as a luxury. Her narrative highlights a dissonance between what she has to do and what she wants to do.

*In Medicine our performance indicator was our discharge summaries. We had efficiency experts that were there on a daily basis, employed by the hospital, to manage us, so that we managed to achieve discharge summaries within 48 to 72 hours. There are big graphs on the walls to show who's doing their job and who's not so that it's a big competition. It works well, but it takes away from what the focus should be. So, it's down to numbers and dollars. And then you have nursing staff, some who were just toxic to the environment, they just wanted to get them in, and get them out.*

*It's hard if you feel under attack, to then go and put on a smiley face and go and have a chat to somebody.*

(NB. Discharge summaries are an important means of communication providing continuity in care between a hospital and a patient's General Practitioner. They are time consuming and often result in Junior Doctors claiming significant over-time payments).

Austerity measures and financial performance indicators create extra pressures. Combined with team members who are unsupportive, willing to compromise patient care, and place efficiency ahead of probity, these pressures erode her ability to 'put on a smiley face' when engaging with others. This is especially so in an environment where she feels under attack,

using a war metaphor, suggestive of clinical practice being a battlefield, where colleagues are 'toxic' and compassion is at odds with competition.

These ongoing emotional demands take their toll on Grace who felt 'burnt out' by the end of her medical term, as described in her reflection:

*I was very worried at the end of my medical term. I was completely burnt out! Absolutely! I was so glad to be going on holidays after that because I don't think I would've been able to go back, and then, find the energy. But I just recuperated and I feel a lot better...*

Almost twelve months since she started her intern year, Grace and I met for our final interview. I asked her what it had been like overall. She responded accordingly:

*I think it was a challenging year because I was trying to survive, learn a lot of new skills, learn a new environment, but then still keep in mind that it was about patient-centric care... and I think sometimes it gets a bit lost and work gets a bit overwhelming and so, that takes a back seat a little bit.*

Grace's last rotation which she had just completed when I interviewed her was Intensive Care; she emphasised how different it was:

*They have 10 patients that they micromanage and they deal very much with the families 'coz most of these people are critically ill. So, you're not discussing things about them and it's very much a consultant-based area. Okay. So, they're people who are incredibly intelligent but a huge part of their job is supporting families and it was really interesting to see that none of the nurses, allied health, doctors said anything negative about anybody, not even in jest. It was a very pleasant environment and I'd never come across somewhere that didn't use that as a coping mechanism. They all seem to just rally. Yeah, so I mean, as opposed to Emergency, where everything's so fast-paced, everybody takes the micky out of each other and out of patient presentations and it's just a way of coping, which is fine, but then I think that gets a little bit lost as well. It can sometimes be a little bit more of an unpleasant environment and it cultures that sort of environment. Whereas Intensive Care is calm*

*and considerate and I realised that it was possible to practice that way, it was a bit of a turning point for me.*

Grace's narrative illustrates how her experience in intensive care was crucial to her learning, shaping her identity, her understanding of who she can be and how she can practice. Significant for her reflection is how she perceives all members of the team as positive in their outlook and behaviour, including the nursing staff who in other rotations she has experienced as quite negative in their outlook. Despite the patients being critically ill, the coping mechanism of 'black' humour is not used. This experience reaffirmed for her that there was an acceptable way to practice within the confines of the medical culture which aligned with the way in which she aspired to practice as a doctor.

In reflecting on how the year has changed her she wrote:

*Well, everything is a little bit more automatic now... So, I feel like I can judge a situation clinically and manage and act on that situation much more efficiently than I could at the start of the year. So that's opened up time for me. And after having seen the way that everybody practices their medicine, I feel like... I guess I know what's important to me and that's being a thorough clinician and being a compassionate one and being very conscious of patients and families.*

For Grace, the clinical experience she garnered over the year has resulted in her clinical reasoning and management becoming more 'automatic', she has shifted from consciously incompetent to consciously competent, freeing up time for her to engage and connect more fully with her patients, the affective aspects of her role becoming more to the fore. This afforded her a more holistic approach in the tailored care she provided depending on the needs of the specific patient:

*I think to have more time to then spend with the patient and work out what's good for them when they're there, to have that more holistic approach. I think that that's where you need the time.*

Interestingly, Grace expected her compassion to erode over the year as she assumed the frustrations she faced would impact on her practice:

*I thought I'd get to the end and I'd be frustrated and I'd have seen too many silly people and silly problems. Yeah. And I got to the end and... I don't know, Intensive Care changed everything, but I'm now in Emergency again, which is exactly back to where I started.*

Although Grace returned to Emergency her narrative suggests that her experience in tandem with the affirmation she received in the Intensive Care Unit (ICU) has given her a robustness that will allow her to resist the pressures of defaulting to the coping behaviours of her colleagues using humour and negativity in responding to the demands of their role.

While very focused on compassionate, patient-centred care, her reflection at the end of the year illustrates how she still clearly defines her role as a doctor, and carefully crafts boundaries around the expectations of her role:

In our final interview, I asked Grace if overall she feels engagement and being compassionate towards patients has been encouraged.

*I think some people have encouraged it just by demonstrating it and they expect you to learn from the way they demonstrate their medicine.*

This comment from Grace reinforces the influence of engagement and participation in the work environment being central to the learning achieved.

*Some places, it's just being very numbers, and then, Intensive Care – just the way the environment was – pushed you towards that rather than out and expressing that. Medicine pushed through numbers. Surgery, although it pushed through numbers, it also was dealing with ladies with breast cancer, so it is... it was expected that you were compassionate... Surgeons of course... they're not particularly compassionate people, they anaesthetise you and take you to theatre, and if they can't cut it out, they can't fix it.*

Grace's reflections highlight the many influences on the expressions of compassion, including the nature of the patient's disease, illness or injury such as breast cancer, where there is an expectation of compassion, whilst in other places it becomes a numbers game where time and resources are quantified and compassion becomes more difficult as healthcare is commodified. And then there is her pervasive belief that surgeons only act as cutters, and

therefore overall as a group lack compassion, when they also have a potential role in pre and post-operative care when patients are at their most vulnerable and many opportunities for compassion are potentially lost.

*I think you look at what you're there to fix and what your role is, and it's not as a social worker and you're not the patient, you're the doctor and that's what they need you to be. So I think, in a way, you've just got to blunt yourself from some aspects.*

Reflecting on her educational experience as a student, she commented:

*We certainly did a lot of the biopsychosocial model approach to medicine but as a student, without really applying it and all you wanted to do was get through exams, you didn't focus on it terribly much.*

Her comments again highlight the difference between the teaching curriculum, and learning through practice, and how as a student the learner's motivation is overwhelmingly shaped by assessment; the need to pass exams as the primary focus of herself and her student cohort, which in turn may contribute to diminishing the humanistic aspects of care as less valuable behaviours and attributes when aspiring to become a doctor. What she learned in practice over her intern year was how these less measurable humanistic aspects of care are central to patient centred care, the 'little things' that mean so much to both her as a doctor and to her patients.

### 6.1.2.7 Dr. Paul Grey – A Hell of a Way to Learn...

Paul is a thirty-three year old, English speaking Canadian. According to Paul, his father was a GP who kept ‘pushing’ him to do medicine... he said, at the time, ‘I just didn’t feel I was ready and I think because he was pushing so hard, I was rebellious’. After studying physiology and anatomy he worked in media relations and communications for a pharmaceutical company. He was working on a Christmas time promotional campaign for children with HIV and AIDS, writing a brief when he thought ‘this is stupid ... I could be writing about helping people or I could be helping people... so I suddenly decided, ‘Nope. This is not for me. I’m going to go into medicine’, and so he moved to Australia to study medicine.

#### PAUL’S STUDENT REFLECTION

In responding to my original question asking the final year student cohort how they have learned to express compassion in the clinical context, Paul wrote:

*role models: in clinical coaching and communication skills, general practice, watching how the school of medicine handles conflict (either poorly or well) role models in other fields (physio/OT/sales/counselling/teaching) watching how other students communicate past experiences of the individual (with either poor or good communication).*

Paul’s reflection highlights the range of role models, both negative and positive, who have impacted on his initial perceptions of how to express compassion. Noteworthy is how Paul looked beyond clinical role models to closely observe the faculty looking for evidence in the behaviour of academic teachers and administrators. He also looked beyond the confines of the clinical and academic context of medicine, beyond the medical defined boundaries of being a doctor clinically, to be inclusive of parameters across the broader team, and formative experiences he has had external to medicine. Observing people’s communication skills, or lack of, has also been formative in framing how he manifests compassion as both a student, and as a feature embedded throughout his learning experiences over the intern year.

## PROFESSIONAL STORY - PAUL STARTS HIS INTERNSHIP

In his first journal entry Paul wrote:

*This is my second week of ED. So far, it's been a whirlwind of successes and failures, all small, none large. It's a little bit of a struggle because after only two weeks of ED training in a private hospital [as a student] with limited patient contact, the shift to a public hospital with an overcrowded ED is completely overwhelming. Not to mention I'm trying to learn different systems, forms and procedures...*

The systems, forms and procedures to which Paul alludes are the artefacts of patient management, abstract system processes reified as concrete procedures and forms demanding time, thought and energy which, as cognitive distractions, become barriers to his expression of affective compassionate care.

*I always walk into work a little nervous, a little nauseated, but soon settle in when I see my first patient. I think the shock factor really hit when a nurse said to me, 'what do you want to do, you're the doctor!' While a little 'trial by fire-ish,' it was the truth. A little more preparation would have been nice. Still, I'm in it...*

Paul's journal reflections captured how his initial experience was visceral, embodied in his physical response of feeling nervous and nauseated. The nurse's question directed to him as a new doctor is significant, it could be interpreted as a hostile undercurrent in their relationship. The nurse offers an invite to the new doctor challenging him to participate as a legitimate member of the community of practice. The unnecessary use of the title 'Dr', suggests an unfriendly introduction to the clinical environment, an open acknowledgement of a struggle for authority, a differentiation of power and status, the nurse may have experience but the doctor has the title and incumbent authority. Therein lies a subtext, a sense of 'so you're the expert, what are you going to do?' it is suggestive of support being withheld, which diminishes the role of their working together as part of a team to care for the patient who should be at the centre of their practice, the patient's care ideally being a common goal. In this unwelcoming environment, far removed from the ideal proffered in the theoretical construct of a shared community of practice,

Paul finds himself juggling priorities and struggling with the system, an environment where compassion for himself, his colleagues or patients is not foremost in his thoughts.

Paul's journal entry 'Still I'm in it...' is important, Paul has crossed a boundary, no longer the student on the periphery, loosely attached or tethered to a team, but a doctor with all the incumbent expectations of the role. Despite holding this title, acceptance and recognition remain conditional; it is a role underpinned by responsibility with expected knowledge, skills and behaviour dependent on engagement across the reified team; an abstract construct given a concrete meaning (Bleakley, Bligh and Browne, 2011).

*It's interesting seeing the diversity of patients at (location), and some of the problems that I haven't been exposed to. Additionally, some of the knowledge about investigations we learned in medical school is just wrong.*

Paul's journal entry sheds light on the range of factors which impact on his introduction to his doctor role, including the range of patients and their problems and the knowledge that some of what he has learned being perceived as wrong, creating a level of uncertainty.

*The patients themselves have been wonderful. Everyone I've talked to has been friendly, and it's amazing how people confide in their doctor. It's also amazing how people may come in for one thing, but talk about something completely different - as though all they feel they needed was someone to listen (aside from the emergent medical condition).*

For Paul in this initial entry, the patients being 'wonderful', and the friendly environment are important as they represent important features of a supportive work and learning environment for him. Paul wrote about the need for the patients to be listened to, he foregrounds listening to the patient as a priority alongside their medical condition.

*One of the biggest issues I think I'm going to have to face is to meet the expectations of the staff. I know it's only week two and I've had 6 shifts, but it seems like we're supposed (supposed) to be seeing 6-8 patients (per shift) already and moving them through as efficiently and fast as possible while still being safe. For someone that's just learning the*



*ropes, it's a daunting task and to be honest, seemingly impossible. I've spoken with some registrars and they said that ED was a great rotation, but one of the worst ones to start on because you have to know so much so quickly, and you have to do it right away... Still, most of the staff are wonderful and are able to help out when available, as well as provide advice.*

Staff expectations are a primary concern for Paul, his perception of their expectations coupled with inexperience, patient throughput, being fast, efficient and safe, places enormous pressure on him. Each of these demands, for him as a novice, distract from compassionate care.

*I think, I hope it will be okay. I have yet to meet my supervisor – I just sent him an email. I'm hoping he can provide more advice to me and just give the reassurance I need.*

Paul acknowledges his desire for reassurance, and while in general he finds staff supportive, it is week two and he is yet to meet his supervisor. Paul paints a picture of uncertainty underpinned by inexperience; his willingness and motivation to perform well are overshadowed by his lack of confidence in his own ability, a further distraction from the provision of compassionate care.

*The biggest fear I have is failing this rotation because of stupid mistakes, or because I was completely unaware that I needed to know something. And of course the fear of me killing someone... I guess for now, I'll keep doing what I'm doing, trying to think on my feet, keep busy, keep learning and keep my fingers crossed.*

He writes about failing the term as his biggest fear, 'and of course' unintentionally killing a patient, his use of 'of course' suggesting it is a common fear felt by all novice doctors. Using the metaphor 'keeping my fingers crossed' is suggestive of luck and fate rather than competency and planning in avoiding these dire consequences.

Unfortunately for Paul, a patient's death is a traumatic but formative learning experience, as he described below:

*Today I had my first patient die on me... He came into ED and was being seen for an infected lesion... but was completely belligerent and*

aggressive towards me. Swearing up a 'blue streak', he was much more friendly to the female nurse than to me. After attempting to take a history from him, which failed miserably and ended in him telling me to fuck off, I went to go and speak to my consultant about what I knew so far and an initial plan including getting a collateral history. I was gone only two minutes and when I went back, he wasn't breathing...

One of his greatest fears was to unintentionally 'kill' a patient. While he did not contribute to this patient's death, the way in which he has written his journal entry personalises the experience 'today I had my first patient die on me'.

Paul's response to the death is further personalised in his journal reflection when he relates how the patient looks like his grandfather. He captures his fears and expectations and lack of control in his reference to the roller-coaster ride, and his feeling of being 'stuck' in not knowing what to do. His reflection captures the complexity and the confusing, conflicting nature of his emotions, embodied in his feelings of wanting to vomit and cry and being 'frozen'.

*Luckily, my boss came over and as the patient was NFR, told everyone to step away... I had a little debrief with my boss and everyone was really supportive – which was awesome because I felt like vomiting, then crying.*

He attributes his 'boss's' intervention as luck, rather than supportive supervision. The debrief with his boss and the support of the team are important factors signposting his growing alignment with his team and contributing to shaping his learning within the confines of his fledgling professional identity.

*But the good part in all this was watching my consultant phone the family to let them know. She was absolutely incredible! Friendly, compassionate, firm and fair, realistic, supportive... asking if they wanted to come in and see the body immediately, or later. Asking if they needed support immediately or later. Asking if she could call anyone or whether they wanted to... I don't think I would be prepared to do that, despite the training in 'Breaking Bad News'. It was a hell of a way to learn and I think one of the things I picked up from that is that although*

*we can be jaded at work (happening quite quickly), we're still responsible for the lives of a person who is important to someone...*

Paul's reflection sheds light on the power of the positive role model and the role of learning embedded in the messiness of clinical practice. His account of how his supervising consultant, and his description of her, which abounds with positive adjectives are important. His use of the pronoun my, 'my consultant' is significant as it suggests a shift in identity as he aligns himself with a senior colleague who supports him. He recognises that the training he had previously received in 'breaking bad news' has been inadequate in providing him with the skills to undertake the role in the reality of practice. He writes of being quite 'jaded at work already', the patients are no longer all 'wonderful' and 'friendly'. Most importantly he recognises that despite his less positive view of patients in general and the inappropriate aggressive behaviour of this specific patient, they are 'important to someone ...'

Paul's awareness of becoming 'jaded' at work so quickly is a theme which he explores further when he returns to it in his journal as he approached the end of his emergency rotation, only ten weeks into his intern year.

*As I'm approaching the end of my Emergency rotation, I find myself becoming more and more jaded with people – patients specifically... I'm not sure if it's just the patient population around here, but I would think that if you are coming to the hospital and can get pregnant 3 times before the age of 18, perhaps you should know if you have any medication allergies or have a significant past medical history. Then again, maybe I'm just used to being around medical people who think like me... and I have to realise that not all people do.*

His reflections connote a separation of himself, a distancing from the patients and a further alignment with his team – he writes of the 'patient population' and 'medical people'.

*There are also patients that are I see and when I ask specific questions they give very vague answers:*

*Q: how long did the chest pain last?*

*A: a while*

*I can remember thinking, 'IDIOT!!! Do you think that helps me figure out how to help you best?'... I remember hearing someone tell me that as doctors, we're in the top 10 per cent intellect when compared to the general population. After being in medical school for 4 years and now in the field, I hear the same type of word phrases all day and forget that I've been trained to know what those things mean.*

Paul's journal articulates how language and medical jargon are an artefact which create a boundary between himself and the patient while creating a bond with his team and community of practice. His reflection sheds light on and builds understanding on his sense-making of why some patients appear so 'idiotic' and in reflecting on his own training he can reframe his own expertise relative to the general population. His intention does not appear to be to alleviate his own status but to better understand the ignorance of some of his patients' own health literacy and self-care.

*I guess the big challenge for me is to approach everything with a sense of humour... not see the answers as stupid, but as a funny thing and take from it a chance to educate the patient about their health and why things like chest pain duration is important to note.*

*One of the largest frustrations I'm having is people not knowing their own health status. Patience is something I thought I had – but I realise I have to work on it a little more.*

*Switching from Emergency to Medical rotation, I've noticed a real difference in the interactions between staff hierarchy levels. It seems like consultant 'appeasement' is much more a priority and 'individual thought' is less acceptable. It's almost like the registrars are more afraid of their bosses/consultants than in ED. I wonder if that affects how they interact with their patients.*

Paul's reflection is notable as it aligns his immediate peers behaviours with authority medical figures; he wrote about registrars being 'afraid' and queries how this influences how they interact with patients. His concerns are valid; research by de Zulueta (2013) suggests the more fearful a person becomes, the more narrow and reductionist their approach.

*Pain is one of the strangest things I've encountered so far and it's shaped so much my dealings with people. I've learned that everyone reacts differently... I've often found that this helps to develop a trust with my patients – and it's as simple as saying: 'wow – looks like you're in a lot of pain...' Sounds a little obvious, eh?*

In describing the care he provided to a woman in pain, Paul wrote:

*Anxiety comes into pain a lot as well... and I guess helping to alleviate that anxiety helps to decrease the patient's experience of pain (if not the pain itself)... although she was in pain, which we were trying to fix within the measures available to us, I found that holding her hand and letting her squeeze it (and me squeezing back) was enough to slow down her heart rate a little and have her breath a little easier (figuratively and literally). I think it's the anxiety of the unknown that's associated with the pain... 'is it going to get worse? Is it going to get better? Is someone going to help me?' When you hold hands (even more so than with a hand on the shoulder or something like that), it seems that patients take it as are affirmation that you are going to help them and someone they can depend on. While it sounds mushy/gushy, I do think that it helps to relax them... and relaxation can alleviate pain as well!*

In this reflection Paul crosses boundaries many doctor fear to tread, he is not just touching a shoulder but holding the patient's hand, an act which literally places the doctor and the patient going hand in hand in the patient's journey. He wrote about reaffirmation that you are going to help, that you can be depended on – for him it is an act which affirms 'you are going to help' it is giving that little bit extra of himself to the patient.

*I know it's sometimes a little unprofessional, but I find joking with patients about stuff, even the weird stuff and their disease, often puts them at ease... I think it may have something to do with the fact that if they see that you're not stressed out, it maybe makes them feel like you can have it under control – maybe in the same way that sometimes when a kid falls down, they look to see if the parents are freaking out before they start crying.*

Paul's acknowledgement that humour may be perceived as a little unprofessional is interesting; for the use of humour as a coping strategy for clinicians confronting the day-to-day tragedy of human misery receives tacit acceptance within medicine and yet he is tentative in the context of humour and the patient perspective or journey. His joking with the patients and the way in which he references back to the child and parent relationship is a conscious acknowledgement of the role the doctor plays, the influence his status has for some patients in determining the gravity of their own situation and how they should respond. It also suggests that appearing in control, as a doctor, is really important.

In responding to a question I asked regarding how he felt he met the patients' emotional needs he responded:

*I don't think I go and actively say, 'Hey, what's this person's emotional needs? And what I need to address here. For me, I think it comes out in the type of person I am. I think... And it sounds really just... douche baggy for me to say this about myself, but it's... I think I'm a pretty emotional person. I like connecting, but like making sure they're happy, that they're smiling, that they're okay. It's part of my... I think it's a little bit of a self-esteem thing, too. Making sure they're happy with me and making sure they like me – it's a little bit of that as well. And for me, if you're not emotionally invested as well in what you're doing, why would you want to do it?*

I asked Paul, 'and do you feel you've been given permission – 12 months down the track – to maintain that and to develop that side of your personality?' He responded accordingly:

*I think it's... well, it's... I think it's been validated. I think... about the Staff Member of the Month award in (location of hospital) for December... It's kind of lame and embarrassing. But it's... I mean, it was a patient-nominated award and 4 or 5 patients wrote something about me throughout the year... it's really cheesy but for me, it validated that I'm actually doing something right.*

*It was read out to me. And it just was like, 'he was caring', 'he really understood me', 'he connected with me', 'he believed me when no one else would', things like that.*

While Paul does not explicitly frame his journal entries around the question of compassion, many of his reflections are illustrative of compassionate acts, such as: the act of listening, the touch of comfort, attempting to ease anxiety, pain and fear, using humour as a coping strategy for himself and his patients. Paul draws on his own experience as a teenager, a time when he had a serious and chronic health condition, in attempting to be empathetic, through placing himself in his patients' shoes. While at times he has struggled with the frustrations of caring for more challenging patients or situations, his narrative is one of growth. His desire to be compassionate and caring has remained core to how he has identified and acted in his role. Engagement and connection with both his patients and his colleagues have been central to the crafting of his compassionate doctor identity where he can act on his desire to help while consciously recognising both his own emotions and those of the patients. He does not eschew being emotional, asking 'if you're not emotionally invested as well in what you're doing, why would you want to do it?' This self-awareness appears to act as an anchor for the way in which he shows he cares, transcending his identity as a doctor, to being someone who can help through taking risks beyond the restrictive confines of detached concern model of care prescribed by the medical model. Paul's actions and behaviour challenge this notion of conformity encapsulated in the medical paradigm, through recognising common vulnerability shared by himself and his patients. Paul actively sought to engage and connect with his patients wholistically embracing the social and emotional aspects of care alongside the physical. In doing so he illustrates a way to express care which is protective of both the doctor and their patient's emotional wellbeing while embracing the ethics of imperfection (Shapiro, 2008), a topic further explored in the thematic analysis. His consciously nuanced engagement with patients allows him to work fluidly across the boundaries of professional and personal engagement, the 'edge of intimacy' (Shapiro, 2008), not an impermeable barrier, but a permeable boundary, for him to criss-cross dependent on his patients' and his own needs, affording him the opportunity to be the kind of doctor to which he

aspires to be, enabling him to act on his original desire to practice medicine as a way to help people.



### 6.1.2.8 Dr. Nathan Jones - To Act Humanely

Doctor Nathan Jones is a 30 year old who initially studied pharmacy which he practised for a couple of years prior to undertaking medicine. During our initial interview he explained what drew him to medicine:

*I just felt like I wasn't able to do anything. Like, I wasn't finding I was actually able to impact patient outcomes ...It wasn't really what I saw myself doing. I thought I wanted to be a bit more hands-on. I wanted to be more involved and actually make some decisions and that kind of thing and just the fascination of it, I just wanted to know more about each condition ...*

#### NATHAN'S STUDENT REFLECTION

In responding to the student reflection he wrote:

*Observing senior doctors showing compassion has been the biggest influence, when they do this I can't help but be influenced. It shows me that these people with years of experience and heavy workloads still are able to spend time with their patients and display evidence that they care about them. It also showed me that it is alright to be compassionate, junior doctors and students have to learn the appropriate level of connection to have with their patients and may err on the side of coldness, it is good to see senior doctors be compassionate to remind everyone what the whole point of patient care really is. Senior doctors who do not display compassion may also affect negatively as I may model their behaviour without realising. Personal experience is another influence. Having family members who have been through medical problems or been in hospital for whatever reason are a reminder of the fact that patients are all people with families and friends and the outcomes are real and felt by many people. A negative influence for showing compassion is spending time learning from books as it takes the person out of learning, positive influence is spending time in the wards for the reverse reason.*

Nathan's reflection captures the influence, both positive and negative; his senior colleagues have on him as a medical student. The positive senior role

models to whom he is exposed and who he wishes to emulate, both give him permission to be compassionate as well as show him 'appropriate' ways to 'display evidence that you care'. Most importantly, they reinforce his belief that being compassionate is both valued, and possible, despite the time constraints imposed by a busy clinical workload, and in doing so demonstrating how not all clinicians become hardened as their years of service grow. His reflection highlights the richness of learning embedded in practice; he emphasises the importance of 'the person' a central theme woven throughout his journals and interviews. His personal family experiences act as a reminder that patients are real people with real families who care. He writes how junior doctors and students 'may err on the side of coldness' in trying to determine the right level of connection with a patient. He actively seeks out appropriate ways to express compassion, it is as though 'coldness' and emotional distance are the default in practising medicine, and he has to actively pursue alternative strategies to engage compassionately with patients. This is revealed in his comment regarding the way in which negative behaviours can be modelled unconsciously, yet it is the positive role models and behaviours he consciously seeks out and where his attention is directed.

## **PROFESSIONAL STORY - NATHAN STARTS HIS INTERNSHIP**

Nathan's intern year is spent at a regional hospital, this is important as it influences the patient acuity and throughput, for example, an intern in a large urban teaching hospital based in Emergency will see between 4 – 8 patients in a day's shift for an intern in a smaller regional hospital, system and service delivery demands will see them pressured into seeing many more.

After his first week, Nathan wrote the following:

*Didn't think too much about compassion this week. The sudden realisation of being responsible for patients was a big moment. The patients have become my own and no-one else is going to care for them if I don't. This is a big change from student days, where I was an observer in other peoples care. Now that the patients are mine I have realised I must care for all their needs and this involves the emotional. I realised this week that it was my job to be compassionate toward the patients and I alone had to do this.*

Nathan's reflection captures the enormity of his transition from student to doctor. He reflects on how different his identity is as a doctor compared to being a student, which while a legitimate observer his student role, it was a role bounded by being on the periphery of practice, and the subsequent circumscribed responsibility. Despite being a newcomer to a community of practice which has both formal and informal support networks in place, there is a sense of isolation in Nathan's reflection – 'I alone had to do this'. While he consciously reflects on compassion, his reflection acknowledges how the realisation of his changed role has the potential to distract him from acting compassionately. This sense of aloneness, combined with feeling he has total responsibility for 'his' patients subjects him to future diminished wellbeing if left unchecked.

It is just week one but Nathan already acknowledges the difficulty he already faces in expressing compassion equally to all patients:

*When trying to help people they are sometimes rude or stand-offish this does not help my compassion. An occasion happened this week where a lady came in and she was initially unpleasant in our dealings, in the end she had a very poor diagnosis and was in need of much compassion, however her initial attitude toward me definitely affected how much I cared. I knew that it shouldn't and that I should be professional and treat all the same and I certainly tried, but it remains a fact that I could not feel the compassion toward her that I could toward other pleasant patients.*

He articulates how each individual patient's demeanour and behaviour in turn impacts on his emotional response and his own thoughts, feeling and resultant behaviour. He acknowledges his effort to be professional, which he describes as treating all patients equally, however he recognises his inability to do this, and how it is easier to be caring and compassionate with the more pleasant patients. At this early stage of his learning trajectory his desire to be compassionate becomes conditional and compromised.

Week two in his role and Nathan identifies system factors which further distract him and inhibit his capacity to express compassion towards his patients:

*Interferences with ability to have compassion include stress and being overworked and being new to the job. I spent a lot of time running around trying to figure out the admin side of medicine, writing forms, making referrals. The job became an exercise in admin and I felt like I was floundering in the forms and notes I had to complete. In this setting I lost sight of the actual patient and basically forgot compassion in order to get the job completed as fast as I could. Everything I was doing was for the patient but may have missed satisfying all the patient needs.*

So for Nathan, patient management and the reification of the role, manifested in forms, referrals and system imperatives overshadow and distract him from being able to care for the patients. The patient continues to be the centre of his practice; however his connection with the patient is remote.

Towards the end of his first month as an intern, Nathan clearly articulates how having empathy for the patient is directly influenced by his ability to relate to the patient due to a common 'ground or life experience'.

*Being able to relate to patients makes it more likely for me to feel compassion – I guess this relates to me being able to put myself in their position and understand their fears/pain etc. If I cannot put myself in their position due less common ground or life experience I find it harder to relate and harder to have compassion.*

*Egg a young male patient I cared for I was able to relate to easily and understood that he was sick and needed help because hospitals are not a place for young people.*

*Contrasted with an elderly lady, who I couldn't relate to her experience in life as it is so far removed from mine.*

His reflection further emphasises, how the visibility and severity of the illness influence his ability to express compassion, as both enabling or inhibiting factors.

*The young man was visibly ill and I knew from his history that he was at risk of dying from his illness, in contrast to the old lady who was not obviously ill and I could find no firm diagnosis. Although the lady was more concerned than the young man I felt more compassion for the*

*more sick patient. I think perhaps the more severe the illness the more compassion I have.*

So as a novice unable to make a diagnosis for the older female patient whose 'illness' was less visible, results in Nathan showing less compassion towards her than the young man, who he has more in common with, and who also has a definite and severe/acute diagnosis. Again his compassion is conditional.

During the first few weeks Nathan emphasised how each patient's demeanour affected his ability to be compassionate, five weeks into the role, he further reflects on how his own mood and wellbeing impact on his own mindset and subsequently curtail his ability to be compassionate.

*My own state of mind has become important, i.e. if I am in a good mood then I am more likely to affect my ability to have compassion and when I am stressed or ill or tired I have less compassion. Certain stressors tend to affect my mindset such as workload and support from the senior doctors. When the senior doctors are critical then it affects my confidence in being able to adequately care for patients, and this in turn makes me feel like a fraud in front of my patients and as if I do not have the right to be caring for them and showing compassion. The reverse of this is that when I feel like I am doing well at my job I find it very easy to have compassion.*

For Nathan, his ability to be a compassionate doctor is closely aligned with his confidence and perceived competence. His reflection demonstrates the influence of his more senior peers not only as role models but as supervisors who can nurture him in giving constructive feedback which allays his feelings of uncertainty or which can undermine him in his role – where he feels a fraud - this perceived underperformance influences him in his role where he feels 'he has no right to be compassionate' the notion of being a competent doctor both over-rides and underpins his role as a caring and compassionate human being.

The artificial dichotomy of focussing on the patients immediate medical concerns, as opposed to their needs for understanding, (which Nathan perceived as a dominant discourse in medical school), in tandem with the emphasis on the acuity of the patients in emergency initially influenced Nathan

in the way in which he delivered care, with an emphasis on speed and acuity. His senior colleagues' behaviour towards a patient and the patient's wife, illustrated how compassion can be extended to the family as described below:

*I had a patient during this week who had dementia. He was happy enough, or at least it was not his decision to come to hospital, but his wife was very run down. She was having to care for him 24h a day and had come to the end of her rope. She presented with her husband to ED because she did not know where else to go. Through medical school we have always been taught to seek medical concerns, and ED I have learned to try to clear patients as fast as possible and to focus on emergencies. I was impressed by my senior consultants who recognised the hopelessness of the wife's situation and encouraged me to have the patient admitted. It showed me that compassion extends to the family and not just your patient. You must care for them as a whole.*

This example of care provided Nathan with a richer understanding of 'whole patient centred' care embedded in practice.

The following reflection shows a shift in Nathan's thinking, a growth in his confidence and competence as a doctor:

*I had a patient with a fracture who was an IVDU and had HCV. He used opiates recreationally and as such was difficult to manage pain wise. He was a reminder that, regardless of the place in society the patient comes from, they need our help and deserve our care and attention. Negative comments always happen between staff with these kind of patients; from comments about drug seeking to implications of being less of a person than others. These are inappropriate and have no place in healthcare. The underprivileged often bear the bulk of a community's burden of disease and therefore if you have no compassion for their situation you probably have no place in delivering healthcare.*

Two months into his role and Nathan anchors his compassionate care in social justice, his reflection demonstrates a growing awareness which is reflected in his practice. There is an obvious shift and growth from his initial few weeks where, while he was focussed on patient centred care, he found the reality of

difficult patients and his own mood to be influential factors which inhibited his compassion. He appears to have transcended these factors embedding his beliefs in equity and fairness as his foundations which he then actively applies to his practice; he has gained the confidence and the skills to embed his patient-centred approach which is core to his belief system into everyday practice. Allowing him to resist the populist talk which frames the patient in a demeaning way, he is now capable of embracing more difficult patients, despite them having a messy diagnosis and a possible dysfunctional social history, patients who according to Nathan, often bear the brunt of negative comments and innuendo in the clinical environment according to Nathan often bear the brunt of negative comments and innuendo.

In completing a term in Obstetrics, Nathan shares how the perceived health of the patients influenced his focus on compassion, however this changes when there is an adverse event resulting in the death of a newborn baby.

*I didn't really think about compassion. As the norm the patients were generally healthy and not in need of much compassion. One occasion compassion was required was when a baby died soon after delivery. Obviously this is a terrible time for everyone involved and much compassion was needed, not just for the patient but for the staff also. My co-worker was involved in the delivery and thus was feeling terrible and guilty. I was not involved with the patient but felt it was up to me to support my team-mate. It was a reminder that patients are not the only people in need of care and support.*

Nathan realises that showing compassion to a team member is also a part of his role. After completing a term in orthopaedics Nathan wrote:

*I have encountered more suffering and death than in my previous rotations. The patients are often old and have often fallen for a reason – they may have had some illness at the time... These patients often do not do well.*

*Also on ortho I again have become the primary carer for the patients on my team. I know the patients best and get to know their concerns and fears due to the time I spend with them day to day.*

Nathan's growing confidence in his role and doctor persona is reflected in the way in which he writes, he is more assured, sounding less hesitant and more confident in how he spends his time.

*I find that having compassion means having the respect to spend time with the patient, the empathy to appreciate their concerns and the commitment to attempt to alleviate them. Concerns may be as simple as pain, or as difficult as loneliness, but they must be identified to be able to have compassion.*

Nathan no longer focuses on acuity or emphasises speed, he understands that emotional and physical pain are not unconnected, and that through spending time with the patient he can uncover their needs.

*I have learnt that expressing compassion can be as simple as a quick comment or joke on your way past, something to show them that I consider them a person, not just a patient.*

He has developed strategies to connect with the patients.

For Nathan, a growing maturity is evident as his range of experiences improved confidence in his role has a major impact on his ability to show he cares, and allows him flexibility in how he undertakes his role, as illustrated in his narrative below:

*When you start being sort of confident in your job, like in your ability and stuff and it takes a while to get that in your intern year... Yeah. But once you start getting that confidence, it's easier to sort of choose your own path ... you can sort of do what you want with the rest of your, I don't know, behaviours and things, I think. I think it gives you a bit of flexibility. As long as you're getting the work done, then you're allowed to do what you want ... as long as you get the work done... I think that's the kind of thing, once you start getting good at your job, I think it frees up you... you free yourself up to do a bit extra. So if you wanted to do the more compassionate or whatever, then you sort of give yourself the permission to do it...*

Reflecting back on when he commenced the role he says:



*Like, when you start anything, I suppose, initially you're model behaviours are those who are doing the job already. In order to become more comfortable yourself, you start to choose what you want to take and what you want to discard... You choose your own model of how you want to care for people.*

As he grows more confident in his role, Nathan is more confident in giving a little more of himself. Although he clearly has boundaries separating the personal from the professional, connection between himself and the patient is important to him, and he has found giving a little of himself helps build that connection, as relayed below:

*Just having a little quick chat about something non-medical every time I see them or every other time you see them – just a quick chat, a little bit about their life or something or about your life... I don't like to tell people about my own life. I like to keep that separate, but every now and then, it's quite nice just to share a bit of something with them. Yeah, yeah! That makes them feel like they're actually connecting rather than you're a robot. I think just the growing confidence in the job. Yeah. And in my own ability.*

Nathan reflects on how his previously narrow peer group, your friends, school and classmates within the confines of studying and working restrict those people with whom you come in contact. Now having spent close to a year relating to a range of people representing a much broader demographic he is less restrictive on who is deserving of care and compassion.

*Like, there's so much time... you know, your friends or your classmates or schoolmates and... and you spend so much time studying and just working and... and those guys... I think your peer group gets very narrow and I think that reflects more on myself than on a patient or a system or anything. It's just that... I think at that time, right back at the start of the year, I hadn't spent much time with... you know, other demographics. Sure. So, I probably found it a bit harder to relate to them, how to communicate.*

His view on those who are acutely ill being more deserving of compassion than the less acutely ill is also redefined. In our interview, I remind Nathan

about his previous reflection regarding 'the sicker the patient, the more compassionate you were' and whether that was still his understanding, he responded accordingly:

*Like, I don't think... I don't think sickness is a good reflector of how much compassion needs. Some people can be terribly unwell but they're still pretty strong and they can handle it and other people are scared a lot easier ... and they're the ones who need more compassion.*

It is no longer how sick you but how you are coping with your sickness, which influences how Nathan provides compassionate care to you as a patient.

In talking about learning from experience Nathan reflects as follows:

*you learn the most when you can attach an emotion to it, I think...I think there's a certain point when you show someone good care, it feels good to know that you've connected with someone or made contact or when you haven't, you feel terrible. And those are the times... that's how you pick up and say, 'Well, I won't do that again' or 'I'll do it better next time' or 'Keep doing it like that.'*

His articulates how his emotional response, 'feels good' or in feeling 'terrible' influences his future behaviour and how he determines what to build on or to actively dismiss.

Nathan's summing up of his intern year highlights the many pressures and influences he confronted in straddling the divide between what is expected of you as a doctor and your own personal beliefs and values, as he articulates below:

*Through med school, through your work. It's always... there's constant reminders of what you are and aren't meant to do and all that and that's all fine but I think at the end of the day... there's all these rules and protocols and all that kind of stuff, but I think they aren't the most important things... break a few rules or break a few stereotypes or... you've done the right thing by you and the person in front of you, that's the most important thing.*

He talks of the persona you create, the mask you wear, as a surgeon or a doctor and the preconceived notions you have 'what you are and aren't meant

to be' but what appears to transcend all these factors is his belief that you a fellow person helping another person who needs your help.

Towards the end of our final interview in reflecting on the year Nathan returns to his initial transition and the new role you play as a doctor, he says:

*At the start of the year... I started introducing myself as a junior doctor and things like that. At the start of the year, it was a massive thing. You'd walk into a room and there'd be three of you and they don't know who's the consultant and the registrar and you. They have no idea... And they don't know that it's your first week on the team ... They just, 'You're the doctor. You know everything.'*

For Nathan, being a junior doctor is no longer a defining feature of his doctor identity. He has come to the realisation that, to the patient, he is either a doctor or not a doctor. The patient does not want to know about seniority within the doctor role. This is an important realisation for Nathan, that for the patient being a doctor is a binary statement. His narrative of his intern year is illustrative of his developing and evolving identity in his role as a doctor; he entered medicine with the motivation and willingness to make a difference, the intern year provided him with the confidence and competence to act on his beliefs in a way in which was appropriate for the clinical community of practice. His narrative highlights the temporal nature of change, in relation to Nathan's perspective and perception of both his own identity as both a doctor and person, and the identity of the patient as both a patient and person; the subsequent change in his ability; his growing confidence allowing him to relax and be a compassionate, caring doctor aligning his personal and professional values.

## 6.2 DEFINING COMPASSION AS A SOCIAL CONSTRUCT – THE INTERNS' PERSPECTIVES

This study, in interpreting the interns' journey as learners, uses the lens of compassionate care. How the participating interns interpret the meaning of compassionate care is central to this study acting as a backdrop for a more nuanced interpretation of the data. The emergent construct acts as linchpin for the interns' ongoing learning trajectories.

In consenting to my study, the participating interns were provided with information which outlined that the main focus of my research was to explore 'how junior doctors learn to express compassion in the clinical context'. They were not, however, provided with a definition or concept for compassion, as I did not want to stifle their understanding or experiences, or shape their expectations or interpretations.

In our first interview, three months into their intern year, in the context of their lived experience, and the stories they shared with me, I asked each of them to articulate what they meant when they used the term compassion, emphasising that there was no right or wrong answer. Each of their responses was influenced by their formative years blended with the immediacy of their experience in the clinical environment. Throughout the year as I invited them to share their experiences, and as their subsequent stories unfolded, there were numerous accounts of how they expressed compassion rooted in their everyday routines, or alternatively lost opportunities where their expression of compassion was thwarted, hindered or neglected, eclipsed by other demands. Their increasing roles and responsibilities, entrenched within day to day practice, provided scaffolding on which to enact their compassionate care. Their reflections illustrate their growing understanding; building a rich tapestry of the possibilities within their role as they progress through the year, shifting from a novice on the periphery to a more experienced clinician as they become more immersed in their community of practice.

### 6.2.1 TWO DIMENSIONS

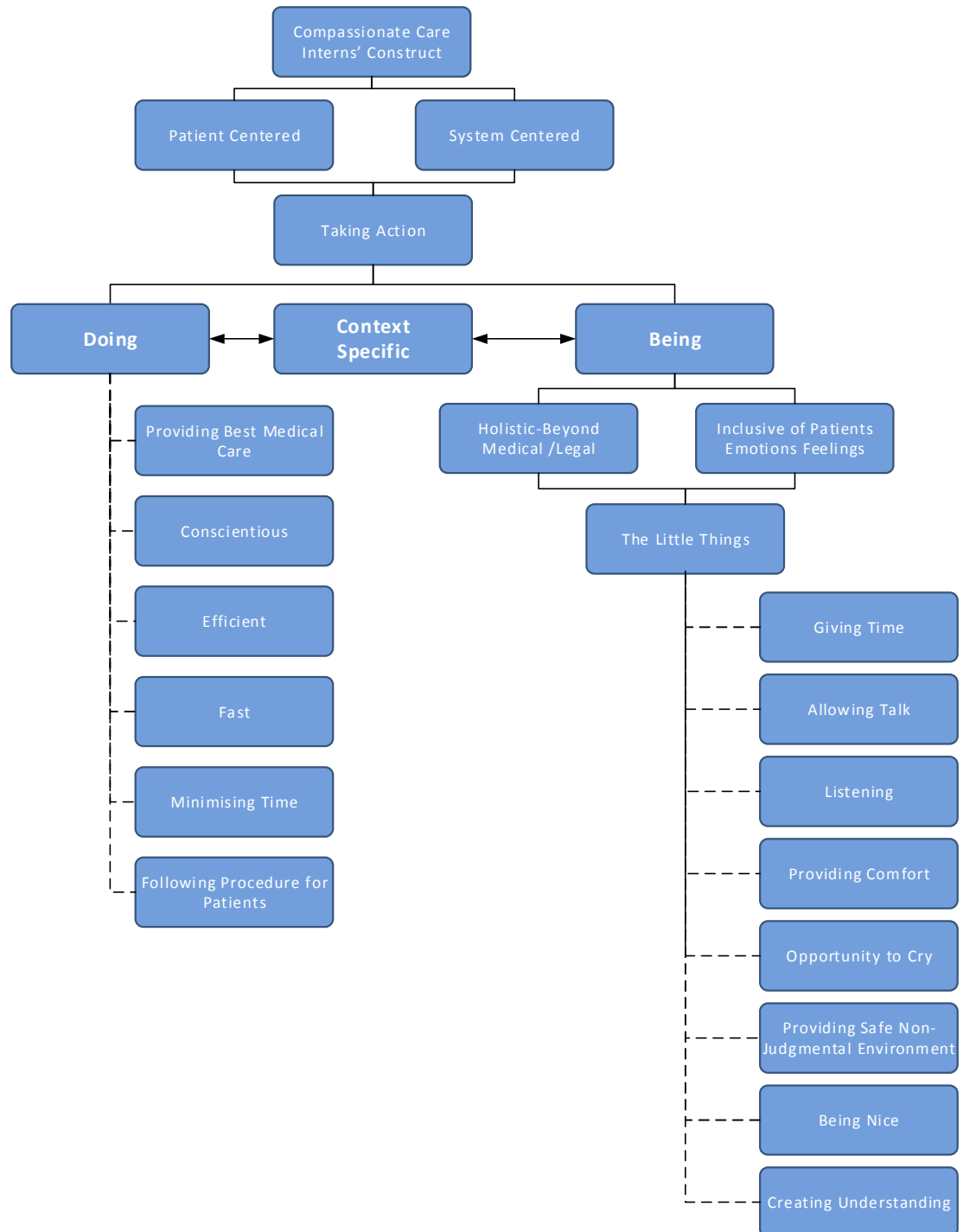
At first glance their texts, filled with specifics about patient interactions and at times contrasting motivations, appeared to be diverse in their meaning. However, through a closer analysis two overriding, dominant dimensions were identified in the data:

- Dimension One: system centred care – providing care to a patient
- Dimension Two - patient centred care – qualities of being – caring for a patient

From these two dimensions flowed sub-categories which capture how the interns constructed meaning in providing system and patient centred care and

what actions they took to 'operationalise' compassionate care. Most importantly the interns' shift in understanding is captured in how they provide compassionate care, with a shift over time for some, from 'actions of doing' to 'ways of being'.

I have outlined this construct in Figure 3.



**Figure 3 - Compassionate Care - Intern Construct**

### 6.2.1.1 Dimension One – System-centred – ‘doing’

In the early stages of their intern year, the interns found compassion a difficult concept to articulate, their inchoate definitions a product of their limited practical experience in the work environment, depriving them of a framework to smoothly transition from theory to practice. Their different understandings at times sat outside the accepted meaning of compassionate care with their emphasis framed around system centred actions and goals.

As illustrated in Bill’s quote:

*I guess I'd think compassion is just providing the best medical care you or (the) unit can provide and making sure that the patient is happy about it or on side about it.*

Interestingly his definition of compassion not only includes his role as a doctor but also the role of his unit, suggesting compassion is not solely about engagement between individuals but also extends to the broader workplace. Working within the confines of the hospital system again frames his understanding when he writes:

*But that's not the way the hospital system works I suppose. I've really just had to grin and bear it with this situation, and that's as compassionate as I'll get.*

In this quote Bill is framing his notion of compassion in responding to the situation and the ‘system’ and not to the individual needs of the patient. This emphasis on system demands is further illustrated in Bill’s quote:

*This actually makes me work faster, and helps me deliver better care to patients.*

He equates working faster with delivering better care. The contradictions in this notion of speed and efficiency being at odds with compassionate care are captured by Nathan:

*In this setting I lost sight of the actual patient and basically forgot compassion in order to get the job completed as fast as I could. Everything I was doing was for the patient but may have missed satisfying all the patient needs*

For Neel, compassion was defined as ‘doing anything beyond what is legally required... beyond the minimum requirement which every intern must do to pass internship...’ He provided an example the following example, when he is finishing up to go home and:

*if I were sitting at the office, doing, for example, a discharge summary and I get a page (an electronic communication system), I call back and then the nurse says, ‘So-and-so family is here and would like to discuss whatever is going on.’ Like, I could say, ‘Okay, I’ll be there in one hour’s time.’ Or I could just say, ‘Okay, I’ll come over now.’ Yeah. Okay. So I could simply make the family wait for an hour or I could just go immediately and... whichever way I choose to do... like, to approach it, it’s acceptable both ways. It’s not wrong and I would have, like, a legal excuse.*

Neel uses the term ‘what is legally required’ as a surrogate term for basic medical care; acting compassionately is the ‘icing on the cake’ of care, an optional extra. Whether his action is compassionate or not is unclear, the act of responding swiftly to a patient or their family’s needs is conscientious, ‘professional’ and perhaps altruistic. This action is not compassionate within itself. How he engages with the patient’s family would be a better indicator of the expression of compassionate care in this context: is he impatient and frustrated with the intrusion on his time and paperwork, allowing these emotions to influence his interaction with the patient’s family or is he comforting and caring in his interaction?

Being conscientious framed Phoebe’s initial understanding;

*Well I guess, at the moment being a conscientious doctor is better than being a feeling doctor just because um, I want to be a conscientious doctor cause that means I am good to my patients even when I am having a terrible day.*

In consciously being ‘good’ to all her patients, Phoebe has enhanced her professional behaviour in the way in which she delivers care. Significantly she assumes this improved professionalism equates with heightened compassion, illustrating the inexperience and naivety of the novice. Reflecting the learning

trajectory of each of the interns this changes over time as discussed below and as a major theme within their individual and collective narratives.

While initially the interns seemed to place system and patient-centred approaches in opposition to each other, (as illustrated in Figure 3) there were connecting threads; the more they mastered medical competence, the more compassionate they felt they could become.

### 6.2.1.2 Dimension Two - Patient-centered – ‘being’

If it were not for the inherent difficulty in framing a concept around something which it is not, then this theme would be labelled ‘not just medical’. This nihilistic framing of compassionate care provides a premise from which the interns extended their notion of care beyond immediate medical issues. Being patient-centred plays out in the intern data in a number of ways, for example:

*addressing the patient’s cares and concerns, taking a bit of a patient focussed approach; rather than just a medical approach, treating the person as an individual and yeah, trying to address some of their needs – emotionally.*

*(Intern Nathan)*

Being patient-centred in this context is perceived to be about responding to the individual cares and concerns of the patient, which appears, within the intern data to be the antithesis of the medical approach. This is an important finding as it influences the way in which care is delivered. This dynamic is discussed in the thematic analysis in the context of the hierarchy of care and the triaging of compassionate care based on whether a patient is perceived as deserving or undeserving of compassionate care.

Being patient-centred was commonly treated synonymously with considering the patient’s emotional issues, while encompassing their broader psychosocial issues. The interns’ quotes place emphasis on relating to the individual patient, and their needs; their emotional needs; their feelings, as illustrated in this quote:

*Expressing compassion makes the patient aware that you care about their feelings.*



This quote suggests it is not only important to express concern for the patient's emotional needs but it was important that the patient was aware of your effort to do this.

For Phoebe her hesitation in defining compassion is captured in her quote, which she frames within the context of addressing social issues through a more holistic approach:

*Um, it's difficult really. I suppose compassionate care um... all of the issues um, pertaining to their social situation... I think it is just a holistic approach to the patient.*

Trevor's initial response, in his first interview, when he was still relatively new to his community of practice highlights what he perceived to be the difference between empathy and compassion as described below:

*'empathy basically is the ability to see where someone else is coming from. Compassion is the way that you act. So, I guess, empathy is an understanding whereas compassion is an action.'*

How this unfolds in practice is yet to be determined for him, however his response is textbook perfect.

This distinction between empathy and compassion, highlighted by Trevor, is a significant point of difference between the two constructs emphasised in the literature. According to Bierhoff (2005), empathy is about perspective taking, whereas in defining compassion, he emphasises the motivations which drive pro-social behaviour, recognising the desire to act on the feeling, as the differentiating element between the two attributes. This pro-social behaviour is dependent on a relational interaction, and according to Haidt (2003), who frames compassion as a moral emotion, it is an emotion 'that goes beyond the direct interests of the self' (Haidt et al., 2003, p. 854) an emotion which promotes a 'pro-social action tendency' (Haidt et al., 2003, p. 867) a desire to engage in 'goal-related activities' (Haidt et al., 2003, p. 867) which in the context of compassionate care is an action taken to relieve the emotional suffering of another, to provide emotional comfort.

This notion of how you act develops as a prominent theme within the intern data as the year progresses. Their nuanced actions are operationalised in a number of ways in how they perform specific acts, which capture qualities of being as illustrated in their journal entries below:

For Phoebe, time is a major factor, she consciously 'puts down her folder', sets 'no time limits' stating it is about 'not just making time but that you are there for them'. She stresses 'Make it very clear, (you are) there for as long as needed'. Finding time, a precious resource, is a constant challenge identified within the interns' texts as a major inhibiting factor in expressing compassionate care, especially in their initial transition to practice when they are coping with many unfamiliar competing demands. Time is discussed more fully as an overarching theme in the thematic analysis below:

For Grace it is less of a conscious act:

*Perhaps I won't deal as well with somebody as I would like and I walk off and I'll think, I don't think that was the most appropriate way to deal with that patient, I should go back there and have a discussion with them, I think that would be better for their care um but I don't actively talking to somebody think I have to compassionately deal with this patient.*

As the year progresses, Pheobe looking for guidance and reluctant to move on in the context of her reflective journal, seeks out a definition for compassion from the internet, to which she tethers her response:

*Compassion:  
'a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering'.*

*(Dictionary.com, ) referred to by Phoebe*

A number of the compassionate acts are referred to as 'the little things'.

For Phoebe, in comparing a term in emergency to a surgical term she writes:

*There's heaps of anti-emetics [for vomiting] and analgesics to offer patients and besides that a bottle of water or an extra warm blanket never goes astray.*

*This term has probably taught me a lot about doing the things that make people feel cared for even if it's not the things that make you feel that you are caring for them. To me, caring for someone is giving them a diagnosis, a prognosis or a solution. For them it seems that it's more about the little things. Whether that's because patients associate caring about the small things with caring about the big things or because patients in pain care more about their sore foot than their heart failure that is causing it I don't know. Either way, I'll be offering more bottles of water from now on.*

When first in her role as a doctor Phoebe was highly motivated to be a compassionate doctor but influenced by a host of conflicting issues (discussed in her themed story), she felt at times she acted conscientiously rather than compassionately. Again, the notion of medical care being separate from compassionate care is iterated in her reflection when significantly she emphasises how to her care is 'a diagnosis, a prognosis or solution'. Pheobe's narrative highlights the inherent contradiction in the delivery of care, the patient's focus on the 'little things' and the novice doctor's focus on the 'medical' things. This changed for her over the course of the year, as she developed increased confidence in her role, in reflecting on her comment above about 'the little things' she wrote:

*An expression of compassion I have only really managed in the last rotation or so, when I finally developed enough confidence in my ability to do the job, that I can just make time to do the things that I want to do.*

Grace also emphasises how she has done very 'little', as she trivialises her listening role, as follows:

*I have had a couple of emails with positive feedback from patients and it absolutely makes my day! In these two instances I had done very little as there had been very little wrong with them. I didn't find a strange sign and order a cool test or diagnose a weird or wonderful syndrome; I listened. Plain and simple. I'm in this profession because it's interesting*

*and rewarding. The patient is here because they have a problem, however trivial, and they want someone to listen to them and take them seriously.*

For Mary her definition of compassion is heavily influenced by her rotation through mental health. Woven throughout her narrative 'the little things' again are evident; listening, providing opportunities for other issues to be raised, opportunities for talk, as follows:

*I guess compassionate care is... listening to the patient when they're telling you why they came in. Looking for more... If something is off, then looking for more than just that surface explanation and accepting it. And this is just from the Mental Health side of view, but trying to do a more inclusive kind of stuff rather than just say, 'Oh, yeah. This patient came with a fracture. We fixed it. We can send him home.' I mean, just saying, 'Okay. Are there any other...? Do you have any other issues? Do you want to talk about it? It might be trying too hard but I think it's always nice for just that little bit extra than just what's there.*

Mary's reflection emphasises the significance of context to the expression of compassion. Influential factors include the function of the unit, the patient mix and the subsequent way in which care is provided. For a patient with a mental health issue, a fracture is not just a fracture, but an opportunity to also ascertain whether there are less obvious issues requiring attention. Mary emphasises listening which, though considered a 'little thing' by the interns, as an action appears throughout their texts and appears to act as a gateway to the provision of compassionate care: an opportunity to talk, to 'hear,' to understand the concerns of the patient. Listening requires time, creating an enormous challenge for the interns who feel pressured by the constraints of competing demands, the confines of limited experience and the vagueness of decisions made in haste and underpinned by uncertainty.

Paul reframes the emotional aspect of compassionate care as his being emotionally vulnerable and open. His reflection echoes similar threads to his participating peers, with an emphasis on providing comfort, being accessible emotionally, creating a safe space for the patient or their family to express their emotional needs, as quoted:

*Um... I think it's just... for me, compassion is... for me, opening myself up emotionally? Yeah? To them. Showing them that I can be vulnerable to their needs, either the patient's or the family's. So that, making sure that they are comfortable, able to any question they want, request any need they want, cry if they want and that I'm a safe person to do that around. I won't judge them, I'll offer support, I'll offer advice, get them what they need.*

In our final interview, Trevor reflects:

*I was thinking that... It's just being nice to people. You know? Just break it down to that. So, you know, very simplistic. I think that that covers most of it.*

He has moved on from his earlier definition where he differentiates between empathy and compassion. His response is now embedded in daily practice.

### **6.2.1.3 Concluding Comments**

The interns' definitions evolved over the year; their experiences influenced their sense making and the way in which they constructed knowledge based on new understandings gained from being embedded in the culture of medical practice. As the year unfolds, the interns' increased confidence in their competence frees them up to focus on 'the little things' a theme which this study returns to several times as it is a central tenet of the study's findings. Their shared understandings highlight the complexity of compassion as a construct emphasising the need for actions to be understood in context as a way of 'being' as well as 'doing'. Most significantly the 'little things', these 'qualities of being', which mattered to so many of their patients, were often perceived as 'doing nothing' by the interns, emphasising the fundamental disconnect between the biomedical view of providing care and the social and emotional needs of patients needing care. These issues are explored in more detail in their narratives and in the following thematic analysis which further reveals the essence of their transformative journeys.

## 6.3 THEMATIC ANALYSIS

As a qualitative researcher undertaking this thematic analysis, reducing the interns' narrative accounts into discrete themes to illustrate shared constructs was demanding. I gathered between 20,000 and 35,000 words of text from each of the intern's reflective journals and interviews. Finding a way to capture and do justice to the range and intensity of the formative and transformative events, was challenging, especially considering the intersection of key concepts and the temporal nature of their journeys. The task was further complicated by the relational and sociocultural nature of their role being both multidimensional and layered, neither linear nor binary, thereby escaping easy thematic categorisation. However, through iterative readings of the narratives, patterns emerged which were common to each of their stories, capturing the themes across their individual narratives and providing a more, in-depth, understanding of their learning.

In undertaking this study I have used broad parameters within Wenger's Community of Practice (2007) focusing on the sociocultural context of learning. Complementing this interpretation, Bandura's (1977) model of self-efficacy is also used to shed light on how the individual creates meaning for themselves in how well they are undertaking their role, which in turn shapes their practice.

Building on the eight narratives this thematic analysis and synthesis looks at the key findings, shifting the researcher and reader's gaze from the individual narratives to the collective analysis. In highlighting consistent patterns and similarities, this interpretation provides a nuanced exploration of the enabling and inhibiting factors which influence interns in providing compassionate care, as both a commodity within the confines of service delivery and as a pro-social moral emotion (Haidt et al., 2003). These broader concepts are discussed in the context of the existing literature and research.

### 6.3.1 EMOTIONAL VULNERABILITY

In interpreting the interns' narratives I sought answers as to how the interns learned to express compassion. What their stories revealed is how they struggle to maintain their compassionate aspirations when confronted with the

complexity and competing demands of daily practice. Their emotional distress was not difficult to discern, forming a dominant discourse consistently woven throughout their narratives. However, more difficult to determine and disentangle from the texts was how, and why, their emotional distress came to frame the way in which they provided compassionate care. Emotional vulnerability emerged as the over-riding theme to frame this learning trajectory.

For the interns in this study, anonymously untethered from the judgement of their peers and supervisors, they write unashamedly, unabashedly of their feelings; their unconscious journaling and at times, imperfect prose, capture their raw emotion and reveal their emotional vulnerability, both visceral and embodied.

The unscrambling of this over-riding theme of emotional vulnerability, set to the backdrop of their developing identity as a doctor, is captured and illustrated in a number of sub-themes which manifest in their feelings of being overwhelmed, pursuing perfection, fearing failure, and seeking certainty, all contributing to a see-sawing of their self-efficacy and acting as enablers or inhibitors in their expression of compassion.

### 6.3.1.1 III Prepared and Overwhelmed

*I've started my internship in Emergency. The first two weeks were so overwhelming, it was like being a medical student with too much responsibility... I wanted to cry at some point during every one of these shifts and was adamant (sic) it was unfair to throw us in the deep end like this.*

*(Intern Grace)*

Despite being exposed to clinical practice during rotations as a medical student, a key theme, highly influential in shaping the learning trajectory and practice of each of the participating interns, was the way in which they struggled with the entry to their conditional year of internship. While being ill-prepared is a familiar trope in the existing literature (Ackerman et al., 2009) (Brady, Corbie-Smith and Branch, 2002) (Kilminster et al., 2011), central to

this interpretation of their transition in the context of compassionate care is their emotional response to their new role and consequent vulnerability.

This response is evident throughout their narratives which describe the emotional turmoil of their difficult and daunting transition:

*I had a little debrief with my boss and everyone was really supportive – which was awesome because I felt like vomiting, then crying.*

*(Intern Paul)*

The enormity of the responsibility required of the interns initially took them by surprise; they were scared, shocked and overwhelmed by their experiences.

*This case occurred during my first few weeks as an intern, and I will never forget it. I felt out of my depth.... I actually felt scared*

*(Intern Bill)*

*... an overcrowded ED is completely overwhelming. Not to mention I'm trying to learn different systems, forms and procedures...*

*(Intern Paul)*

The interns talked and wrote about what they 'felt' and their 'feelings', articulating both a sense of foreboding for their role as a doctor and the enormity of the responsibility attached to it.

*when I started this rotation I had a lot of foreboding into what it would actually be like and um, whether I could handle or how I would survive as an entity in a field of strong personalities*

*(Intern Trevor)*

The journal entries paint a vivid picture of the interns feeling out of their depth: being exposed emotionally and struggling for survival. Not physical, but psychological survival.

The interns' emotional turmoil is set against the backdrop of their emergent identity as a doctor transitioning to their Community of Clinical Practice (Egan and Jaye, 2009) (Wenger, 2007).

*I think the shock factor really hit when a nurse said to me, 'what do you want to do, you're the doctor!'*



(Intern Paul)

The expectations the interns ascribed to their new role were highly inconsistent with their perceived level of experience and competence. They emerged from their studies graduating with a notional sense of what it is to be a doctor, the practice of which is suspended for three months (in Australia doctors complete their studies in November and commence working mid-January of the following year) thereby heightening the stress of the difficulty in transition as described below:

*...you get a lot more respect ....but then, you also get a lot of higher expectations and they expect you to go away on holidays for 3 months in between finishing Uni and working and all of a sudden have doctor knowledge instead of medical student knowledge. And there was plenty of drinking in between...*

(Intern Grace)

According to social learning theory, this transition should be considered as an ideal progressive shift from the periphery of practice, working towards fuller roles and responsibilities (Wenger, 2007). Instead, it was likened to 'being thrown in the deep-end' (Intern Grace). The interns' learning within practice was relational, engaging with both patients and colleagues alike. Their learning was manifest in a range of ways. As a social construct, the doctors' identity emerged, being shaped and redrawn as they evolved in their role. Their individual and collective narratives illustrated the influence of time and place on their learning trajectories embedded in their everyday clinical practice.

For the novice doctors, their transition was complicated by the tensions of system and service delivery demands, competing with both supervised and unsupervised learning opportunities embedded in practice. These competing priorities reinforced their sense of feeling overwhelmed. They grappled with the system, forms, procedures and system demands, their struggle became all consuming, resulting in the reification of care as their focus incrementally narrowed. The interns attention shifted from patient care to patient management as they concentrated on paperwork and engagement with clinical colleagues in the context of system management.

*Interferences with ability to have compassion include stress and being overworked and being new to the job. I spent a lot of time running around trying to figure out the admin side of medicine, writing forms, making referrals. The job became an exercise in admin and I felt like I was floundering in the forms and notes I had to complete. In this setting I lost sight of the actual patient and basically forgot compassion in order to get the job completed as fast as I could. Everything I was doing was for the patient but may have missed satisfying all the patient needs*

*(Intern Nathan)*

The language the interns use is noteworthy; their words reflect not only a sense of responsibility and ownership, but also isolation. While there is recognition that the administrative aspect of their role contributes to patient management, it also distracts from other significant aspects of care which demand patient engagement.

*Didn't think too much about compassion this week. The sudden realisation of being responsible for patients was a big moment. The patients have become my own and no-one else is going to care for them if I don't. This is a big change from student days, where I was an observer in other peoples care. Now that the patients are mine I have realised I must care for all their needs and this involves the emotional. I realised this week that it was my job to be compassionate toward the patients and I alone had to do this.*

*(Intern Nathan)*

The shift from student observer to fuller participant with ensuing responsibility resonated loudly for the interns, creating a tension between what they know, and what they need to do, to be perceived to be fulfilling the role. Compassion towards the patient is perceived as a significant attribute for their role, something for which they are responsible, but also something for which, while being focussed on their developing role and identity, they have had little time to consider. So, while they embrace the notion of compassionate care, they also acknowledge how distracted they are from that notion. Their emotional response to the overwhelming responsibility attached to their newly acquired doctor identity, in tandem with the demands of service delivery, overshadows their caring role. Their narrative highlights the inconsistency in the

expectations they held as a student entering practice and commencing their anticipated role. They appeared to have little comprehension of the relevance or necessity of the competing and extensive responsibilities they would have to undertake.

For the interns in this study, their overwhelming emotional response, buttressed with feeling ill-prepared for the competing and complex demands of service and system delivery, acted as a catalyst for a pattern of behaviour across the cohort, influencing the way in which they performed their role in the context of providing compassionate care.

### 6.3.1.2 Pursuing Perfection and Fearing Failure

*How can you transcend to be perfect and compassionate and empathetic clinician when you don't know where you stand?*

(Intern Trevor)

A significant sub-theme interpreted through the interns' narrative is the idealised notion of perfection. Perfection in this context is a complex construct underpinned by their uncertainty, risk aversion and control, all ostensibly linked to the fear of failure. Failure, in this context, is the failure to fulfil both the doctor identity as well as the role.

The doctors enter their practice with the idealised notion of perfection. They aspire to be the perfect doctor, a doctor with perfect knowledge. They also construct the notion of the perfect patient. The sub-themes of uncertainty and the idealised notion of the perfect patient are discussed in more detail in later chapters. This section focuses on the idealised notion of the perfect doctor.

In entering practice, the interns expectations and aspirations are idealistic. They initially perceive the 'perfect doctor' as a doctor who is caring and competent. Captured in their quotes is a desire, a desire to be wonderful, perfect, with sole responsibility, knowing everything. However this notion of perfection is all inextricably bound by the fear of failure.

This fear of failure is aligned to their identity as a doctor who aspires towards perfection; perfection not as generally perceived as striving to do our best but, defined as the fear of failure as judged by others (Brown, 2010). Underpinning

this construct (of fear) is the belief that, 'if we live perfect, look perfect, and act perfect, we can minimise or avoid the pain of blame, judgement and shame (Brown, 2010, p. 56). For the participating interns, this idealised notion of perfection frames what they aspire to, what they fear (failure) and builds on the perceptions of others – in attempting to please and perform – being highly dependent on feedback whether positive praise or negative criticism.

Fear of failure is an emotion which appears to be a constant in the lives of the interns as they negotiate their new roles. It underpins many of their more overt expressions of emotion: their anger, frustration, impatience, and uncertainty. They fear doing the 'wrong thing', litigation, killing someone.

*And from an outsider, it was a very fearful thing to move within it*

*(Intern Trevor)*

*I have been in the position of notifying families of the impending death of a patient several times now on ortho. Initially I was scared of this interaction, however now I see it as an opportunity to really make a difference. (Intern Nathan)*

Fear of litigation specifically features as a deterrent in engaging with patients and families.

*Although I can understand the shock that occurs with hearing your loved one has incurable cancer, it was difficult for me to feel compassion for them since they fought against everything we offered them. After the son threatened legal action, I actually felt scared, and wanted to avoid his room altogether. Obviously I didn't do this, but I felt like it.*

*(Intern Bill)*

The interns fear manifests in a range of ways from the personal (assessments) to the external (killing someone) as illustrated in the quote below:

*The biggest fear I have is failing this rotation because of stupid mistakes, or because I was completely unaware that I needed to know something. And of course the fear of me killing someone...*

*(Intern Paul)*

The idealised notion of the good doctor is a dominant discourse throughout medical literature (Monrouxe, 2009). The good doctor is a social construct which influences the selection of medical students, curriculum design, and the delivery of medical education and training across the continuum, from undergraduate students to vocational trainees and their senior supervisors (Whitehead, 2011). Determining the attributes of a good doctor differs markedly, depending on, to whom the question is directed. For example, 'patients value communication and care, colleagues seek competence and camaraderie, medical students prize cheerfulness; by contrast, admission panels focus on chemistry grades' (The Lancet, 2010, p. 658).

'Factors at play for the notional good doctor include knowledge paradigms (what does a good doctor need to know), identity paradigms (who can become a good doctor) and notions about the relationship of doctors to society (the social responsibility or social accountability of the good doctor). As with any social phenomenon, the constructs of the good doctor are historically derived and socially negotiated' (Whitehead, 2011, p. ii).

In interpreting the interns' aspirations, this notion of the good doctor is extended and the expectations intensified, to an idealised notion of perfection. The idealised notion of perfection is illustrated in the intern data at a number of levels, including: the doctor's developing identity in how they see themselves (flawed); how they want to see themselves (perfect); and how they judge their patient and colleagues relationships - all of which directly influence their self-efficacy as discussed below.

As the interns become increasingly overwhelmed, their thinking narrows. Restrained by thoughts and feelings of incompetence, diminishing confidence and an inability to acquire certainty in their actions, a disconnect develops between how they would like to be compassionate, and how they compromise on what they do – being clinically competent.

The interns' reflections also demonstrate the primacy of participation in their new learning environment. They differentiate themselves from their student role, where they were observers attached to a team. This contrasts sharply to the expectations of their new role as a doctor, where learning and service delivery of patient care are based on direct participation. Acceptance within

the community of practice is contingent on performing the prescribed role successfully. Undertaking tasks where competence and scope of practice are continually under assessment places their developing identity as a doctor under threat; if one fails to fulfil the role, there is a risk of remaining on the periphery of practice, or more significantly failing their rotation.

### 6.3.1.3 Searching for Certainty

A closely inter-related and embedded theme to emerge from within the data is the search for certainty. Uncertainty and risk aversion were common tropes within the interns' narrative, often framing or defining their emotional vulnerability. Their reflections are replete with the fear of doing the 'wrong' thing, not getting it 'right', and general feelings of inadequacy. This is unsurprising; the articulated feelings of low confidence and competence are an expected norm for any novice embarking upon a new demanding role with immediacy and accuracy required for clinical decision making. However, buried within the interns' narrative and framing their feelings of inadequacy, is an insecurity which reaches beyond the initial hesitancy expected of a novice.

*The old lady who was not obviously ill and I could find no firm diagnosis.*

*(Intern Nathan)*

*One of the largest frustrations I'm having is people not knowing their own health status.*

*(Intern Paul)*

There is an underlying and over-riding desire for certainty, equated with being able to know and do everything expected of a doctor; an expectation they have of themselves and one that many patients have for them, regardless of their level of experience. The title 'doctor' is all encompassing:

*I started introducing myself as a junior doctor and things like that. At the start of the year, it was a massive thing. You'd walk into a room and there'd be three of you and they don't know who's the consultant and the registrar and you. (laughs) They have no idea ... And they don't know that it's your first week on the team... They just, 'You're the doctor. You know everything.*

(Intern Nathan)

While certainty is about 'knowing' and thereby a cognitive state, it is its absence which triggers an affective response in the interns, influencing how they feel and act. The interns' journals reflect their self-doubt. The phrase 'I don't know' is a recurrent theme echoed through their narratives. This search for certainty has a direct impact on their levels of confidence and self-perceived competence compounding their emotional vulnerability.

*I no longer feel like crying but I'll often go home and wonder if I've done the right thing and persevere over little mistakes I've made.*

(Intern Grace)

This expectation and aspiration is aligned with doing the right, as opposed to the wrong thing, for and by, the patient. In their quotes below, uncertainty is perceived as a foible of the inexperienced novice rather than the reality of medical practice:

*Honestly, I do feel that I am a compassionate doctor. I really do feel for my patients. However, I am easily frustrated with them. I suspect I become frustrated and express less compassion when I don't know how to deal with them. I avoid emotional issues because I don't think I have the skills to handle them. I am very aware that being a good doctor means being able to deal with these problems but at the moment I feel so incompetent in so many areas that it seems the least of my worries.*

(Intern Phoebe)

This unexpected uncertainty creates an emotionally and psychologically destructive cycle, which feeds on, and is fed by, their increasingly diminished self-confidence and perceived 'incompetence'. Working in an environment which is complex, and at times chaotic, escalates the interns' feelings of inadequacy. The perceptions of the stressful environment, where the stakes are high, and potential consequences dire, result in the idealised notion of the 'perfect doctor' morphing into a reductionist reframing of their role which, in turn, inhibits their ability to be compassionate.

*The practice of compassion is made much easier by feeling in control at work and by having sufficient knowledge to feel comfortable discussing care with patients. At times when I've felt overwhelmed at work, my expression of compassion has suffered. Similarly, when bosses have*

*clearly communicated their understanding of a patient's situation and rationale for the treatment decisions made, my ability to communicate confidently with patients in turn has improved.*

*(Intern Phoebe)*

Importantly the enormous influence supervisors have when they communicate clearly is also evident, resulting in the novice feeling more confident and therefore more willing to engage confidently with the patient. As novice doctors, the interns seek certainty as they undertake a role which is both highly visible and outwardly judged by the patients, their peers, and their senior colleagues as assessors. Exacerbating this need for certainty is the way in which their role is perceived socioculturally. The title 'doctor' holds very specific community expectations and demands a certain standard of personal and professional behaviour. This expectation is reinforced through mass media including television, film, and literature - capturing behaviours of both heroic doctors contrasted with those who garner media attention through unethical or unprofessional behaviour.

Uncertainty for the intern, in not being able to make a diagnosis or in not knowing what to do, or where you 'stand', leads to feelings of inadequacy. Uncertainty engenders a whole host of emotions which diminish the interns' confidence and self-perceived competence in their role. Uncertainty is a feeling for which they appear both ill-equipped emotionally and unprepared cognitively. By not having the 'know how' and understanding required to accept uncertainty as an unavoidable feature of medicine, the intern is unable to develop supportive skills and strategies to assist them in coping and to perform optimally.

#### **6.3.1.4 See-Sawing Self-efficacy**

In interpreting the interns' narrative through the lens of compassionate care, and using the former themes of aspiring to perfection and avoiding uncertainty as significant influences in shaping the novice doctors' identity, the doctors' self-efficacy (Bandura, 1994) emerges as a significant theme. Within the interns' narrative it is evident that their self-efficacy, how they perceive they are performing in their prescribed role, is shaped both implicitly and explicitly.



The former tied to their emotional vulnerability influenced by how they individually interpret, and make meaning of their experiences, the latter related to the interpersonal context of their learning and practice and primarily shaped by feedback from their peers and patients. These factors, in tandem with the sociocultural expectations of the role and linked to both their personal and professional identity, conspire to diminish or enhance the interns self-efficacy and their resultant confidence in their ability to express compassion.

Questioning their competence and feeling low in confidence, the interns become self-critical. Conversely, positive feedback results in them feeling good about how they undertake their role, boosting their confidence and perceived competence. In both scenarios, the feedback they receive, both unfavourable or favourable, from their supervisors, colleagues, and patients, is a major influence on their emotional wellbeing and relates directly to how they express compassion. Significantly, the interns are at the mercy of the approval of others, striving to conform to acceptable standards, both personally and professionally. This feedback loop triggers a roller-coaster effect on their self-efficacy, the highs and lows being derived by input from others.

Judgements about self-efficacy, which are derived from four key sources (Bandura, 1994) (Kaufman and Mann, 2010) were highly influential in determining how the interns expressed compassion.

Throughout the interns' narrative they constantly reflect on their own performance. Performance attainment, defined as one's perception of one's own performance as a new learner and measured by succeeding or failing in undertaking a specific task, is a core component (Bandura, 1994) Most significantly, 'physiological state', perceived through the lens of physical state is an indicator of capability. A heightened state of arousal associated with a task is often perceived as sign of vulnerability – suggestive of failure – with less tension and arousal associated with success than with failure (Bandura, 1994) (Kaufman and Mann, 2010). The emotional vulnerability of the interns referenced in the introduction to this thematic analysis highlights how their emotional state influences their self belief in their ability to undertake their role.

Observation of their peers as doctor role models is also a significant factor in learning through vicarious experience (Bandura, 1994). The interns continually

observed their peers to gain insights in how they should, or shouldn't behave, when engaging with their patients.

*I also learned a bit from watching how senior colleagues deal with patients – this has probably taught me more how NOT to deal with patients than how to deal with them though.*

*Intern Bill*

As an influential trope, verbal persuasion, (Bandura, 1994) as a central feature of self-efficacy is evident throughout their narrative and manifests as the feedback they receive from their peers and patients.

Initially, the interns feel under attack and are directly influenced by criticism from others:

*And feeling attacked at every angle. You get into the office at 7:30 and you don't start officially till 8 and there are people in, they just sort of harassing you with who's going today, who's leaving and why aren't you doing this, why aren't you doing that, so it's just... It's hard because just simple things like a referral or ordering certain investigations require talking to senior colleagues and sometimes that can be a bit daunting, but then when you've got everybody from the door clerk, who is a horrible woman... To the nursing team leaders to your senior colleagues, everybody is just... you gear up for a fight every day. It's exhausting.*

*(Intern Grace)*

*Certain stressors tend to affect my mindset such as workload and support from the senior doctors. When the senior doctors are critical then it affects my confidence in being able to adequately care for patients, and this in turn makes me feel like a fraud in front of my patients and as if I do not have the right to be caring for them and showing compassion. The reverse of this is that when I feel like I am doing well at my job I find it very easy to have compassion.*

*(Intern Nathan)*

Positive feedback from colleagues and peers, correspondence and/or compliments from patients and their families and patient-nominated awards all directly influence the interns' self-efficacy.

*I have had a couple of emails with positive feedback from patients and it absolutely makes my day!*

*(Intern Grace)*

*When family members of patients come in feeling anxious and sceptical, but appear noticeably much more contented and relaxed after chatting with me (and/or the registrar). Some have complimented me directly after our discussions and these moments make it all seem worthwhile, amidst all the mayhem of the usual intern's day.*

*(Intern Neel)*

*It's kind of lame and embarrassing. But it's... I mean, it was a patient-nominated award and 4 or 5 patients wrote something about me throughout the year... it's really cheesy but for me, it validated that I'm actually doing something right. It was read out to me. And it just was like, 'he was caring', 'he really understood me', 'he connected with me', 'he believed me when no one else would', things like that.*

*(Intern Paul)*

The interns' self-efficacy has a direct influence on how they express compassion. When feeling good about their ability to do the role, they feel less encumbered and more able to embrace being caring, kind and compassionate towards others.

*expression of compassion I have only really managed in the last rotation or so, when I finally developed enough confidence in my ability to do the job, that I can just make time to do the things that I want to do.*

*(Intern Phoebe)*

Feeling more consciously competent also affords the interns more time to spend with the patients. Conversely, a crisis of confidence results in a narrowing of focus and reduced engagement and as a consequence a reductionist expression of patient care, reified as patient management.

The relationship between diminished self-efficacy and the withholding of compassion is an important finding. It again signifies the relational nature of the intern's role but is also tied to the compassion becoming conditional, an outcome discussed in more detail below. It is human nature to align ourselves with those that make us feel good about ourselves, those we like, those who reinforce a positive self-image.

Throughout their journal and interviews, the interns refer to their desire for support from their supervisors, emphasising the relational nature of their learning in practice. The nature of practice based supervision is a significant but under-researched area in medical education. Research undertaken by Kilminster et al (2011) found that supervision is often ad-hoc, dependent on the hours and shift the doctor is working (night duty, on-call), the level of availability and commitment of the individual staff rostered on at the same time, all of which can result in the junior doctor having to work outside their scope of practice.

*If you're not being made to feel safe in your practice by the people supervising you, you're not being able to make those... you know, you're not having your basic needs met, you know, the nutrition of the practice, in the sense, the shelter of your practice, you know, the basic things you need to support, then how can you achieve the higher levels? How can you transcend to be perfect and compassionate and empathetic clinician when you don't know where you stand, you don't know when you're going to get your head bit off next.*

*(Intern Trevor)*

This relational dependence on colleagues for support is crucial at this time. However, as articulated in the quote, the relentless demands of the hospital environment and a perceived culture of blame add to a sense of being overwhelmed and isolated. For the interns, their perceived reality is that the only feedback you receive is when something goes wrong or isn't done correctly. Intern Trevor writes of the 'nutrition of practice', a metaphor for the sustenance for growth, how the need for support then allows you to transcend to be the 'perfect and compassionate and empathetic clinician'. It is as though the interns are under regular attack from their supervisors, colleagues,

patients and their own self-criticism, all conspiring to undo their notion of being the perfect doctor.

*And this might be a bit of a shock to you, but the patients are just little buoys going past you in a very fast river...It just is, they change so often. So the patterns that you have and the way that you deal with them and your default intention towards them become more and more formed by other people around you, not by them.*

*(Intern Trevor)*

*I think I've honed my compassion mostly from trial and error by my own dealings with patients every day. I also learned a bit from watching how senior colleagues deal with patients – this has probably taught me more how NOT to deal with patients than how to deal with them though.*

The interns' narrative provides insights into how, by wanting to protect themselves both personally and professionally, they develop a range of coping strategies which are the focus of the ensuing sub-themes.

## 6.3.2 COPING MECHANISMS

The interns articulated reflections provide insight into the emotional response of the novice and the difficult situations they confront. The narratives illustrate how they develop a range of coping mechanisms which result in a change in their behaviour and diminish both their empathy and compassion. They articulate their frustrations, their lack of patience, their anger and fears and describe how their emotions influence the way in which they respond to the medical, social and emotional needs of the patient and their family.

### 6.3.2.1 Drawing Boundaries

The interns' struggle with their envisaged role within the system is visceral. Their journal entries are replete with their emotional responses embodied in wanting to cry, and/or vomit, feeling sad, putting their emotions on hold (e.g. going home to cry), while simultaneously drawing boundaries around the emotional needs of their patients by not engaging too closely.

*I hate it and I'm counting down the days. This is also mainly about working with families but it is within a geriatric population. They all*

*remind me of my own grandparents and it pulls on my heart strings. I do a lot of 'Not for resuscitation' orders, death certificates and family meetings. I almost find it bizarre how removed I am from it, I don't know if it is a lack of interest in the area or just a protective mechanism.*

*(Intern Grace)*

*I learned that getting to be friendly with patients makes it almost sad when they leave the ward. In future, I'll always be nice to patients, but keep most of the conversation professional, for my own sake.*

*(Intern Bill)*

*I also worked in kids' rehab which included spinal cord and acquired brain injuries which was devastating. I had a great allied health team to work with and we often had a debrief on how horrible life can be over a piece of cake. I had nightmares about those kids and would come home feeling so drained. I found compassion easy but exhausting and much harder to remove myself from. One child was a sole survivor in a motor vehicle accident. One was a brain injury because the mother was so tired she forgot the baby was on her bed not in the cot. I think they just appreciated having people to listen so in paediatrics a lot of time was invested in the parents as the kids were incredibly resilient (or too young to understand). I didn't just work in the most depressing unit- I did a lot of interesting work too and loved working with likeminded people*

*(Intern Grace)*

There is an expectation that doctors respond to patients' emotional needs in tandem with their physical needs, yet, we do not support or teach our medical students or doctors how to cope with their own emotional response. McNaughton (2013, p. 71), in her analysis of emotion, suggests that 'emotion within medical education rests between the idealised and the invisible'. While emotion is difficult to define, McNaughton captures the construct across three key discourses, framing emotion as a physiology, as a skill, and as a sociocultural mediator. She posits that, despite more than two decades of research which recognises emotion as socially constructed, we continue to

see emotion as individualised. Furthermore, she suggests that within medical practice, emotion and reason are falsely dichotomised and emotion is perceived as corrupting reason. Despite emotion being accepted as a core professional value within medical education, McNaughton suggests this is not reflected in the socialisation of doctors into their profession where emotion is absent or reframed as detached concern (McNaughton, 2013). This, she purports is reflected in the commonly asked question by the lay person 'whether it is preferable to be treated by a brilliant surgeon who has awful bedside manners or a less-than-brilliant surgeon who will hold the patient's hand' (McNaughton, 2013, p. 72). According to McNaughton, this reductive thinking, has implications for professional identity formation. Identity within a community of practice is a catalyst for framing both thoughts and feelings from 'who I am', to 'who we are'. This is significant for this study as the term, doctor, and the role, a doctor holds, are meaningless when removed from their sociocultural context. For the novice doctors in this study, identity is a crucial construct, acting as a cornerstone between individual and collective agency. The very nature of the title 'doctor' evokes a manifold range of expectations and aspirations, framing acceptance and belonging as emphasised by Wenger (2007, p. 207), in the following quote:

'it is the power to belong, to be a certain person, to claim a place with the legitimacy of membership; and on the other hand, it is the vulnerability of belonging to, identifying with, and being part of some communities that contribute to defining who we are and thus have a hold on us'.

For the interns in this study the doctor identity creates a tension in their expression of emotion, it can act as both an enabler or inhibitor dependent on how, and to whom, their emotion is expressed. According to McNaughton (2013), emotion is disparaged as unscientific and gendered rendering the doctor who traverses these boundaries vulnerable to criticism.

Redrawing boundaries manifests in a number of ways. As a social construct, their identity as a doctor is redrawn as they evolve in their role over time and place embedded in clinical experience. They learn behaviours to create boundaries which then prevent them from becoming too close to the patient. These arbitrary boundaries in distancing and separation create a 'them and us'

mentality which allows the novice doctor to function safely within the parameters of their role.

### 6.3.2.2 Belonging and ‘Othering’

An emergent theme, central to being accepted into the community of clinical practice and the emergent doctor’s identity, is the notion of belonging – aimed at becoming, or being, an insider - this can lead to a form of exclusion known as ‘othering’ (Shapiro, 2008).

‘Othering’ happens at a number of levels for the novice doctors within their community of clinical practice. The othering of the new doctor by the existing team, and the othering of the new doctor aligning with the his/her clinical colleagues to the exclusion of the patient. The eye-rolling of the nurses is a form of exclusion, another iteration of the ‘them and us’ mentality, a form of ‘othering’ of the new doctor as an outsider entering the team. The ‘eye roll’ also provides a non-verbal act of bonding – separating the staff from the patients – another iteration of the them and us mentality.

This act of ‘othering’ by the interns, allows one to see difference rather than sameness in one’s needs. Seeing our sameness, recognising ourselves in others, and knowing this could be me, are all reflections which enable us as humans to express compassion; it allows us to see suffering in the context of our common humanity. For the interns, the act of bonding with their team and treating patients as ‘them’, is a form of othering.

‘Othering is a process that identifies those that are thought to be different from oneself or the mainstream and can reinforce and reproduce positions of domination and subordination’ (Johnson et al., 2004, p. 253). In forming this social boundary, the them and us mentality is emphasised thereby diminishing the capacity for compassion.

*Negative comments always happen between staff with these kind of patients; from comments about drug seeking to implications of being less of a person than others.*

*(Intern Nathan)*



*I am much more comfortable operating with black humour, particularly as I did with... joking with colleagues. Yeah! But I feel strong enough here to do that. Have a joke privately in (at) the expense of a situation or person, but still have empathy and compassion towards them.*

*(Intern Trevor)*

Derived from the data, this construct of 'othering' echoes the observations of Shapiro (2008). Shapiro (2008, p. 3) explores the 'binarism of self-other' in the context of the delivery of healthcare, suggesting the construct acts as a 'strict demarcation of the sick from the well'. Extending the work of psychoanalytic theorists and social philosophers, Shapiro (2008) proposes that the human tendency to emphasise difference, as opposed to sameness, underlies a threat from that perceived difference. For the doctors to survive with their identity intact, othering provides a safe boundary which clearly defines 'you' as different from the sick and vulnerable. Shapiro (2008) suggests that this artificial dichotomy of the sick and well also results in scapegoating – where the unwell person is perceived as responsible for their own illness; a concept evident in the narrative provided by the interns in this study. Patients are blamed for their health problems because of situations they are perceived to have created for themselves, for example, being overweight, an unplanned pregnancy or not coping. This concept is discussed below in the context of the 'idealised notion of the perfect patient.' Shapiro (2008) advocates a reframing of this paradigm. Instead of distancing oneself from the sick patient as a coping mechanism, we need to draw on an 'ethics of imperfection', a term coined by Morris (1998, p. 162) which simultaneously recognises our common vulnerability and capability. Shapiro (2008) suggests a way forward, by taking the best of the existing biomedical paradigm and adding an acknowledgement of both doctor and patient frailty which occupies 'the edge between intimacy and detachment' . Shapiro (2008) outlines practical examples of ways in which this could be implemented which I extend in my recommendations.

### **6.3.2.3 Reification - Reductionist Reframing**

*The tension you have as a first year is that you want to help everyone. I think most people do. But you really can't do it in the way that you want to in the hospital system..there is no way to give everyone the detailed*

*personal attention that your instincts crave to give... So, ah there has to be a compromise, you know you can't give 100% time that you would like to.*

*(Intern Trevor)*

The notion of the perfect doctor is intrinsic to the way in which the interns perform their role since it frames what they value and consequently, how they spend their time. Their focus is initially on diagnosis, prognosis and treatment; they perceive those tasks to be a test or measure of their knowledge and its application, their clinical reasoning and their ability to undertake procedures. This reductionist reframing of their roles results in the reification of care. Smadjor defines reification as 'the tendency to regard other entities as mere things' (Smajdor, 2013). In this study, humanistic behaviours such as listening to a patient, become reified functions of patient and system management. The interns begin to believe, that to be a good doctor, they have to be a perfect clinician before they can embrace their common humanity and focus on the 'little things' which are so meaningful to many patients.

The artefacts of patient management begin to dominate the novice doctor's practice; forms, referrals and discharge summaries result in an overwhelming sense of responsibility.

This overwhelming responsibility and desire to cope, perform and survive, overshadows everything, especially in the context of their role being conditional and dependent on successful assessment. This struggle, in tandem with the pressures of service delivery in a complex system, results in the interns desire to both act, and be perceived as, competent. This behaviour leads to a redefining of their roles, which then undergo a reductionist reframing. In the hierarchy of care, clinical competence, defined as knowledge, skills and clinical reasoning transcend the social and emotional aspects of care, framing their learning trajectory with direct consequences for their expression of compassion.

#### 6.3.2.4 Triaging Compassionate Care

*Christianity as I see it states that compassion should be expressed towards patients, however obnoxious they can be. In theory, that is. In reality... I try hard.*

*(Intern Neel)*

In the previous section I have outlined the way in which the idealised notion of the good doctor has manifested within the interns' discourse; the interns escalate their aspirations in wanting to be the idealised notion of the 'perfect' doctor. What emerges in this longitudinal study as a dominant theme and parallel discourse is the idealised notion of the 'perfect' patient.

*'In a perfect world, all physicians are perfect, all patients are perfect and all doctor patient relationships are perfect. But, in the real world, this is not always the case' (Salz, 2012, p. 38)*

The way in which the notion of 'perfect' patient is socially constructed by the interns through their lived experience within the clinical context has been revealed through their texts in a number of ways. For the interns, this catches them off guard creating both discomfort and dissonance in their self-perception, threatening their identity as the 'perfect' doctor. This is, in part, due to the expectations and assumptions that underpin this notion of the 'perfect patient'.

The interns in my study commence their intern year with a generally positive view of themselves, aspiring to be the 'good' doctor. Phoebe writes, 'I want to be a wonderful caring doctor for my patients'. This positive view also extends to their patients with Paul in his first few days writing, 'The patients themselves have been wonderful. Everyone I've talked to has been friendly, and it's amazing how people confide in their doctor'.

However, in iterative readings of the interns' journals and reflections, a lesser known theme is woven throughout, and across, their texts. This thread, embedded within the interns' reflections, uncovers a narrative which, in the context of medical students and novice doctors self-reporting of an erosion of empathy, is relatively overlooked in the medical education literature. This dominant discourse reflects the lived experience of engaging with, and

managing the care of patients, whom the interns perceive to be undeserving of compassionate care. The interns' reflections and narrative unearth an ad hoc triaging of compassionate care, illustrated in (Section 6.3.2 Figure 4) and explored in more detail in the following discussion.

The interns participating in this longitudinal study shared positive stories about their patient relationships which are discussed throughout this thesis. However, it is their interactions with patients who do not meet their expectations which appears to take them by surprise and challenge their preconceived notions and aspirations about individual patients, patient populations, and themselves, as doctors. Their reflections show an inability to disengage or detach from this negativity, at times taking the patient's behaviour personally and then responding emotionally, thereby allowing their judgement to be clouded despite being able to consciously reflect on the interaction.

What emerges through their narrative is the expectation of the 'perfect' patient: the patient who is likeable, curable (or at least accepting), compliant, and grateful. The relational nature of the interns engagement with patients debunks this expectation. Contrasting with this idealised notion of the perfect patient is the patient whose behaviours and attributes are perceived by the interns to manifest in a range of negative behaviours and attributes, directly influencing how the interns provide care. This is reinforced by an informal hierarchy of care that influences what the interns prioritise as requiring their immediate attention, with medical needs over-riding emotional needs as highlighted in the following quote:

*it's how much time you've got and how much stress and pressure in a day and just sort of based on a hierarchy of what you need to achieve on that day. I guess, topping the hierarchy is the patient's medical needs and somewhere further down is their emotional needs...So I guess anything that's interfering with your... with your time or productivity in a day, like stress or workload or staff on the floor, you can get into that, I guess, without thinking. You know, it might not be a conscious thought thing but you just start cutting a few things..*

*(Intern Nathan)*

While these behaviour and attributes do not fall into a neat typology or easy categorisation, there are dominant sub-themes embedded in the stories they share. This theme builds on, and overlaps with, the interns' developing identity and the constructs of belonging and othering in the context of becoming an accepted member of their community of clinical practice. In unpacking the idealised notion of the 'perfect patient' I use six key sub-themes as follows:

#### 6.3.2.4.1 Anti-Social Behaviour

Interns describe numerous encounters with patients and their families which I have placed under the sub-theme, anti-social behaviour. Behaviours perceived as inappropriate range from unappreciative, demanding and rude to more violent threats and actions. Patient aggression is a common concern raised by the interns.

##### *Nathan writes*

*'When trying to help people they are sometimes rude or stand-offish this does not help my compassion. An occasion happened this week where a lady came in and she was initially unpleasant in our dealings, in the end she had a very poor diagnosis and was in need of much compassion; however her initial attitude toward me definitely affected how much I cared. I knew that it shouldn't and that I should be professional and treat all the same and I certainly tried, but it remains a fact that I could not feel the compassion toward her that I could toward other pleasant patients.'*

Nathan's reflection occurred during week 1 of his intern year and captures how the patient's attitude and behaviour directly affects the ability of the junior doctor to show how they care for the patient. In his reflection, Nathan is conscious of his feelings towards the patient, his attempt to be professional and his inability to 'feel compassion'. The patient's hostility becomes a major barrier to expressing compassion.

In her journal entries, Mary describes her worst patient as follows:

*Worst patient I've had is probably this drunk who threatened to rape the female staff and swore and threw punches and refused*

*treatment...I handed him over to another intern, a male one because like hell I was going to stay around to be abused like that.*

The level of aggression, verbal abuse and potential violence resulted in an immediate distancing from the patient by the intern. Her language reflects her disdain; when she describes the patient as 'this drunk', his symptoms, diagnosis and treatment become secondary. The opportunity for compassion is totally derailed by the patient's behaviour and the novice doctor's inability to personally, or professionally, influence and control the situation or curtail the patient's aggressive behaviour. This is despite Australian health systems actively promoting a zero tolerance of aggressive behaviour in hospitals. The fragmented nature of care which ensues when confronted by aggression is again the topic of concern for Paul when he journals:

*He came into ED and was being seen for an infected lesion... but was completely belligerent and aggressive towards me. Swearing up a 'blue streak', he was much more friendly to the female nurse than to me. After attempting to take a history from him, which failed miserably and ended in him telling me to fuck off, I went to go and speak to my consultant about what I knew so far and an initial plan including getting a collateral history. I was gone only two minutes and when I went back, he wasn't breathing...*

For Paul, the patient's behaviour not only restricted his ability to engage compassionately with the patient but also made it difficult for him to take a history and make a diagnosis.

When the patient responds in a way in which the junior doctor perceives contrary to their expectation, it has an immediate impact on the way in which the novice doctor delivers care. Neel writes:

*the situations in which acts or words of kindness by doctors (myself included) are simply met with apathy or negative sentiment, are the occasions where I sometimes feel that patients simply do not deserve any 'extra' care beyond the minimum of taking a medical history, examining them, admitting them as inpatients, prescribing drugs etc.*

A constant thread recurring through the interns' reflections is the belief that, if the patient's behaviour is perceived to be inappropriate, then they are less deserving of 'extra' care. Compassion appears to be an optional adjunct to their role with medical knowledge, clinical reasoning and procedural skills determining their core competencies as a good doctor.

#### 6.3.2.4.2 Likeability

*I've found myself saying more and more often, 'I don't like Mr [insert name]'.*

*(Intern Mary)*

Liking, or not liking, their patient was also a persuasive emotion throughout the texts which profoundly influenced the way in which the interns responded to the patients' needs. It is however, a complex construct since it may not necessarily be the patient they dislike. In the case of the opening quote, it was the feelings of inadequacy the patient engendered in them which the intern disliked.

The interns' narratives are complex with a range of factors both consciously, and unconsciously, contributing to an overall determination as to whether the patient is deserving of their compassion. Being likeable is a welcome attribute. Interns are more forgiving if the patient is likeable and liking a patient appears to transcend all other factors which may normally deny them compassion, Nathan described giving a little extra time to an elderly lady he felt was isolated and sad, writing 'I came to like her a lot'.

The behaviour of the patient appears to be a defining factor in influencing whether the doctor finds the patient likeable or not, an emotion which then has a compounding influence on an assessment as to whether the patient (and by extension their family) are deserving of compassionate care, not liking the patient patently eroding the doctor's willingness to care compassionately. This is evident in the quotes below:

*I can recognise now that because I didn't particularly like the patient and his wife, I probably would have offered sub-standard care to them had he actually needed medical care.*

*(Intern Bill)*

*Equally though, ED puts you more frequently in contact with people unlikely to inspire any sort of sympathy or liking.*

*(Intern Phoebe)*

Not liking the patient or their behaviour creates enormous dissonance as illustrated in the following quote:

*One night shift I saw three young and healthy men with colds. The last one was 19, had a cold 2 weeks ago and kept giggling about how I was a doctor and really smart. I'm still not sure why that was funny. I came very close to shouting at him. I may also have found myself placing sutures in the head of inebriated gentleman who probably wasn't completely anaesthetised. I probably would have given the 2nd dose a miss even if he wasn't inebriated and even if he wasn't an inappropriate douche bag given that there was only one suture remaining. However, I very much don't like the feeling this situation gave me when considered in retrospect.*

*(Intern Phoebe)*

Bill writes:

*I really just had to pretend to care about the patient and his wife in this case. I can understand the stress they must be under with his medical problems and the fact that his wife can't take any more time off work. However, a hospital is not a hostel for patients to stay without a reason, and I was actually resentful to them for treating it as such.*

Bill's reflection highlights two key elements underpinning this difficult dynamic: the perceived exploitation of the hospital for a non-medical problem and the knowledge that he doesn't like the patient or his wife. Fabricating a caring facade is a strategy Bill uses to ensure his identity as a 'good' doctor remains intact.

For the participating interns in my study, the realisation that not all patients are likeable takes them by surprise and creates a high level of conflict, dissonance and cynicism in their approach to patient care. This outcome, can be compounded by their existing feelings of incompetence and low levels of confidence (which are to be expected at this stage of their career), creating an



additional tension for the novice doctor and further adding to their sense of isolation and uncertainty.

#### 6.3.2.4.3 Self-inflicted

Judging the patient as responsible for their own ill health has dire consequences in the provision of care as shown here:

*This is another one of those cases where I have to keep my own frustrations in check to provide appropriate patient care. I'm of the mind that it was kind of the patient's own fault for getting so fat that she can't fit through her doorway anymore, so why should we have to spend our time sorting out her living arrangements. But that's not the way the hospital system works I suppose. I've really just had to grin and bear it with this situation, and that's as compassionate as I'll get.*

*(Intern Bill)*

Without the patient's social and medical history it is difficult to ascertain what contributed to the patient's health problem. However, the intern is quick to judge. Not only does he judge the patient as responsible for their weight problem, in his telling of the patient's story he de-medicalises their problem: 'not being able to fit through her doorway' creates an access problem. The problem is now about the patient's living arrangement, perceived by the intern to be outside his scope of practice as a doctor, and a belief which then allows him to ascribe the patient as undeserving. The intern's judgement is twofold: she brought the condition upon herself, and her problem does not fit the biomedical model of patient care.

Grace's narrative highlights how both medical management and compassionate care are influenced by the perception of blame. Her narrative illustrates how a mental health (MH) patient who had self-harmed was perceived by her medical peers as being responsible for the consequences of her behaviour and therefore only had herself to blame.

*Everything is that little bit harder for MH patients but I don't think we were very well equipped for it... I just always felt there was one girl going on 16 and she had issues of self harm, and the surgeons said no you have had too many surgeries we won't operate any more, she had*

*a big abscess on her abdomen from swallowing razor blades um and she was just very unwell and had a lot of pain and it was going to be chronic pain with her um but I felt she was way to unwell to go home. My consultant came over and said no that's it out you go, too bad, no one is going to touch you anyway, off you go home. I felt awful about her going home, but there was nothing I could do, as it was the consultant's call. And it's not her fault, and she's saying it's not my fault that I am so unwell, and he's saying yeah, you caused it all, you knew what would happen but I think it is just the most unfair situation, watching her sit there and cry. And um, she said I didn't know that I would be this unwell and need surgery and now to be blames, she's going to die. But this all stems from sexual abuse as a child . I think certain people have lower tolerance for these sort of things. There is still a lot of stigma attached um especially with self-harming patients and personality disorders, it is really difficult. And I know some people that if someone with a personality disorder walked into the department , they say this person has a personality disorder don't waste too much time on them. Just get them sorted...*

*(Intern Grace)*

#### 6.3.2.4.4 Perceived Ignorance

Further adding to the complexity of giving or withholding compassionate care is the perceived ignorance the patient has of their situation (injury, illness, medication), a perception which appears to reinforce the novice doctor's feelings of frustration and uncertainty and decreasing their likelihood to express compassion, as evident in the following quote:

*One of the largest frustrations I'm having is people not knowing their own health status. When I ask what I think are simple questions from younger, competent people like, 'do you know what medications you're taking?' and they answer, 'I dunno – a couple of pills, but I'm not sure... one's blue and one's white.' I'm STUNNED!!! How are you taking pills and not know what they are for?*

*(Intern Paul)*

#### 6.3.2.4.5 Perceived Exploitation

After reflection on an interaction with an aggressive patient whom he perceived to be exploitative, Bill wrote:

*I'm pushing to get this patient out of hospital as soon as possible. He is an absolute drain on our resources and my time. I actually don't really care where he goes, just so long as it's out of hospital. This makes me uncompassionate, but it doesn't really bother me. He'll be back as soon as there is something else wrong with him.*

*(Intern Bill)*

Intern Bill's dislike of the patient and his behaviour is embedded within the context of limited resources and constant time constraints: themes which are consistently raised throughout the intern reflections. The notion of resources is closely tied to the perception of the patients exploiting the system for 'nuisance' complaints or for non-medical, self-inflicted complaints.

The low acuity of the patient's complaint was a source of frustration for Mary, again reflecting the hierarchy of care, when she wrote:

*I think we can talk about patient-centric care and being compassionate doctors all we want, but when you're faced with patients who'll get angry at you because they've had to wait to be seen for their left arm tingling that's been there for a year, it's hard. Especially when you've just come from seeing a patient who's got an aortic rupture.*

*(Intern Mary)*

Patients can be perceived by the intern to be exploiting the system for a number of reasons as illustrated below:

*The worst thing about Emergency is how many patients don't need actual emergent management. How many people come in to Emergency just wanting a bed for the night or food? The people who waste time and money and bed space because they want a day off from work. Who come in with a problem they've had for ages because they're unhappy with how they've been looked after by a GP.*

*(Intern Phoebe)*

The intern is quick to judge the patient who visits the Emergency Department for what they consider is a waste of time - a bed for the night, or food – failing to recognise that these are, in fact, the most basic necessities of human care or acknowledging the broader social disadvantage which may have contributed to the patients circumstances. This judgement contrasts sharply with an opinion piece written by more experienced emergency care physicians. When viewing these concerns in the context of escalating fiscal pressures and financial austerity, O'Reilly et al (2003) wrote: 'For people at the margins of society, the local ED can be a place of solace... The ED provides 24-hour access and thankfully, can refuse admission to nobody. For many people it serves as a refuge, a source of basic comforts and basic human values. It becomes their family... One could imagine a situation in which hospitals might adjust the 'loneliness score' or manipulate the 'compassion index' to maximise income. But the service that is being provided is one of human kindness and compassion — the basis of a civilised society. This human aspect of medical care should be acknowledged and celebrated, rather than measured.' (O'Reilly, Mori and Cameron , 2003, p. 649-650).

For the interns, their constant negatively framed preconceptions colour how they deliver the care they ration. Psychological wellbeing, including mild anxiety to severe depression, is trivialised as an insignificant health problem by some of the participating interns and their extended teams. This is illustrated below in the following intern journal entry:

*'I still struggle at times to put aside preconceptions e.g. in chronic pain. We all joke about psych issues or trivial complaints, but we are just doing what anyone needs to do to get the job done*

*And there are certain illnesses with stigmas attached to them like chronic pain, like chronic fatigue, like fibromyalgia. Um even unfortunately depression and anxiety.*

*... automatically before you have even met the person have that preconceived idea who that type of patient is before you even go and see them*

*(Intern Grace)*

Intern Grace writes of her preconceptions despite mental health being widely recognised for its enormous emotional toll on society as a whole, including doctors and their own wellbeing (beyondblue, 2013).

#### 6.3.2.4.6 Visibility and Severity

*Also with these two patients I could highlight another point – The visibility and severity of illness. The young man was visibly ill and I knew from his history that he was at risk of dying from his illness, in contrast to the old lady who was not obviously ill and I could find no firm diagnosis. Although the lady was more concerned than the young man I felt more compassion for the more sick patient. I think perhaps the more severe the illness the more compassion I have.*

*(Intern Nathan)*

Nathan's reflection is interesting, especially in the context of a novice doctor, whose clinically reasoning is unsophisticated and risky. An inability to ascertain a diagnosis, and an absence of obvious signs of illness or disease are very superficial indicators of patient acuity. Yet, these assumptions underpin and hinder his reasoning, and determine the level of compassion he shows towards the patient.

*I think it is just one of those things that people come in with and they have got poor education and they have chronic pain issues which are difficult to deal with. So they come in for the 5<sup>th</sup> time to emergency with the same pain but it's gotten worse um, but they haven't been going to their physio appointment or haven't been taking their regular medication, it's frustrating. Expecting an immediate cure for a pain that's been going on for 10 years.*

*(Intern Grace)*

Similarly, as this reflection illustrates, patient acuity and non-compliance can collude to create a patient profile which is perceived as less deserving of compassion. The patient in this reflection, portrayed as having a chronic condition for which they have been non-compliant due to their non-attendance at their physiotherapy appointment and/or not taking their medication. Non-

compliance categorises them as less worthy of compassion despite the intern not knowing the reasons why the patient was non-compliant. Each contributing factor acts to increase the perception of the intern that the patients is undeserving of compassionate care, one attribute or action being layered upon the next.

Existing research suggests that, for most aspiring medical students their motivation in undertaking medicine is shaped by the desire to help others, with an expectation of positive interactions underpinning their engagement with patients (Arnetz, 2001) (Wallace and Lemaire, 2007). Likewise, connecting with patients and developing satisfying doctor–patient relationships, which are perceived to contribute to making a positive difference in the patients life, are also considered key predictors of a doctor’s own well-being (Wallace and Lemaire, 2007) (Horowitz et al., 2003). Research undertaken by McCue (1982) et al, highlights the obvious contradictions for medical students’ experiences which become evident when their chosen career consists of routinely interacting with persons who are ‘anxious, uncomfortable, and often unable to express gratitude or affection ... as the social graces that ordinarily make human interactions enjoyable are stripped away by sickness and pain... with fear and pain increasing the intensity of this interaction’ (McCue, 1982, p. 459). This thesis asserts that when this crucial dynamic between the patient and doctor is disrupted by the behaviour of the patient, the novice doctor’s journey, rather than unfolding with a planned trajectory, unravels untidily, creating disharmony not only for the individual doctor and their identity, but also potentially for the collective profession.

Within the literature it’s recognised that, for every physician, there will be a time when they personally and professionally clash with a specific patient (Groves, 1978) (Lentz, 2012). Conflict is to be expected, and, set within the broader spectrum of human relationships, it would be remarkable if this wasn’t the case. More subtle however is the acknowledgement that there will be a patient who clashes with all care providers: the difficult, or as Grant (1980) termed, the ‘hateful’ patient. What is unique in my study is the way in which this concept has morphed from the notion of the individual patient who is difficult, to language which ascribes these attributes to a sub-population of patients ‘en masse’.

This construct plays out in the interns' narrated reflection in the way in which they refer to the individual patient as the collective 'the patients' and as a population who are 'demanding' further contributing to the intern's inability to freely express compassion

*Of course it is free and so unfortunately it attracts a rather demanding clientele who can't or won't pay for services. I saw so many people in the first few days who came walking in with 10/10 pain and refusing to purchase their own scripts as well as an equal number of people with nothing more serious wrong with them than a minor cold. I became sick of investing energy into them than (sic) wasn't rewarded with a diagnosis or resolution and cynical about finding anything wrong with them.*

*(Intern Phoebe)*

*As I'm approaching the end of my Emergency rotation, I find myself becoming more and more jaded with people – patients specifically... I'm not sure if it's just the patient population around here...*

*(Intern Paul)*

While each patient may not individually have all the issues or traits identified by the interns, when evident, either in isolation or together, they appear to overwhelm the novice doctors' perception of the patient and, whether conflated and/or distorted, appear to have a dramatic impact on the ability of the novice doctor to provide compassionate care. Depending on the context of the situation, it may be the family or friend 'advocating' for the patient who poses the threat, especially when extended family, friends, carers or guardians threaten legal action.

For the interns, the perceived undesirable behaviour of the 'difficult patient' has severely blunted their ability to respond in a compassionate way to the patient (and their family). Their reflective journals reveal a desire for the intern to retreat from contact with the patient, wanting to avoid engaging with them or their family. They write about feeling angry, frustrated and impatient.

Unique within this study is the finding that, within the group of patients judged as 'difficult', the perception of being demanding, exploitative patients resulted

in the interns becoming cynical in their approach to patient care and thereby triaged compassion as to whether they thought the patient was deserving or not.

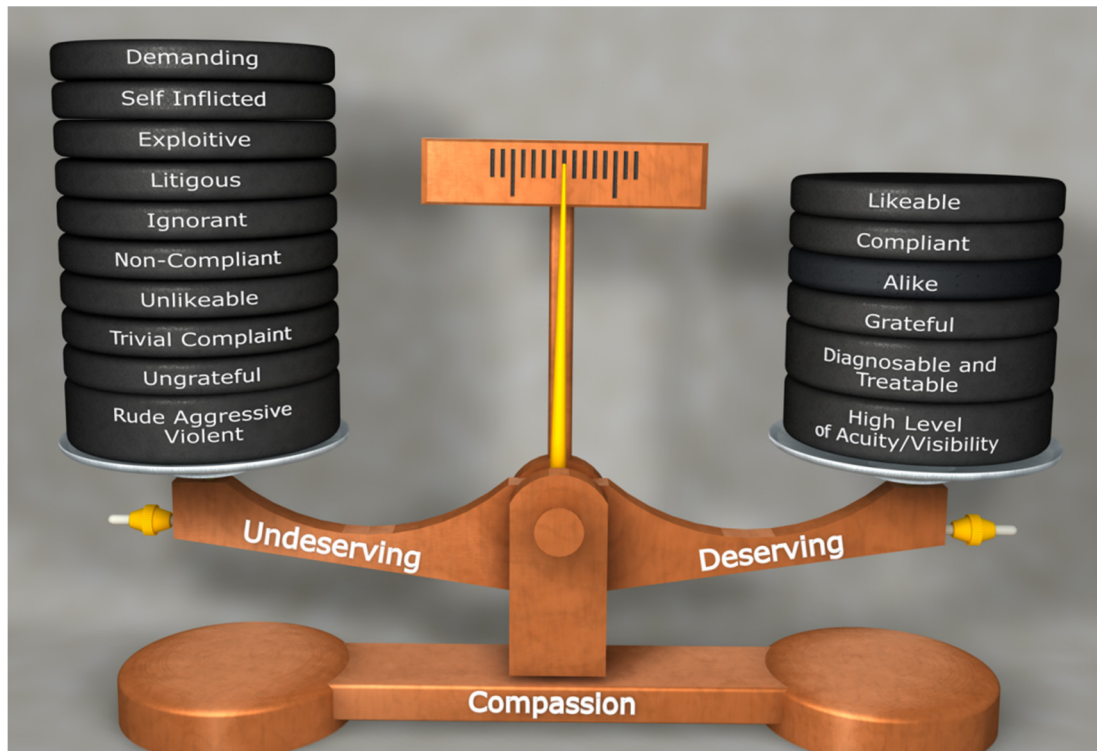


Figure 4 - Triage of Compassionate Care – Conditional Compassion

### 6.3.3 TRANSCENDING IDENTITY - COMMON HUMANITY

In following the interns across twelve months, a shift in their thinking and behaviour becomes evident, opportunistically and over time. In completing their twelve month internship, their growth as reflective practitioners is evident. There is evidence of resilience and empowerment which enables them to reconnect with their original intent to be a compassionate practitioner.

When they are feeling confident and competent, or as they incrementally become more comfortable with their role and identity as a doctor, they are freed up to be more caring for their patients, they refer to the little things – the things which they consider not doing anything – the ‘things’ related to compassionate care. Interestingly, these aspects of care are initially trivialised by the interns, touch, talking and listening are reframed as reified acts of patient management rather than opportunities to engage in a compassionate caring way.



### 6.3.3.1 The Little Things – Listening, Talk, Touch and Time

As the interns grow more confident, experienced and their self-efficacy increases, they become more attuned to the patients' social and emotional needs, and less encumbered by doubts in their ability to express compassion. Their compassionate behaviour is commonly manifested by listening, which affords opportunities for the patient to talk and, through the use of non-clinical touch as illustrated in the following quotes :

*In these two instances I had done very little as there had been very little wrong with them. I didn't find a strange sign and order a cool test or diagnose a weird or wonderful syndrome; I listened. Plain and simple. I'm in this profession because it's interesting and rewarding. The patient is here because they have a problem, however trivial, and they want someone to listen to them and take them seriously.*

*(Intern Grace)*

*I made a point of just saying hello from time to time and having a little chat and this seemed to have some affect.*

*(Intern Nathan)*

Throughout their narrative the interns often underplay the act of listening and yet, it is listening, or letting the patient talk, which is also highlighted in their reflections as being so meaningful to many of the patients' experience of care. Nevertheless, for such a basic act of care it is still only towards the end of their intern year that the interns learn to be comfortable with this aspect of their role.

*So, you know, just giving them a little bit of time, just listening to them and just doing those non-medical things for them... you know, stuff that might not be typically your job, you know? Like, getting them an extra pillow or blanket or something like that... Just little nice things like that or... just make time to be... to listen to their complaints or something like that*

*Prioritising what you're going to do with your time, you know, everyone's got the same amount of time in a day...you can't go back and see everyone for 20 minutes every day or anything, but you sort of pick up on the cues and recognise when something is important to do...*

*some part of it is creating time, so actually just becoming more efficient in your work day, but also just prioritising certain things and realising that this is a thing that's important, maybe more so than other clinical things that are going on at the same time*

*(Intern Nathan)*

*As you get more confident and more capable, those things kind of disappear. And you're left... you start to... the task side of your job becomes easier and you begin to have more of the time and more thoughts towards other parts of your job, I think*

*(Intern Nathan)*

*I think sometimes you just need to decide who needs a bit more of your time. Sometimes people need more time than they need more medical management. Just knowing who those patients are is important.*

*(Intern Grace)*

The interns suggest that this increased confidence and perceived competence and familiarity with their roles allows them to refocus on what could be considered the 'softer' skills. The 'little things' like food, water, blankets and listening, thereby allowing them to care for their patients, rather than simply manage them.

The use of touch is central to many of their reflections:

*One of the consultants there was very good at showing us the use of touch. Some people really steered away from it. (I) tried to see where it is appropriate. Um. Especially with the little old ladies, it's always nice, sometimes they just want to hold your hand while they have a little talk. Um... one of the consultants there was incredible. Um. And she was really concerned with comfort things most important for the patients. So, just little things like extra blankets, positioning on the bed for comfort.*

*(Intern Grace)*

It is evident from the interns narrative that the use of touch is closely bound by both gender and age.

*I definitely feel a lot more comfortable doing it – sitting on people's beds, you know, putting a hand, like, resting a hand on their leg, giving them a pat on the thigh or a pat on the back or a squeeze of the hand... it's... I feel very comfortable doing that now.*

*(Intern Paul)*

*I wouldn't say I hug anyone... like, just taking their pulse and at the same time, just sort of holding their hand a little bit. Yeah, using two hands to take your pulse, I think that's quite nice, so you're not just purely touching them emotionally, there's sort of a medical reason why you're doing it; at the same time, you're sort of making a bit of a connection there, I suppose.*

*(Intern Trevor)*

Clinical management provides a safe avenue and legitimises the action as within the acceptable scope of the doctor-patient relationship.

*I certainly tried to see where it's appropriate, especially with the little old ladies in general. It's always nice. Yeah. Sometimes they just want to hold your hand while I have a bit of a talk. They're really sweet.*

*(Intern Grace)*

*You have to hold their hand... to find me the best vein. But quite often, you know, the person grabs your hand, wanting you to hold them. So, like, you're not necessarily trying to... to provide comfort, but that's often what they want, so... so you need to play the role! Because you can see what they're looking for. And really, you're happy to just turn over their hand and find a vein. While engaging with the person as a person otherwise, but yeah, it's interesting to see... you read how the person feels and sometimes, you know, even old guys, you know, you shake their hand but they're just feeling unsure and they just want you to hold on, so you just... you know, in a very manly way, you hold their hand, so... it's incredibly nuanced for the new and naïve.*

*(Intern Trevor)*

*I have been making physical contact with patients (patting on the shoulder) - to elderly patients especially, but in the ED, this has now been extended to pregnant women who get a diagnosis of miscarriage/threatened miscarriage (to cheer them up), as well as male teenagers/young male adult patients (makes me feel momentarily like a big brother to them!).*

*(Intern Neel)*

The last two quotes illustrate how nuanced the use of touch can be, crossing the boundaries from doctor to patient, to, person to person. The latter quote could be interpreted by the patient in a paternalistic sense, but the narrating intern represents his fraternal behaviour as a caring act.

In concluding the thematic analysis, two journal entries capture the complexity of learning in practice.

For Mary, her final journal entry illustrates how the everyday demands of the role continued to intrude on her desire to be compassionate. As she finished the year she reflected on the relevance and meaning of caring in a compassionate way:

*Compassion tends to be the first emotion ditched when I'm busy. Intellectually, I know I should care about what the patients and their families are going through but it's just easier not to because there's no time. Got to get that cannula in. Get those bloods sent off. Get the referral done. Get imaging forms in. I was filling out the care of the dying pathway form and I realised I hadn't even SPOKEN to the patient or his family. But I just didn't care. Until now ...*

*(Intern Mary)*

In his final journal entry for the year, Nathan captures the essence of many of the inter-related themes referred to across the interns' narrative and subsequent analysis. He writes how, initially focused on developing his identity as a doctor, he crafted a professional persona which created boundaries and a power differential within the 'doctor patient relationship', emphasising difference rather than sameness.

*After a year of working I feel I have reached a conclusion regarding compassion. The term 'doctor-patient relationship' is a term which*

*reminds us to consider themes like duty, confidentiality, boundaries, power differential and illness. But I feel this term detracts from the real relationship which is a human-human interaction. I think generally people have a natural ability for compassion but are distracted by a professional persona which seems appropriate at the time. If someone's family member were ill compassion would not be a problem, and that is how we should see medicine; as being a stranger invited into a privileged position within a patient's family to assist them through difficult times. The primary consideration in all patient care should be to act humanely. We do not get to choose who we will need to care for, and we must remember that patients are sick, scared and away from home. Whatever our personal feeling regarding a patient they all deserve compassion from their doctor.*

*(Intern Nathan)*

What is learned after a year embedded in practice is that the doctor-patient relationship, above all else, is a human to human relationship, where boundaries transcend both the personal and professional.

## 6.4 DISCUSSION AND MODEL OF LEARNING TO BE COMPASSIONATE THROUGH PRACTICE

In drawing together commonalities across the individual narratives, the thematic analysis, as a collective narrative, illuminates for the reader how the complex interplay between the novice doctors' expectations and aspirations unfolds as they transition from the periphery, to fuller practice. Thus, the emergent themes, constructed through the lens of compassionate care, capture the relational nature of the novice doctors' learning through engagement in practice.

Their collective voice tells a story of the competing tensions which confront them. Aspiring to the idealised notion of the perfect doctor, when feeling emotionally overwhelmed, uncertain, imperfect - fearing failure - and confronted with competing priorities, the interns initially compromise, reframe and reify their role to a more reductionist function focused on clinical competency.

Struggling with their own and their patients' emotional demands, they develop protective barriers, creating a distance between themselves and their patients, while aligning themselves with their colleagues. Engagement and connection with their peers, colleagues and patients are key features of their journey as interns.

Self-efficacy, their self-perception of how well they are achieving in their role, is shaped by several key factors. According to Bandura (2001, p. 10), self-efficacy is a powerful determinant of behaviour as it influences 'what challenges to undertake, how much effort to expend in the endeavour, how long to persevere in the face of obstacles and failures, and whether failures are motivating or demoralizing. For the interns in this study, their own perceived success or failure in expressing compassion is a major enabler or inhibitor in how they learn to express compassion care in their developing role. The observation of other doctors as highly influential role models, in their practice of compassion, or their lack of compassion in practice, is also a significant influence. The consequences of their own, and or others behaviours, either negative or positive, alongside the feedback they receive from others were major influences on how they felt and how they acted towards their patients.

Foregrounding the individual's cognition, self-efficacy provides us with a window of understanding into the interplay between emotion and cognition in constructing a doctor's identity. For the interns in this study, sociocultural expectations and the relational connection and engagement with other people, provide a feedback loop which shapes the way in which the doctor expresses compassion.

Self-efficacy is also closely aligned with their desire to survive psychologically. As interns they grappled with their personal and professional identities as they confronted both the day to day reality of patient suffering and the, at times, hostile reception of their colleagues, all encountered within the confines of a system driven by time and cost efficiencies.

Narveaz's (2014) studies in moral development provide a useful lens in understanding how each of the themes converge to influence the expression of compassion. Narveaz (2014) suggests that, when a child (or adult) is feeling

insecure, he or she is more likely to view the world as an unsafe place. The consequence being they adopt a 'safety ethic' where the need for self-protection transcends their prosocial emotions and behaviours; their 'prosocial ethic'. Narveaz (2014) suggests the person may enact this safety ethic by becoming defensive and belligerent towards others when feeling insecure. At the other end of the spectrum they may act submissively or passively, as a protective measure for self-preservation. Extending Narveaz's (2014) research on the 'safety ethic', Brown (2012), in her work on shame, suggests compassion is not our default mechanism, suggesting instead that self-protection is the more dominant paradigm. de Zulueta (de Zulueta, 2013) also writes about a similar mechanism, describing how when survival (in the context of this study, the interns' identity as a doctor) is under threat we narrow our focus resulting in a diminished ability to be kind and caring (de Zulueta, 2013).

In exploring these concepts in the context of school students, Zakrzewski (2015) suggests we cannot cultivate emotional intelligence in the absence of a moral rudder. She suggests that in order to cultivate a pro-social ethic for ourselves and others we need to encourage self-reflection and self-awareness (Zakrzewski, 2015). She provides an example where, when she finds herself being less compassionate, she analyses her thoughts and emotional response, asking herself: Am I in a rush? Do I feel the person deserved their suffering? Am I overwhelmed by my own emotional situation? Do I feel more powerful than the person needing help? Do I feel safe? She then reflects on how she can reframe her thinking and behaviour.

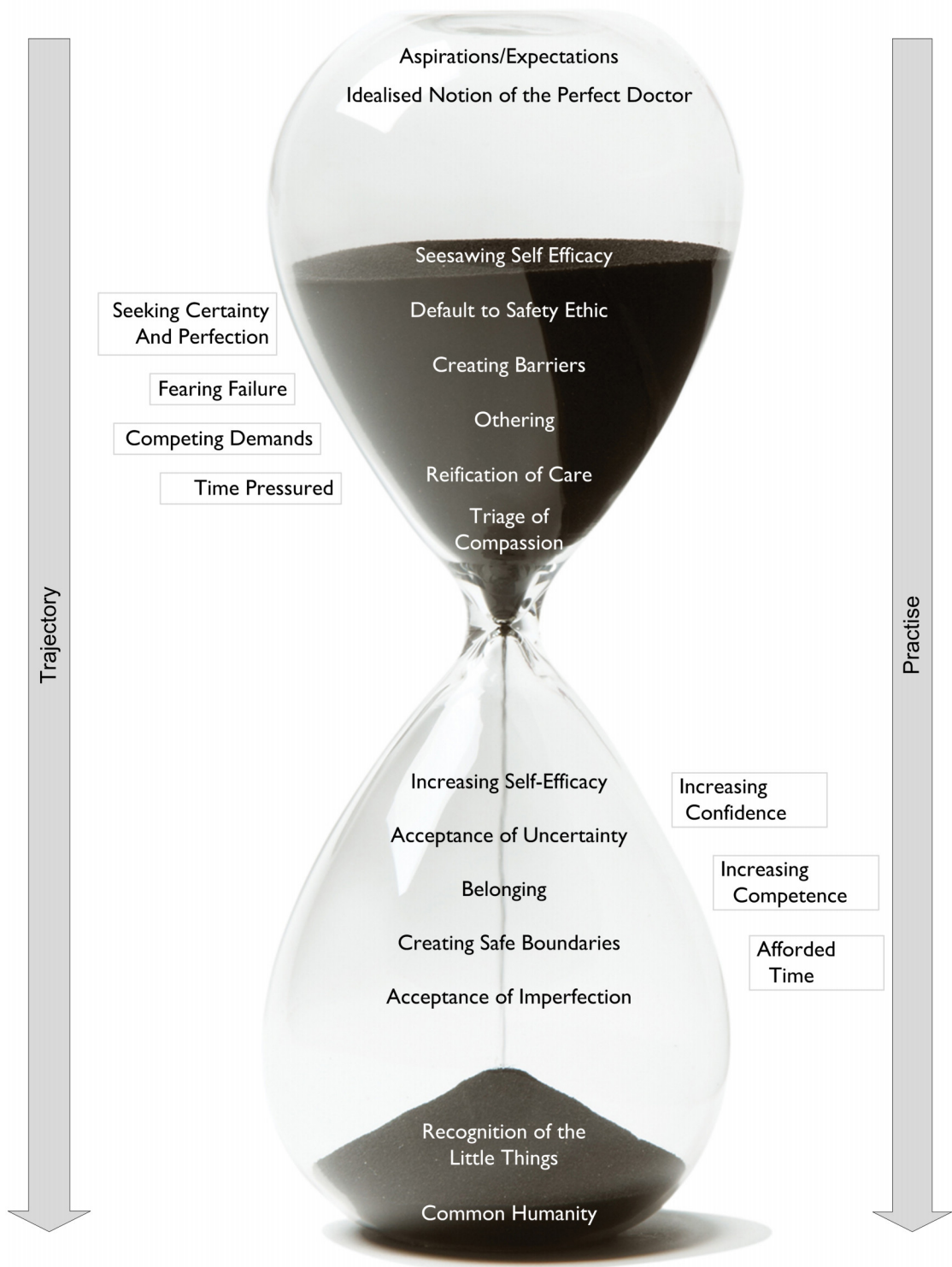
The questions Zakrzewski (2015) raises resonate strongly with the experiences of the interns and closely align with the themes identified in their narrative. Entering their clinical practice, the interns feel unsafe and uncertain. They are overwhelmed by their emotional response. Their expectation and aspirations, for themselves and others, and others' expectations of themselves, are idealistic and unrealistic. They are ill-prepared, inexperienced, self-doubting, and time-short. Their patients' needs are intellectually and emotionally challenging. The stakes are high, a mistake can literally lead to life or death outcomes. They become risk averse. A whole host of protective

behaviours then ensue which initially result in a diminished capacity for the interns to express compassion for others.

The key themes and sub-themes which were found to be common to each of the interns' narratives are illustrated in Figure 5.



Compassion Pro-Social Moral Emotion



**Figure 5 – Compassion in Practice**

The hour glass acts metaphorically as a conduit for the passage of time and the acquisition of wisdom from experience, as reflected in the following quote, often attributed to Machievelli, but believed to originate from Richter in the 18<sup>th</sup>

century, (O'Toole, n.d.), 'the more sand has escaped from the hourglass of our life, the clearer we should see through it'. For the interns in this study, emotional vulnerability initially clouds their thinking and feelings. The interns enter practice with high ideals and expectations, expansive views which are represented by the breadth of the glass. In seeking perfection and certainty and fearing failure in a time pressured environment, the competing demands become influential inhibitors to compassionate care. These inhibiting factors create a seesawing self-efficacy which subsequently narrows their scope of practice and acts as a catalyst to their defaulting to the safety ethic of survival; as illustrated by the narrowing of the hourglass. The narrowest point in the shape of the glass representing constricted practice. In a struggle for survival and as their expression of compassion becomes conditional they reify compassionate care as patient management.

Significantly though, with practice and time, for most in this study their self-efficacy improves, providing an increased sense of confidence and competence, affording them more time to provide compassionate care. Their practice expands as does the way in which they provide care. They reconnect with their original aspirations, learn to be more accepting of imperfection and uncertainty and embrace our common humanity, allowing them the time to refocus on the 'little things' as an expression of their compassionate care.

The passage of time, and learning embedded in practice, is a major influence on how the doctors provide care. However, the doctor's self-efficacy is fragile. When challenged in practice, the doctor's self-efficacy can be easily destabilised – analogous to the hourglass being inverted. The doctor's thoughts, feeling and actions again become clouded. Feeling vulnerable, they readily default to the safety ethic of self protection. Responding to the needs of patients who the interns perceive as undeserving continues to trigger this sense of vulnerability. The novice doctor's inexperience in not knowing how to respond when these patients affront their sense of identity continues to be a trigger to their default back to the safety ethic, narrowing their scope of practice.

In my study, the passage of sand in the hour-glass is in a state of flux dependent on the emotional vulnerability of the individual intern. The amount of time it takes for each intern to reach the point of common humanity is dependent on their individual learning and their practice context. For some, it is quicker than others. Some take the full year. Some switch back and forth, and one is yet to reach this point. With respect to the latter, one could question whether they will ever reach it and the consequences of that outcome.

Their ability to return to their original aspiration to be a compassionate, caring doctor, is dependent on both self-awareness and self-understanding. Without understanding the nature of these influential dynamics, interns may remain captive to a repetitive and destructive cycle of diminished self-efficacy and self-criticism, detrimental to both themselves and the patients for whom they care; a constant inverting of the hour-glass where they become stuck in the default for survival.

The model illustrates diagrammatically the influence enabling and inhibiting factors have on how a novice doctor learns 'to be' compassionate in practice. While the influences are neither binary or linear, the model provides a way of understanding the complex interplay between individual meaning making and the sociocultural context of practice. The model illustrates how each of the collective themes shed light on how novice doctors learn to be compassionate as they enter their community of practice, endowed with the title of doctor. The model demonstrates how a complex social construct - identity - with all its incumbent societal expectations and individual aspirations, enmeshed with a fragile self-efficacy, shapes the novice transitioning from the periphery of practice on an inbound and eventually insider trajectory.

#### 6.4.1 KEY FINDINGS

The interns' narratives capture the thoughts, feelings and emotions which impact on their expression of compassion while engaged in a complex community of practice. In summary, the thematic analysis illuminated the following key themes which shed light and build understanding of novice doctors learning to be compassionate in practice, as follows:

#### **6.4.1.1 Ill-Prepared – Emotionally and Clinically**

The interns felt ill-prepared for their role. Due to their ill-preparedness for the emotional demands of their role – both their own and their patients’– the interns felt emotionally vulnerable triggering a default from the pro-social moral emotion of compassion to a safety ethic where to survive they reduced whole patient care of, and for the patient, to a more narrowly defined patient management function. This was compounded by system demands and time pressures which, for the novice doctor, created a further cognitive distraction from their caring role.

#### **6.4.1.2 Distancing Emotion**

Reflecting the unwritten rules of their community of practice – the hidden curriculum – which continues to promote detached concern, the interns preferred to ‘act on the side of coldness’ rather than to be seen as too emotional. This triggered a range of protective behaviours as they built a protective armoury, erecting reactive barriers around emotion and patient engagement.

#### **6.4.1.3 Seeking Perfection – Fearing Failure**

Identity, and the interns’ unmet expectations and aspirations based on an idealised notion of perfection – the perfect doctor, perfect knowledge and perfect patient – compounded the overwhelming sense of uncertainty they confronted in undertaking their role. They feared failure, which resulted in a further narrowing of their scope of practice to clinical competencies for which they are assessed.

#### **6.4.1.4 Seesawing Self-efficacy**

The interns’ self-efficacy had a major influence on how they delivered care. Their own perceived success or failures, in addition to the consequences of observing their peers and colleagues as both positive and negative role models, all contributed to how they learned to care. Feedback from peers, senior colleagues and patients was central to their ongoing confidence and

competence creating a seesawing effect, where positive or negative feedback created an emotional rollercoaster heightening their vulnerability. This was compounded by their inability to hide their emotional response to their role, at times 'wanting to cry and wanting to vomit'. Their emotional response, both embodied and visceral, sat uncomfortably with the professional identity they wished to create for themselves as a doctor while meeting their patients' needs.

#### **6.4.1.5 The Triage of Compassionate Care**

Alongside the expectations the interns created for themselves as doctors, they simultaneously held an idealised notion of the 'perfect patient'. This idealised notion of the perfect patient, portrayed the patient as someone likeable, treatable and grateful: a romanticised representation far removed from the reality of day to day practice. Some patients are some of those things, many are not, especially when unwell and feeling stressed and distressed. For the interns the relational nature of their engagement with patients in an environment where they felt time pressure, stressed and uncertain, contradicted this expectation. Contrasting with this idealised notion of the perfect patient, was the patient whose behaviours and attributes were perceived by the interns to manifest in a range of negative ways directly influencing how they provided care. What ensued was a triage of compassionate care where the interns determined whether a patient was deserving or undeserving of their compassion based on the patient's behaviour and demeanour. This was reinforced by an informal hierarchy of care which influenced what the interns prioritised as requiring their immediate attention, with medical needs over-riding emotional needs.

#### **6.4.1.6 Common Humanity – Transcending the Doctor Identity**

As the interns completed their internship, a shift in their thinking and behaviour became evident. There was evidence of resilience and empowerment which enabled them to reconnect with their original intent to be a compassionate practitioner.

Once they felt confident and competent, and as they incrementally became more comfortable with their role and identity as a doctor, they were afforded the time to be more caring for their patients. They referred to the little things – the things which they consider ‘not doing anything’ – the ‘things’ related to compassionate care. Finding a blanket, making sure the patient is not hungry or thirsty – little things – which you do not need to be a doctor to do.

What was learned after a year embedded in practice was that the doctor-patient relationship, above all else, was a human to human relationship, where boundaries transcend both the personal and professional.

### 6.4.1.7 Summary of Enabling and Inhibiting Factors

In undertaking the broader thesis question, I also asked ‘what are the enabling and inhibiting factors which influence the expression of compassion in practice’.

The enabling and inhibiting factors, as discussed in detail in the thematic analysis, are summarised in Table 1. It is important to note, the constructs are dependent on context and thereby may belong in either category dependent on the specifics of the doctor/patient relationship.

Enabling	Inhibiting
Feeling prepared emotionally	Ill-prepared emotionally
Feeling confident	Lacking confidence
Perceived success	Fearing failure/perceived failure
Positive/constructive feedback	Negative feedback/criticism
Accepting imperfection	Seeking perfection
Positive role models	Negative role models
Perception of enough time	Perception of too little time
Perceived competence	Perceived incompetence
Feeling supported	Feeling unsupported
Positive patient engagement	Negative patient engagement
Recognising common humanity	Strong doctor identity
Feeling Valued	Feeling devalued or undervalued
Enhanced self-efficacy	Diminished self-efficacy
Opportunities for safe reflection	Perceiving emotional vulnerability as a weakness
Effective communication	Poor communication
Perception control/influence	Not coping – perceived chaos
Workload under control	Demanding workload
Grateful, accepting patients	Difficult demanding patients

Table 1 – Summary of Enabling and Inhibiting Factors

## CONCLUSIONS

This thesis builds a nuanced understanding of how a cohort of junior doctors learn 'to be' compassionate in transitioning from the medical student to the doctor role embedded within their community of practice during their intern year.

The interns who participated in this study did so because compassion was an attribute they wished to retain, and develop, as core to their personal and professional practice. However, while being compassionate was an attribute they aspired to, their intentions initially became derailed.

The interns' stories not only illustrated how they initially struggled to maintain their compassionate aspirations when confronted with the complexity and competing demands of daily practice but also provided nuanced insights into why they struggled to be compassionate in practice. Their emotional distress formed a dominant discourse woven throughout their narratives. Emotional vulnerability emerged as the over-riding theme to frame their learning trajectory.

The interns' reflections uncover an untold narrative of how emotional vulnerability, underpinned by fear of failure, uncertainty, diminished self-efficacy and risk aversion triggered the safety ethic of the participating interns. This default resulted in their compassion, a prosocial moral emotion, being replaced by a more reductionist approach where patient care is reified as patient management

As young people, the interns' accumulative, transformative experiences created fissures in their worlds, as they confronted death, disease and patient misery - head-on. Their nuanced and complicated behaviours and narrated experiences did not fit neatly into discrete, linear categories. The interns' perceptions shifted over time, illuminating a narrative of growth which builds our understanding of the influence of the enabling and inhibiting factors in how they learn to express compassion in their community of practice. Captured in the novice doctors' collective narrative and thematic analysis is a shared story which adds new understandings to the shaping of the expression of compassion, or at times, the development of cynicism.



The findings from this study closely align with developments in medical education which recognise the primacy of emotion as intimately tied to the development of a doctor's identity (Dornan, 2014) (Girard et al., 1991) (Halpern, 2007) (Marcum, 2008) (Monrouxe and Rees, 2012) (O'Callaghan, 2013) (Riess et al., 2012) (Satterfield and Hughes, 2007) (Shapiro, 2008) (Shapiro, 2011).

To understand why the enabling and inhibiting factors were so influential one needs to explore the broader social context within which the interns practice. The interns' reflections highlight the influential impact of the hidden curriculum - the learning conveyed through the culture of medicine (Fins and Rodríguez del Pozo, 2011) (Gaufberg et al., 2010) (Hafferty and Hafler, 2011) encompassing elements which reflect power and status parcelled in identity. Doctors are expected to respond to patients' emotional needs and to act compassionately, yet they work in a practice and within a medical model which has a high level of discomfort and very nuanced rules, embedded within the hidden curriculum, which frame the expression of emotion. Compounding these factors is an environment where they are being assessed for competence within a culture which frames emotion as 'a corruption of reason to be transcended' ... an illegitimate form of knowledge... (McNaughton, 2013, p. 72) and where the type of competence most valued is that of the unemotional type (Dornan, 2014) (Shapiro, 2011).

This study captures the temporality of the interns' shared journeys and shifting behaviours and actions over time. As they gain experience over their year, their competence and confidence increases. System demands become more familiar and routine, thereby freeing up time, and as they come to the realisation that medicine and uncertainty go hand in hand, the interns become freer to be more compassionate. They recognise the little things such as - a blanket, water, a meal, making time to listen and for talk, and the comfort of touch, as all intrinsic to good care. They come to realise that aspiring to be a good doctor does not have to eclipse being a kind, caring and compassionate human being.

The interns' narratives highlight why and how the feeling of emotional vulnerability can trigger a default from compassion, as a prosocial moral ethic,

to the ethics of safety where compassion is supplanted by self-protective behaviours. The danger is, that this at times unconscious behaviour will erode the motivation for compassionate practice and that coping mechanisms will become ingrained patterns of behaviour at the cost of their own and their patients' future emotional wellbeing. For novice doctors who may not consider compassionate care a priority when they first enter practice this is perhaps an even greater concern.

The collective narrative generated by this study highlights how unreasonable expectations of doctors can be, of themselves and society of them, when translated into everyday practice. It is expected that doctors, including young inexperienced doctors who may have a limited life experience, will deal on a daily basis with patients who are in distress, yet we equip them inadequately with an understanding of how best to respond to emotion, the patients or their own. Compassion, as a prosocial moral emotion (Haidt et al., 2003) is difficult in such a cultural context, since it not only embraces recognising a patient's emotional pain and suffering, but also motivates one to take steps to act on this understanding: it is more than a value or empathetic understanding, it is a practice. According to Gibson (2015), there is a tendency to think of compassion as a superficial kindness. Gibson (2015) asserts that practicing compassion comes with a cost; it requires a preparedness to engage with suffering. For the doctors in this study, this means engaging both with their patients' suffering and their own. This requires both courage and wisdom (Gibson, 2015).

This study highlights how the systemic and cultural pressures toward detachment, efficiency, and productivity continue to collude to inhibit compassionate care. The interns' pervasive perception being that compassion was less an institutional/systemic value than a personal value which they alone aspired to. Importantly the interns needed to feel 'safe' in their role as a competent clinician before they felt comfortable in being a compassionate doctor. Clinical competence afforded protection, implying that compassion is less acceptable in a less clinically competent doctor – further emphasising the distance between doctor identity and common humanity. For the novice doctor, professional identity formation appeared to impede this notion of common humanity, resulting in a shift in the interns' behaviour away from

being patient-centred to being colleague/supervisor-centred. This act of 'othering' reflected in the denial of sameness with vulnerable patients has major repercussions for the expression of compassionate care. This is especially significant in the context of 'difficult' patients who the interns, despite their increased competence and confidence, continued to perceive as undeserving of compassionate care.

Medical education and medical practice frequently fail to overtly provide medical students and doctors safe ways to practice compassionately, ways which allow a doctor to engage compassionately with their patient which do not place their own ongoing emotional wellbeing and professional identity as a doctor, at risk.

The following recommendations seek to redress this both for the individual doctor and their collective practice.

## 8 RECOMMENDATIONS AND IMPLICATIONS FOR FUTURE PRACTICE

In the previous chapter key findings were discussed, from these the following recommendations are suggested. The recommendations extend across the continuum from student to consultant. The changes suggested can be understood and acted on through both individual agency and across teaching and learning within collective practice.

### 8.1 RECOMMENDATIONS FOR NURTURING COMPASSION WITH SELF (INDIVIDUAL AGENCY) – FOR MEDICAL STUDENTS, JUNIOR AND SENIOR DOCTORS

#### 8.1.1 TRANSITIONING TO PRACTICE

- Prior to graduating, take every opportunity you can to spend time in the clinical environment. Spend time becoming familiar with the systems and processes. Despite being on the periphery of practice use every observation as a learning opportunity.

#### 8.1.2 EMOTIONAL VULNERABILITY

- Recognise and accept your own vulnerability as a person.
- Reflect on how you judge yourself – your self-efficacy, self-esteem, and self-worth.
- Develop a deliberate practice of self-awareness, self-understanding, and self-compassion. Consider Neff's (2011) work on the three pillars of self-compassion – kindness, mindfulness and our common humanity.
- Reflect, write, blog, participate and engage in a safe, confidential environment.
- Reflect on how to draw safe boundaries around emotion or as an alternative to reacting with overly protective barriers
- Learn mindfulness through books, audio-visuals, on-line, classes or through one to one counselling.

- If you are struggling emotionally, self-refer to the free, confidential counselling services provided by your employee or university.
- Be wary of identifying your clinical competence as a sole indicator of your worth as a doctor and as a person,
- Question whether your clinical competence must be fully achieved before you feel 'safe' in expressing compassion
- Reflect on what frame of mind you default to, when stressed and emotionally vulnerable or overwhelmed. Extending Zakrzewski's (2015) work, ask yourself:
  - Am I rushing? How am I prioritising my time and competing demands?
  - Do I feel the patient deserved their suffering?
  - Do I consider it my role to decide whether some patients are deserving of compassion and others not?
  - Am I overwhelmed by my own emotional situation, and/or the patients?
  - Do I feel more powerful than the patient needing help?
  - Do I feel safe in my community of practice?
- Pause and reflect on your thoughts and feelings and on how you can reframe your thinking, and who you can ask for support.
- Reflect on how you are judging yourself.

### 8.1.3 IDENTITY

- Embrace our common humanity, the notion of shared suffering. Recognise that suffering is a part of each of our lives, your patient may be suffering, but so too may you in having to respond to their needs.
- Embrace the notion of imperfection, your own, your patients and medicine as an imperfect science.
- Differentiate between uncertainty and inexperience
- Be aware of wanting to belong, 'othering' and the subsequent triage of compassionate care.
- Consider what qualities and attributes you think constitute a "good doctor"

#### 8.1.4 FEEDBACK AND SUPERVISION

- Seek out positive role models who successfully integrate compassionate care into their practices
- Actively communicate your learning and supervisory needs.
- Actively request feedback and support on what you are doing well and how you could improve.
- When you make a mistake or have a slip in your professionalism, be courageous enough to discuss what happened and why, in a safe place with safe people; support others when they do the same.
- Initiate feedback to peers and colleagues on what they have done well and how their practice could improve.
- Initiate safe discussions on how you and/or others feel emotionally when responding to difficult patient scenarios. Provide opportunities for staff to debrief either formally or informally.
- Give constructive feedback when someone has done well or tried and failed.
- Look for behaviours/systems/processes and communications that work well. Comment constructively and consider ways to extend their reach.

## 8.2 GUIDELINES FOR NURTURING COMPASSION WITHIN PRACTICE (COLLECTIVE AGENCY) – UNIVERSITY, HOSPITAL AND HEALTH DEPARTMENT

### 8.2.1 TRANSITIONING FROM PERIPHERAL TO INBOUND, TO INSIDER TRAJECTORY

- In transitioning to the intern space medical students feel ill-prepared. Models such as the New Zealand model, where final year students undertake what is described as a clinical apprenticeship as a trainee intern, should be encouraged. This approach provides an opportunity for the novice to become familiar with the system – maximising opportunities for engagement - and minimising future cognitive distractions when the medical student commences practice as an intern (Forbes and Bersin, 2011).

## 8.2.2 EMOTIONAL VULNERABILITY

- Encourage an understanding and acceptance of the ethics of imperfection – for ourselves, our patients, our knowledge, for medicine as an imperfect science.
- Medical school faculty and curriculum need to explicitly embrace discussion on the expression of emotion, the patients and their own as doctors and educators. Skills need to be nurtured in emotional regulation (Gross, 2007), as a way of recognising and managing emotions which if left unchecked can become overwhelming.
- The notion of detached concern needs to be challenged, redressed and reframed.
- Discussion should be inclusive of what it means to be compassionate and how it requires both courage and wisdom. It is not easy, requiring both new doctors and experienced doctors to dig deep in recognising their own vulnerability.
- The conversation needs to change. Permission needs to be given to discuss not only how you think but also how you feel in response to the expectations of your role and the care you provide.
- Explicit discussion on how the fear of failure, vulnerability and uncertainty can result in defaulting to the safety ethic need to be held.
- The development and promotion of psychoeducational models that address wellbeing issues in a holistic, collaborative, empowerment framework (Lukens and McFarlane, 2004) need to be encouraged.
- Opportunities need to be provided for students and staff to learn to how to respond through building safe boundaries rather than reacting with rigid barriers.
- Self-compassion, self-awareness and self-understanding should be promoted as practices to be valued and encouraged to create resilience to cynicism.
- Opportunities should be provided to nurture wellbeing for the individual and collective.
- Emotional wellbeing support groups, where staff and students can discuss the emotional impact of care safely, without judgement and with understanding, should be provided. Attendance should be optional, not mandatory, and participation (i.e. attendance at mindfulness, Balint Groups, Schwartz Rounds (Schwartz Center for Compassionate Healthcare in Boston USA), self-compassion groups/therapy), should be valued through performance reviews and

job applications influencing merit based promotions. A culture where actively caring for your own wellbeing is seen as crucial to good patient care should be actively promoted and encouraged

- Misunderstandings and myths regarding connecting and engaging leading to burnout and compassion fatigue need to be addressed as an immediate priority.
- Organised opportunities to practice mindfulness should be developed and promoted. Since 1989, Monash University Medical School has incorporated mindfulness into the core curriculum for medical students. Dr. Craig Hassad has been a pioneer in this field <http://monash.edu/counselling/mindfulness.html>
- Supervising doctors and medical faculty should talk out loud about their feelings.
- Free confidential counselling services for both students and junior/senior doctors who are struggling should be promoted as being part of a healthy culture (or promoted more broadly if already existing).
- In meeting the emotional needs of patients, skills should be developed to address difficult communications beyond 'breaking bad news'. Creating an understanding of the patient in difficulty, or the difficult patient, in the context of 'difficult interactions' in which both patients and doctors are contributors, should be encouraged in conjunction with strategies in how to respond to the needs of these patients.
- When using problem or case based learning, faculty should ensure the scenarios are patient-centred, emphasise whole patient care and provide the patient's back-story. Explicit discussion focused on the emotional response engendered by difficult patients and situations should be formally included in the curriculum or debrief. Discussion acknowledging our imperfections –as doctors, patients and people – and the limitations of science should be nurtured.
- Opportunities should be provided during work hours to attend free counselling, support groups or medical appointments. Mental health leave should be built into awards and entitlements to help prevent burn-out or the development of anxiety and depression. Flexibility in the workforce (number of staff to patient ratio) should allow for this to help negate medical staff ignoring their own health and wellbeing because acquiring leave or taking sick leave is perceived as too difficult or letting the team down.
- Skills in pastoral care should be promoted within the university and hospital teaching and clinical faculty.



### 8.2.3 IDENTITY

- Hold explicit discussions which embrace the notion of our common humanity – transcending them (doctor) and us (patient) mentality – recognising our shared suffering as human beings.
- In teaching and learning initiatives, the role of the doctor needs to extend beyond treating and fixing, to embracing caring and healing.

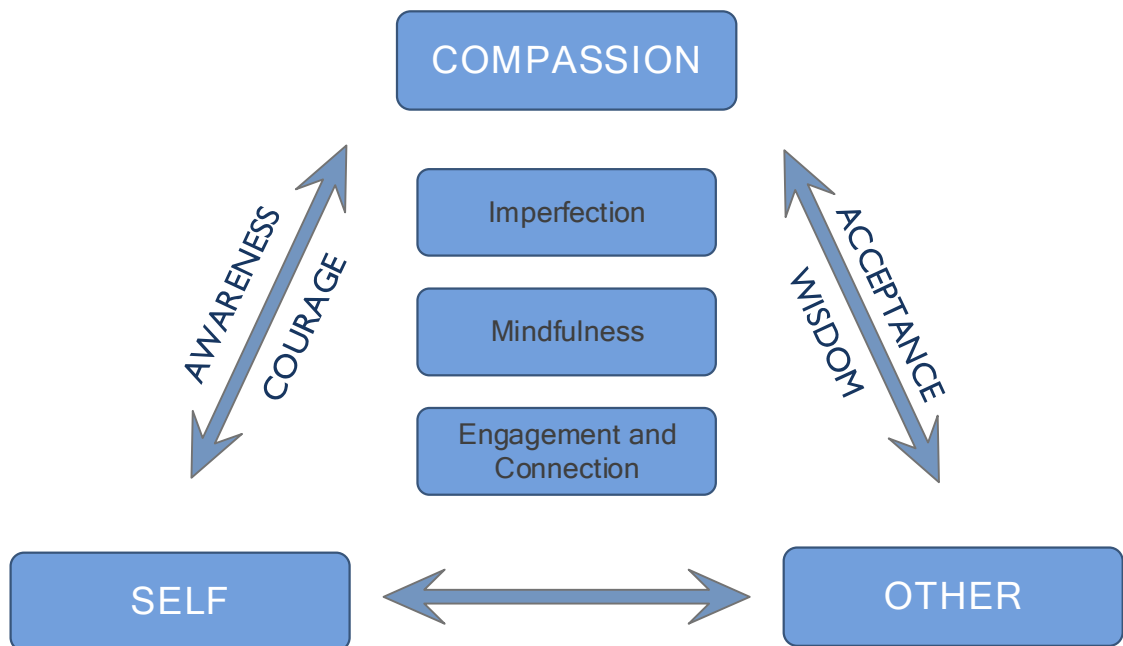
### 8.2.4 FEEDBACK AND SUPERVISION

- Supervising doctors and medical faculty should give constructive feedback, both formally and informally, in and through practice, not just at specific pre-determined dates.
- Communication across teams and individuals needs to be explicit. Novice doctors need close supervision in addressing patients' needs both the physical, social and emotional, especially when working in areas they have a high level of discomfort in or, in which they perceive they may be beyond their scope of practice or level of competency.
- Recognise that each of us, teaching faculty as well as clinicians is being observed as role models.
- Encourage clear communication focused on shared understanding and not solely information transmission.
- Challenge the simplistic binary notion of being either clinical competent or caring – they are not mutually exclusive.
- Safe opportunities to discuss clinical thinking with more experienced colleagues must be provided.
- Staff should be given feedback on their transformative influence as role-models. Ways in which they can and do have influence without increasing their workload should be promoted and openly recognised.
- Appreciative Inquiry (AI) (Cooperrider, Whitney and Stavros, 2008) should be encouraged. AI focuses on how and why the good things happen. Opportunities for appreciate inquiry should be embraced to determine what works well and how it can be duplicated rather than always hearing about the things that are 'broken', emphasising the mistakes that are made. Hearts in Healthcare, a New Zealand organisation co-founded by Robin and Meredith Youngson focuses on the humanising of healthcare, and provides support, training and resources in this field.

- Discussions need to be held regarding the use of time, talk and touch and listening – and establishing safe boundaries.
- Opportunities for safe reflection on near mistakes or mistakes made – acknowledging the need for self-compassion, self- understanding and self- awareness ‘must’ be nurtured.

### 8.3 SUMMARY RECOMMENDATION AND MODEL

In summarising the above recommendations, I have developed a model to assist in explicating the complexity of learning to be self-compassionate in practice. Self-compassion acts as an antidote to self-criticism and as a protective mechanism to assist in preventing compassion fatigue. Self-compassion and the inter-related factors which enable compassionate care, including Neff’s (2011) work on self-compassion, Gibson’s (2015) emphasis on the need for courage and wisdom, and Shapiro’s (2008) promotion of the ethics of imperfection, are illustrated in Figure 6 below:



**Figure 6 - Model Outlining Inter-Related Factors which Nurture Compassion**

When defaulting to the safety ethic, there is a tendency for doctors to blame, shame and judge – both themselves and others. For the doctors in this study, they are critical of the system and at times their colleagues and patients. However, it is for themselves that they reserve their harshest criticism. Self compassion provides a way of reflecting and framing thoughts and feelings

which provides a protective buffer against disproportionate self-criticism. Emotional vulnerability, will always be part of the human condition, but through self-compassion, the doctors can learn ways to accept and act upon their feelings in a safe and caring way.

## CONCLUDING COMMENT

This study does not ask for academics, clinicians, medical educators and health managers to change the curriculum. Instead it asks for each of us to change the culture. Change the culture by changing the conversation. No longer is it good enough to ask 'what do you think?' without also asking 'how do you feel?' Not only in the lecture theatre, but in the surgical theatre. Not only in formal counselling, but over an informal coffee.

Being compassionate is more than a personality trait, or an act, it is also about "how" these actions are performed - as qualities of being, as well as, goal oriented actions – as ways of doing. It is value-based practice in which we need to remain tethered individually, and collectively, across the continuum from student to consultant, doctor and patient as person. One which requires both courage and wisdom.

Following a recent emotional wellbeing support group, I was chatting to a young doctor and recommended Neff's (2011) book on self-compassion, suggesting she be a little less hard on herself. She commented, 'so something else I have to be really good at', the actual antithesis of what self-compassion promotes. It is really important we shift the culture away from aspiring 'to be' something or 'to do' something. We need to nurture a culture which recognises and accepts our imperfection as a foundation on which we build self-compassion as a building block for compassion for others - a recognition of universal suffering and our common humanity.

In providing a lens into how we provide compassionate care, this study, is one small, but very significant, part of a jig-saw puzzle. Without it, the puzzle of patient care, is incomplete.

## LIMITATIONS OF THIS STUDY

Common to all research, this study has a number of limitations or inherent biases.

The process of self-awareness as a researcher is referred to as reflexivity (Begoray and Banister, 2009). What we bring to our research, and your role and responsibilities as a researcher within the subjective context of the co-construction of narrative, is an important aspect of the research process which needs to be both acknowledged and made explicit.

Recognising your motivations and aspirations in undertaking research is important to any study. It's an especially important consideration for qualitative research. Using narrative inquiry as a means for data collection and analysis places even more responsibility on the researcher to be explicit in considering their involvement in the study.

Just as the novice doctor constructs meaning from specific contexts and experiences related to their connectedness with their sociocultural environment, so too am I, as the researcher, on a parallel journey. Reflexivity has facilitated my ongoing critical reflection on how my own biases and assumptions have influenced my research process; providing opportunities to recognise and curtail bias. In my introduction I provided an overview of the influences which drew me to question the expression of compassionate care, including my interests as an educator, my experiences as a professional working in health care, my curiosity as a researcher, and my role as as a consumer of health-care.

However, I acknowledge that, no matter the efforts I make to be inclusive in my research, some aspects of the interns' learning experiences will have escaped my researcher's gaze, and other aspects will have been looked upon with more intensity. Mauthner and Doucet's (2003) research on reflexivity, critiqued by Bishop et al (2011, p. 1285), suggests 'hindsight brings greater insight'. However, it does not provide a portal into the past. As discussed earlier, there is no objective past or true interpretation. Reflexivity provides a mechanism to make my interpretation transparent, not to create an objective certainty.

I have also benefited from the feedback of my supervisors. Having four supervisors has meant I have received their peer review, alternative interpretations and questioning of assumptions. Additionally, I have undertaken a participant validation of the narratives written for each of the interns. However, the intern validated narratives, with a few exceptions, were not formally validated by external confirmation as seeking independent support from patients or supervisors was beyond the scope of this study. Ultimately though, this is a qualitative study, where a singular truth is neither desirable nor possible. Each of us, the intern, the researcher and the reader, will bring our own perspectives which will frame our understandings; these too, may change over time and experience.

Furthermore, the interns who participated in this study may not represent the full diversity of all novice doctors. They obviously valued compassion - yet they struggled. What then for those who do not identify with compassion as a humanistic practice of value for themselves or their patients? Or those who, for a whole range of reasons, did not participate in this study – what of their stories? Exploring the narrative arc of those who chose not to participate could provide further insights into the expression of compassion through practice.

Being an interpretive study, the findings cannot be considered generalisable to all junior doctors. However, transferability of the findings to a similar cohort in a similar context may assist in understanding and supporting their learning and development as doctors and people.

Several alternative narratives could have been developed. Examples including a focus on compassion fatigue or reflective practice. While this thesis touches on these areas, it does not frame its discussion around them as central themes.

This thesis uses constructionism and constructivism as two key learning paradigms in which to interpret the findings. Post-structuralism, which focuses on political context and the influence of power and language, provides an alternative lens in which to view the construction of learning and knowledge (Mann, 2011). While acknowledging the inherent power dynamic between the intern and their supervisor (who may also be their assessor), this study does not attempt to explore the data in this context. Further research using

post-structuralism as the primary interpretive lens, could provide additional insights into the novice doctor's experience of learning to be compassionate through practice.

While embracing the notion of narrative inquiry and storytelling as means of gathering and analysing my data, my primary concern was to capture and do justice to each intern's story. Of course, my interns' stories are incomplete. I am sharing only one part of their story. Their stories will change as they move further along. They may tell them differently, emphasis different aspects, forget parts, embellish others. Storytelling is as much about how, and why, you tell what you tell, just as much as it is about, what you tell. And so, this thesis is written in this spirit of story-telling and I would like to wish 'my' interns well, as their stories develop, change and grow.

And so too has my story changed. In recent weeks I have commenced a new role, joining the School of Medicine, at Notre Dame University, Fremantle, Western Australia. I have spent the last nine years supporting medical students transitioning to the hospital setting as they undertake their intern year as fledgling doctors. My new role contributes to the teaching and learning curriculum (and culture) in the university environment. It's time for me to dig deep and 'walk the talk' of my recommendations ...

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Ethics approval for this longitudinal aspect of the study was approved by the University of Queensland Ethics Committee Oct, 2011. Clearance Number 2011001086.